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

Byron Lamprecht
WPS Government Health Administrators
1000 N 90th Street, Suite 302
Omaha, NE 68114

RE: ***Board Decision* –Medicaid Eligible Days Issues**
Lower Keys Medical Center (Provider No. 10-0150)
FYE 09/30/2019
Case No. 24-0003

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 24-0003*

On **April 20, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2019.

On **October 10, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, the Provider transferred Issues 2, 4 and 5 to Community Health

[1] On January 1, 2026, this issue was withdrawn by the Provider.
[2] On April 11, 2024, this issue was transferred to PRRB Case No. 23-0078GC.
[3] On May 20, 2024, this issue was transferred to PRRB Case No. 22-1006GC.
[4] On May 6, 2024, this issue was transferred to PRRB Case No. 23-0079GC.

groups. The Provider additionally withdrew Issue 1 on **January 1, 2026.** As a result, there is one (1) remaining issue in this appeal: Issue 2 (DSH Payment – Medicaid Eligible Days).

On **October 3, 2023,** the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **October 3, 2023**, the Medicare Contractor requested from the Provider all documentation necessary to resolve Issue 2 (DSH Payment – Medicaid Eligible Days).

On **May 28, 2024**, the Provider timely filed its preliminary position paper.

On **September 4, 2024**, the Medicare Contractor timely filed its preliminary position paper.

On **June 25, 2024**, the Medicare Contractor filed a Jurisdictional Challenge, requesting the dismissal of Issues 1 and 2. The Provider did not file a Jurisdictional Response.

B. Description of Issue 2 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 2 as:

> **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

[5] (Emphasis added).

> of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 16,33,S-D
>
> Estimated Reimbursement Amount: $27,293[6]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[7] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[8]

MAC's Contentions

Issue 2 – DSH Payment – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its 2019 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case

[6] Appeal Request at Issue 2.
[7] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[8] Provider's Preliminary Position Paper at 9.

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

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The MAC filed its Jurisdictional Challenge on June 7, 2023. The Provider did not file a response to the Jurisdictional Challenge.

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue No. 2.

A. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 2 as:

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

[9] *Id*. at 8.

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[10]

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

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

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

[10] Individual Appeal Request, Issue 2.

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[11]

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

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, ***promptly*** forward them to the Board and the opposing party.[14]

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

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

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

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

This appeal was initiated on October 2, 2023 (nearly two and a half years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[15] ***To-date, no listing has been provided—even after the MAC requested the listing***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[16] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board takes administrative notice that it has made similar dismissals in other cases involving CHS providers.[17]

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In summary, the Board hereby dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 24-0003 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/3/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[15] Provider's Preliminary Position Paper at 10.
[16] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[17] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Avenue NW
Washington, DC 20006

RE: ***Board Determination on Disposition of Fully Formed Single Provider CIRP Group AND Request for Expedited Judicial Review***

Case Number: 26-0154GC - Univ of Florida Health CY 2006 Post-Allina II DSH Part C Days CIRP Group

As it relates to:
Shands Jacksonville (Provider Number 10-0001), FYE 06/30/2006

Dear Ms. Webster:

The Provider Reimbursement Review Board (the "Board") is in receipt of correspondence, filed on February 25, 2026, from Ropes & Gray, LLP ("Ropes") requesting that the issue in the subject common issue related party ("CIRP") group be converted to an individual appeal for the sole participant, as well as a simultaneous request for expedited judicial review ("EJR"). A summary of the pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **October 20, 2025**, Ropes filed the "Univ of Florida Health CY 2006 Post-Allina II DSH Part C Days CIRP Group" under Case No. 26-0154GC. The group was formed with the "Direct Add" of Shands Jacksonville (Prov. No. 10-0001) which appealed from its April 21, 2025 Revised Notice of Program Reimbursement ("RNPR").

On **February 25, 2026**, Ropes advised that Case No. 26-0154GC is complete with only a single provider and there are no other providers in the Univ of Florida Health organization that would be appealing RNPRs for the Part C issue for calendar year ("CY") 2006. In addition, Ropes indicated that the Board has already granted EJR for all of Univ of Florida Health's other pre-2014 DSH Part C days appeals, so there are no pending groups with which this case could be consolidated. Therefore, Ropes requested that the Part C issue for Shands Jacksonville be converted to an individual appeal and simultaneously requested EJR.

Board Determination:

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

Board Rule 12.6.1 stipulates that a "CIRP group may be initiated by a single provider under common ownership or control, **but at least two different providers must be in the group upon full formation.**"[1] Further, 42 C.F.R. § 405.1837(b) requires that a group appeal have two or more providers.

After reviewing the facts in this case, the Board agrees to establish a new individual case for the sole group participant, Shands Jacksonville.[2] Accordingly, this letter serves as notice to the Parties that the Board is:

1. Transferring the "Post-Allina II DSH Part C Days" issue from Case No. 26-0154GC to a new individual appeal that is being created for Shands Jacksonville, and
2. Closing Case No. 26-0154GC as there are no remaining participants.

The Parties will receive a Critical Due Dates letter for the newly established individual appeal under separate cover.

With regard to the Provider's request for EJR, 42 C.F.R. § 405.1842(b)(1), states the Board "must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question."

As a prerequisite to rendering an EJR determination, Rule 42.1 explains that:

> A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request.
>
> . . .
>
> The Board will make an EJR determination within 30 days after it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.

[1] Board Rules v. 3.2 (Dec. 15, 2023) (emphasis added).
[2] OH CDMS does not include the capability to "convert a group to an individual appeal" so the Board is establishing a new individual appeal for Shands Jacksonville to pursue the Part C issue.

In this instance, the group appeal is being closed as it does not meet the minimum participant requirements set forth in 42 C.F.R. § 405.1837. Therefore, the Board finds it appropriate to **deny the Provider's request for EJR** in Case No. 26-0154GC as it was filed in a group appeal that did not meet the regulatory requirements. The Provider may elect to re-file a request for EJR in the newly established individual appeal once the case has been acknowledged.

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

For the Board:

3/3/2026

X Kevin D. Smith, CPA

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

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

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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Avenue NW
Washington, DC 20006

RE: ***Board Determination on Disposition of Fully Formed Single Provider CIRP Group AND Request for Expedited Judicial Review***

Case Number 26-0275GC - Allina Health CY 2004 Post-Allina II DSH Part C Days CIRP Group

As it relates to:
Unity Hospital (Provider Number 24-0132), FYE 12/31/2004

Dear Ms. Webster:

The Provider Reimbursement Review Board (the "Board") is in receipt of correspondence, filed on February 25, 2026, from Ropes & Gray, LLP ("Ropes") requesting that the issue in the subject common issue related party ("CIRP") group be converted to an individual appeal for the sole participant, as well as a simultaneous request for expedited judicial review ("EJR"). A summary of the pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **October 30, 2025**, Ropes filed the "Allina Health CY 2004 Post-Allina II DSH Part C Days CIRP Group" under Case No. 26-0275GC. The group was formed with the "Direct Add" of Unity Hospital (Prov. No. 24-0132) which appealed from its June 12, 2025 Revised Notice of Program Reimbursement ("RNPR").

On **February 25, 2026**, Ropes advised that Case No. 26-0275GC is complete with only a single provider and there are no other providers in the Allina Health organization that would be appealing RNPRs for the Part C issue for calendar year ("CY") 2004. In addition, Ropes indicated that the Board has already granted EJR for all of Allina Health's other pre-2014 DSH Part C days appeals, so there are no pending groups with which this case could be consolidated. Therefore, Ropes requested that the Part C issue for Unity Hospital be converted to an individual appeal and simultaneously requested EJR.

Board Determination:

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

Board Rule 12.6.1 stipulates that a "CIRP group may be initiated by a single provider under common ownership or control, **but at least two different providers must be in the group upon full formation.**"[1] Further, 42 C.F.R. § 405.1837(b) requires that a group appeal have two or more providers.

After reviewing the facts in this case, the Board agrees to establish a new individual case for the sole group participant, Unity Hospital.[2] Accordingly, this letter serves as notice to the Parties that the Board is:

1. Transferring the "Post-Allina II DSH Part C Days" issue from Case No. 26-0275GC to a new individual appeal that is being created for Unity Hospital, and
2. Closing Case No. 26-0275GC as there are no remaining participants.

The Parties will receive a Critical Due Dates letter for the newly established individual appeal under separate cover.

With regard to the Provider's request for EJR, prior to determining if the Board has the authority to decide a legal question, it must first determine if the request for hearing was timely and if the amount in controversy requirement has been met. Specifically, 405.1840(a)(2) reads:

> The Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the matters at issue in the appeal before conducting any of the following proceedings:
>
> > (i) Determining its authority to decide a legal question relevant to a matter at issue (as described in § 405.1842 of this subpart).

Further, Rule 42.1 reads:

> A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute,

[1] Board Rules v. 3.2 (Dec. 15, 2023) (Emphasis added).
[2] OH CDMS does not include the capability to "convert a group to an individual appeal" so the Board is establishing a new individual appeal for Unity Hospital to pursue the Part C issue.

> regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request.
>
> . . .
>
> The Board will make an EJR determination within 30 days **after it determines whether it has jurisdiction** and the request for EJR is complete. See 42 C.F.R. § 405.1842. (Bold emphasis added)

In this instance, aside from the group having been closed, the Board finds that the group did not meet the jurisdictional requirements in that it included only a single provider, nor did it meet the $50,000 amount in controversy threshold requirement. Therefore, the Board finds it appropriate to **deny the Provider's request for EJR** in Case No. 26-0275GC, which is now closed. The Provider may elect to re-file a request for EJR in the newly established individual appeal once the case has been acknowledged, documenting that it meets the filing requirements for an individual appeal.

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

For the Board:

3/3/2026

X Kevin D. Smith, CPA

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

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

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Via Electronic Delivery

Perla Alvarado, CFO
Matrix Home Health Services
11351 James Watt, Suite C400
El Paso, TX 79936

Re: "Matrix HHS FFY 2025 Appealing our hospice payment reduction decision Group"
PRRB Case No. 26-1899G

Dear Ms. Alvarado:

The Provider Reimbursement Review Board ("Board") is in receipt of the above-referenced *group* appeal request to which it assigned Case No. 26-1899G. The pertinent facts and background regarding the case and the Board's determination are set forth below.

Pertinent Facts:

On **February 23, 2026**, Matrix Home Health Services ("Matrix"/Prov. No. A9-1630) filed a group appeal with the Board. The group as filed in the Office of Hearings Case & Document Management System ("OH CDMS") includes a single participant, Matrix.

A review of the support uploaded as Matrix's "Issue Statement Document," further reinforces that the appeal was filed on behalf of a ***single*** Provider requesting a reconsideration of the 4% anticipated hospice payment reduction. Board Rule 12.2 discusses the general requirements for a group and explains that the group appeal format is used when there **are at least two providers** appealing ". . . a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers."[1] Correspondingly, Board Rule 12.6.2 instructs that "[O]ptional group appeals must have a minimum of two different providers, both at inception and at full formation of the group."

In support of its appeal, Matrix uploaded the following documentation:

- *Issue Statement Document* -A letter dated August 21, 2025 requesting to "formally request a reconsideration of the 4% anticipated hospice payment reduction, as the HIS and Hospice Surveys were submitted in a timely manner." The document is titled "Reconsideration letter.pdf" and includes the Administrator and Appellant contact information:

- *Final Determination Document* - A copy of the January 6, 2026 Quality Reporting Determination ("QRP Determination") titled "Reconsideration Letter -Hospice Payment Reduction;"

[1] Board Rules Version 3.2 (Dec. 15, 2023)

- *Calculation Support Document* - A document labeled "OCT THRU JAN" which includes a list of patient names with dates of birth ("DOBs");

- *Other Issue Support* - A CMS Hospice Final Validation Report dated July 10, 2024- which also includes patient names, Social Security Numbers ("SSN's") and DOBs);

- *Other Issue Support* - A CMS Hospice Final Validation Report dated January 28, 2025 -which also includes patient names, SSNs and DOBs;

- *Other Issue Support* - A Hospice Survey Participation Exemption for Size Form dated May 22, 2025; and

- *Representation Letter Document* – titled "Reconsideration letter.pdf" (which was the same upload as the Issue Statement Document.

This support does not, however, meet the requirements for a Board appeal as discussed in further detail below.

Background:

As noted, the Provider uploaded the same letter for both its Issue Statement and its Representation Letter. The August 21, 2025 letter consists of four sentences and, although not specifically addressed, appears to be the letter the Provider first used to request the initial reconsideration of the 4% reduction to its hospice payment.

Specifically, Board Rule 5.4 discusses the criteria for a **Representation Letter** and specifies that "the letter designating the case representative must be on the **provider's letterhead** and be signed by an authorizing official of the provider organization."[2]

Further, 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.

[2]The Representation Letter was not submitted on Provider letterhead which IS required, however, the remaining components appear to be included throughout the letter (although not in the standard format).

(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.[3]

In addition, based on the "Controversy Amount" listed in Matrix's issue details, the Provider estimated the **Amount in Controversy** for the appeal at $1. The Calculation Support Document uploaded to demonstrate how the Provider came up with its estimate is a nine-page listing titled "OCT THRU JAN. The listing consists of three pages of patient names (with DOBs) and six more pages of claim dates with payments, adjustments and balances. This document does not meet the criteria of required calculation support, as discussed in Board Rule 6.4. The Rule states, "[a]n individual appeal request must have a total amount in controversy of at least $10,000 at the time of filing. See 42 C.F.R. §§ 405.1835 and 405.1839. A **calculation of the amount** in controversy with supporting documentation must be provided for each issue.

Finally, the appeal contains various supporting documents that include protected health information ("PHI") and personally identifiable information ("PII"). The Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule requires a covered entity and its business associates to make reasonable efforts to limit use, disclosure of, and requests for PHI or other PII to the minimum necessary to accomplish the intended purpose. While the Privacy Rule permits uses and disclosures for litigation, subject to certain conditions, such information is generally not necessary for documentation submitted to the Board. Because the record in Board proceedings may be disclosed to the public, the parties are required to carefully review their documents to ensure that they do not contain patient names, health insurance or social security numbers, addresses, or other information that identifies individuals.

Decision of the Board:

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

42 C.F.R. § 405.1835(b) specifies that, if a Provider's appeal request does not meet the requirements of paragraph (b)(3) of the same section, the Board may dismiss the appeal with prejudice, or take any other remedial action it considers appropriate. Paragraph (b)(3) states in part that the Provider's request must include an issue statement that addresses why the provider believes the Medicare payment to be incorrect, and why it should be determined differently.

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

[3] 42 C.F.R. § 405.1837(b)(2)

providers in a group (CIRP and optional) and specifies that mandatory and optional group appeals must have a *minimum of **two** different providers*.

In this case the Board finds that:

1) The appeal was filed in the wrong (*group)* format as it pertains to a single Provider;
2) The amount in controversy threshold has not been met (**i.e.**, $50K for a group or $10K for an individual appeal);
3) The Provider failed to submit a document that meets the requirements of an Issue Statement;
4) The Provider failed to file a suitable letter of representation,[4] and
5) The appeal includes PHI and PII, which is prohibited in accordance with the HIPPA Act.[5]

In this regard, the documents labeled "OCT THRU JAN," the July 10, 2024 and January 28, 2025 CMS Hospice Final Validation Reports submitted as part of the Provider's Issue support, all of which include PHI/PII, have been permanently removed from the electronic record.

Accordingly, the Board finds that the Provider does not meet the regulatory requirements for filing an appeal (***individual or group***) before the Board. Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules. Case No. 26-1899G 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 105.1877.

Based on the final determination date on the QRP determination uploaded by Matrix, the Provider is still within its appeal period. Therefore, if the Provider elects, it may refile an individual appeal in OH CDMS. Please see 42 CFR 405.1835 and Board Rule 6, which both discuss individual appeal rights, and requirements. Additionally, since the Provider is appealing a QRP determination, it may be helpful to refer to the Frequently Asked Questions ("FAQs") for Quality Reporting Appeals located at https://www.cms.gov/files/document/faqs-quality-reporting-appeals.pdf.

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

For the Board:

3/3/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[4] The Office of Hearings Case & Document Management System ("OH CDMS") also requires **separate uploads** for the Letter of Representation (see Board Rule 5.4), the final determination, the issue statement, audit adjustment pages and calculation support. In the case of a QRP appeal, there are no audit adjustments so an upload stating "there are no adjustments associated with this determination" may be uploaded.
[5] If the Provider elects to file a new appeal, and feels it necessary to include this support, it must be redacted in accordance with Board Rule 1.4.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
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Via Electronic Delivery

Daniel Hettich, Esq.
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RE: ***Expedited Judicial Review Determination***
Case Number: 21-1106GC *Intermountain FFY 2021 IPPS Section 401 Hospitals Rural Floor CIRP Group*
Case Number: 21-1107GC *Steward Health Care FFY 2021 IPPS Section 401 Hospitals Rural Floor CIRP Group*

Dear Mr. Hettich:

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

Issue:

The Petition for EJR describes the issue as follows:

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

[1] The Consolidated Request also included Case Numbers 21-1088GC, 21-1089GC, and 21-1090GC. Those three (3) have been adjudicated under separate cover.
[2] Case Nos. 21-1088GC *et al.*, Consolidated Petition for Expedited Judicial Review at 1 (Jan. 5, 2026).

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

Statutory and Regulatory Background:

1. Wage Index; Rural and Urban Classification

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

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

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

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

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

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

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

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

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

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

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

2. Rural Floor Adjustment

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

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

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

3. Changes to the Wage Index Calculation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Positions of the Parties:

1. Providers' Appeal Requests

The Providers describe the appealed issue as follows:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor for federal fiscal year (FFY) 2021. The Secretary's calculation violates the plain meaning of the rural floor provision of the statute and the requirement to treat reclassified rural hospitals as rural hospitals for all purposes of the prospective payment system.
>
> ****
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
>
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the Inpatient Prospective Payment System Rulemaking for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals. The Secretary continued this policy in FFY 2021.
>
> As a direct result of this policy, in FFY 2021, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states.
>
> ***
>
> This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
>
> For the forging reasons, the Providers in this group appeal are seeking reversal of CMS's policy of divorcing the rural floor from the rural wage index.[36]

[36] Case No. 21-110GC, Statement of the Issue (Mar. 17, 2021).

2. Providers' Request for EJR

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

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

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

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

3. Medicare Contractor's Position

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed a response to the Consolidated Request for Expedited Judicial Review. It took no position on the Request for EJR, but noted that "[t]he MAC will file a substantive claim challenge in 21-1106GC and 21-1107GC."[42]

Substantive Claim Challenges were filed in Case 21-1107GC on **January 19, 2026**, and in Case 21-1106GC on **January 26, 2026**. The Substantive Claim Challenges are addressed below.

Decision of the Board:

The participants that are included in the group appeals filing this EJR request have filed appeals involving FFY 2021 based on policies established in the FFY 2021 IPPS Final Rule published in the Federal Register.

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[37] Case Nos. 21-1088GC, *et al*, Consolidated Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).
[38] *Id.* at 1, 5-6.
[39] *Id.* at 2.
[40] *Id.* at 7.
[41] *Id.* at 6-10.
[42] FSS Response to Expedited Judicial Review Request at 1 (Jan. 12, 2026).

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.

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[43] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[44] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). All of the participants in these cases have fiscal years that began on or after January 1, 2016, so the claim-specific dissatisfaction requirement is not applicable to the Board's analysis regarding jurisdiction.

As previously noted, all of the participants in this group case appealed from the FFY 2021 IPPS Final Rule.[45] The Board has determined that (1) the participants' documentation in the group appeals show that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[46] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that amounts in controversy illustrate the difference between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[47] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amounts in controversy are subject to recalculation by the Medicare contractors for the actual final amounts in each case.

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[43] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[44] *Id.* at 70555.
[45] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[46] *See* 42 C.F.R. § 405.1837.
[47] *E.g.,* Case No. 21-1107GC, Impact Calculation, Steward Carney Hospital (Provider Number 22-0017).

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

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the <u>specific</u> item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **<u>and</u> describing** how the provider calculated the estimated re-imbursement amount for each specific self-disallowed item.[48]

[48] (Bold and underline emphasis added.)

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

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

> report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[49]

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

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

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

> A party that questions whether the one or more participants in a group case (CIRP or optional) included an appropriate claim *on the cost report at issue* for the common issue being appealed in the group **must file a Substantive Claim Challenge sixty (60) days after the group files its final Schedule of Providers (SOP) unless the moving party's filing demonstrates good cause**.[50] The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the Substantive Claim Challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* sample language in Rule 44.2. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
>
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed per Board Rule 42*.---If the final SOP is filed concurrent with an EJR request or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then refer to Rule 44.6 for special instructions on deadlines for filing Substantive Claim Challenges and any response thereto.

On **January 30, 2026**, the Board issued a Scheduling Order explaining:

[49] (Bold and underline emphasis added.)
[50] (Bold and underline emphasis added, italics in original.)

> In these cases, the Providers' representative acknowledged that the groups were complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing the Schedule of Providers, on **March 17, 2022**. Pursuant to Board Rule Board Rule 44.5.2 (2021), any Substantive Claim Challenges would have typically been due no later than **May 16, 2022**. The deadline to file the challenge, however, was indefinitely stayed via Board Alert 19 due to the public health emergency created by the COVID-19 pandemic. (*Available at* https://www.cms.gov/files/document/prrb-alerts.pdf). This indefinite stay was lifted effective December 7, 2022 via Board Alert 23, which stated "***Effective Wednesday, December 7, 2022***, Board Order No. 3 ceases suspension of deadlines and will hold parties to the deadline specified in: (1) *any* Board rule or instruction; and/or (2) *any* Board notice or correspondence issued ***on or after that date.***" (*Available at* https://www.cms.gov/medicare/regulations-guidance/providerreimbursement-review-board/current-prrb-alerts) (emphasis in original). There was no correspondence in Cases 21-1106GC and 21-1107GC, or general notice applicable to this case, which re-established deadlines for Substantive Claim Challenges. As such, the stay for the deadline for a Substantive Claim Challenge was never lifted and FSS' filing was not untimely.

i. *Substantive Claim Challenges*

In Case 21-1106GC, FSS filed a Substantive Claim Challenge on **January 26, 2026** arguing that all the Providers in this group "failed to satisfy the substantive claim requirement of including appropriate cost report claim for the IPPS section 401 hospitals rural floor issue."[51] It argues that there is nothing in the record to suggest the Providers sought to claim full reimbursement for the issue under appeal. Additionally, all the Providers filed their applicable cost reports reflecting $0 in Part A protested amounts, meaning they failed to include a self-disallowed item for the specific issue on appeal.[52]

In Case 21-1107GC, FSS filed a Substantive Claim Challenge on **January 19, 2026** also claiming that all the Providers in this group "failed to satisfy the substantive claim requirement of including appropriate cost report claim for the IPPS section 401 hospitals rural floor issue."[53] It further claims that Nashoba Valley Medical Center (Prov. No. 22-0098, FYEs 12/31/2020 and 12/31/2021) filed its applicable cost reports reflecting $0 in Part A protested amounts. The remaining six (6) Providers did list protested amounts on their cost reports, but the Protested Items listing accompanying the cost reports did not include the issue under appeal.[54]

Based on the foregoing, the Medicare Contractor argues that none of the Providers in these two (2) cases included an appropriate cost report claim for the specific item in dispute.

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[51] Case No. 21-1106GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4 (Jan. 26, 2026).
[52] *Id.* at 4-5.
[53] Case No. 21-1107GC, Medicare Administrative Contractor's Substantive Claim Challenge at 4 (Jan. 19, 2026).
[54] *Id.* at 5.

ii. Providers' Responses

The Providers filed responses to both Substantive Claim Challenges on **February 17, 2026**. With regard to the timeliness of the challenges, the Providers argue that:

> [T]he Board did in fact lift the Alert-19 stay on deadlines. In a Critical Due Dates Notice issued on March 16, 2023, for the above-captioned appeal, the Board "establish[ed] new deadlines for filings that were previously suspended." Critical Due Dates Notice (March 16, 2023) (PRRB Group Appeal No. 21-1107GC). Previously suspended deadlines, including the deadline to file a substantive claim challenge, were therefore reinstated pursuant to Alert 23 and a direct correspondence in this appeal. Accordingly, a Substantive Claim Challenge filed on January 19, 2026, nearly four years after the Providers certified the group was complete, should be considered untimely.[55]

The Board rejects this argument and finds the Substantive Claim Challenges were timely. The March 16, 2023 Critical Due Dates Notices issued in each case indicated that "the Board is establishing new deadlines for filings that were previously suspended[,]" but went on to state "[t]he parties must meet the following due dates[.]"[56] The Notice then listed due dates for preliminary position papers and the Medicare Contractor's jurisdictional review. There was no mention of substantive claim challenge deadlines or 42 C.F.R. §§ 413.24(j) and 405.1873.

With regard to the merits of the Medicare Contractor's arguments, 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*[57] and *Banner Heart Hospital v. Burwell*[58] in support of their position that these regulations are unlawful.[59]

iii. 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))"[60] 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.

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[55] Case No. 21-1107GC, Response to MAC's Substantive Claim Letter at 2 (Feb. 17, 2026). An identical argument was made in the response filed in Case No. 21-1106GC.
[56] (Emphasis added.)
[57] 485 U.S. 399 (1988).
[58] 201 F.Supp.3d 131 (D.D.C. 2016)
[59] *E.g.*, Case No. 21-1107GC, Response to MAC's Substantive Claim Letter at 2-4.
[60] (Emphasis added.)

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

3. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to (1) "calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[61] was made through notice and comment in the form of an uncodified regulation.[62]

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.[63]

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.[64]

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[61] 84 Fed. Reg. 42044 at 42336.
[62] *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."
[63] 84 Fed. Reg. at 42336.
[64] 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 . . . ."

While this appeal involves the FFY 2021 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[65] The FY 2021 IPPS Final Rule did not make any changes to this policy. Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2021.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[66] As a result, the Board finds that EJR is appropriate for the issue for the fiscal years under appeal in the Cases 21-1107GC and 21-1106GC.

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 Cases 21-1107GC and 21-1106GC and that the Providers in each group appeal are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for all Providers in Cases 21-1107GC and 21-1106GC and the Board specifically finds that all providers in both cases failed to include "an appropriate claim for the specific item" that is the subject of their respective group appeals as required under 42 C.F.R. § 413.24(j)(1);

3) Based upon the Providers' assertions regarding the FFY 2021 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule is valid.

[65] 85 Fed. Reg. 58,432, 58,766 (Sept. 18, 2020).
[66] Consolidated Petition for Expedited Judicial Review at 1, 5-6.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2021 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject 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 Case Nos. 21-1107GC and 21-1106GC 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:

3/6/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Kimberly Jones
Appeals Manager
HCA Healthcare, Inc.
One Park Plaza
Nashville, TN 37203

Re: ***Board Decision re: Filing Requirements***
HCA CY 2024 DSH Low Income Pool Florida 1115 Waiver CIRP Group
PRRB Case No.: 26-1911GC

Dear Ms. Jones:

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 reviewing 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 are set forth below.

BACKGROUND:

On February 25, 2026, HCA Healthcare, Inc. ("HCA") filed the "HCA CY 2024 DSH Low Income Pool Florida 1115 Waiver CIRP Group" with the Board under Case No. 26-1911GC.

The group was formed with a single Provider - HCA Florida Fort Walton-Destin Hospital (Prov. No. 10-0223). The Board notes that the final determination type was entered into OH CDMS as a Notice of Program Reimbursement ("NPR") with an issuance date of May 31, 2024.[1] However, the support document uploaded for the final determination is a copy of the calculation support and not a copy of the NPR.

BOARD DECISION:

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

[1] With a final determination date of May 31, 2024, the appeal for HCA Florida Fort Walton-Destin Hospital shows as having been filed 635 days from the determination – which would be considered to be untimely. Because the wrong support document was uploaded, the Board cannot determine the actual final determination date to potentially correct it in OH CDMS.

42 C.F.R. § 405.1835(b) outlines the content requirements for a request for Board hearing from a final determination:

> (b) *Contents of request for a Board hearing on a final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> ***
>
> (3) A copy of the final contractor or Secretary determination under appeal. . .

The Group Rule 16.2 further reiterates the regulatory requirement to submit a copy of the final determination. Rule 12.6 indicates "

> A direct add request must include the same information required for a provider filing an individual appeal (see Rules 6 through 8), **including the determination** and issue-specific information addressed in Rule 7, plus a copy of the representative letter associated with the group appeal. This information must be provided in order for the Board to confirm that the direct add request meets the requirements for a Board hearing. See 42 C.F.R. §§ 405.1835(a), 405.1835(c), 405.1840(a). (Bold emphasis added)

The Board finds that the initiating Provider used to form the subject group appeal does not meet the regulatory requirements for filings as HCA Florida Fort Walton-Destin Hospital failed to submit the final determination on which its appeal is based, as required by 42 C.F.R. § 405.1835(b)(3) and the Board Rules. Therefore, the Board dismisses HCA Florida Fort Walton-Destin Hospital from the group.

With the dismissal of HCA Florida Fort Walton-Destin Hospital, there are no remaining participants in Case No. 26-1911GC. Consequently, the group, as filed on February 25, 2026, does not meet the regulatory requirements for filings, and is hereby dismissed in its entirety, and removed from the 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:

3/9/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Case Number: 21-1373GC *Steward Health Care CY 2021 OPPS Section 401 Hospitals Rural Floor CIRP Group*
Case Number: 20-1662GC *UF Health Central Florida CY 2020 OPPS Section 401 Hospitals Rural Floor CIRP Group*

Dear Mr. Hettich:

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

Issue:

The Petitions for EJR describes the issue as follows:

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

[1] The Consolidated Requests for EJR both included additional cases which have been addressed under separate cover.

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

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

Statutory and Regulatory Background:

1. Wage Index; Rural and Urban Classification

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

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

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

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[2] Case Nos. 21-1373GC *et al.*, Consolidated Petition for Expedited Judicial Review, 1 (Jan. 5, 2026). The Petition for Case Nos. 20-1659GC *et al.*, which includes Case 20-1662GC, and addresses 2020 appeals, is materially identical but does not include the reference to the rulemaking being "carried forward to FFY 2021."
[3] *Id.* at 10.
[4] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[5] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27708, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[6] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[7] of the Department of Health and Human Services.
[8] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited Mar. 9, 2026).

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

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

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

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

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

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

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

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

2. Rural Floor Adjustment

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

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

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

3. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[18] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information

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

("RFI") as part of the FFY 2020 IPPS proposed rule.[19] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[20] In the FFY 2020 IPPS Final Rule, the Secretary proposed several policies to address wage index disparities.[21] Relevant to the issue under appeal here are the Secretary's proposals to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[22,23] The Secretary finalized without modification the proposals

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

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

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[19] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[20] *Id.*
[21] *See generally* 84 Fed. Reg. 42044, 42336-42339 (Aug. 16, 2019).
[22] 42 C.F.R. § 412.103 states in relevant part that:

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

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

that "the inclusion of reclassified hospitals in the rural floor calculation has had the unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals."[26]

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

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

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

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

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

Section 401.[35] CMS has also adopted the FY 2020 IPPS Final Rule's policy in its FY 2021 OPPS Final Rule, meaning for FFY 2021 it will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401.[36]

Positions of the Parties:

1. Providers' Appeal Requests

The Providers in Case No. 20-1662GC describe the appealed issue as follows:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor in the inpatient prospective payment system (IPPS) final rule for federal fiscal year (FY) 2020 to the extent that it has affected the calculation of the wage indices in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2020.
>
> The methodology that the Secretary adopted to calculate the rural floor in the IPPS final rule for FY 2020 violates the plain meaning of the rural floor provision of the statute and the requirement to treat reclassified rural hospitals as rural hospitals for all purposes of the prospective payment system. In addition to understating the Providers' IPPS payments, the Secretary's errors in calculating the rural floor also affected the Providers' OPPS payments. This is because the Secretary's own regulations require him to use the IPPS wage index adjustment factors in calculating OPPS payments. 42 C.F.R. § 419.43(c).
>
> ****
>
> For wage index purposes, there are two types of geographic areas: urban and rural.
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> ***
>
> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the IPPS final rule FY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and

[35] 84 Fed. Reg. 61142, 61187-61188 (Nov. 12, 2019) (stating "as proposed, we are finalizing the use of 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.").
[36] 85 Fed. Reg. 85866, 85916-17 (Dec. 29, 2020) ("FY2021 OPPS Rule") (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").

> all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified rural hospitals; it will be based solely on the wage data of naturally rural hospitals.
>
> As a direct result of this policy, in FY 2020, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states. This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
>
> * * *
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> For the forging reasons, the Providers in this group appeal request that the Board reverse the Secretary's calculation of the rural floor for FY 2020 to the extent it calculated OPPS payments in CY 2020 and direct the Secretary to recalculate the OPPS wage index for CY 2020 in the manner required by the statute. [37]

The issue statement for Case 21-1373GC is materially identical:

> The Providers in this group appeal challenge the Secretary's calculation of the rural floor in the outpatient prospective payment system (OPPS) final rule for calendar year (CY) 2021.
>
> ****
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> For wage index purposes, there are two types of geographic areas: urban and rural.
>
> ***
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> When a hospital reclassifies as rural, its wage and hour data is included in the calculation of the state rural wage index adjustment in the next federal fiscal year.
>
> The Medicare statute contains a provision requiring that no urban hospital can be assigned a wage index adjustment that is lower than the wage index assigned to rural hospitals in the state.
>
> ***
>
> In the IPPS final rule for FFY 2020, the . . . . rural wage index will continue to be calculated based on the average hourly wage of all rural hospitals and all urban hospitals that have reclassified as rural. The rural floor, however, will not include the wage and hour data of reclassified

[37] Case No. 20-1662GC, Statement of the Issue (May 11, 2020).

> rural hospitals; it will be based solely on the wage data of naturally rural hospitals. Since adopting this policy, the Secretary has applied the same rural floor policy to the OPPS final rules for CY 2020 and 2021. In this appeal, the Provider challenges CMS's policy insofar as it was applied in the OPPS final rule for CY 2021.
>
> ***
>
> [A]s a direct result of this policy, in CY 2021, urban hospitals in some states have been assigned a wage index that is lower than the wage index assigned to rural hospitals in those states. This result violates the rural floor, which expressly prohibits the Secretary from assigning a wage index to urban hospitals that is lower than the wage index of rural hospitals in the same state. *See* 42 U.S.C. § 1395ww note. Even if this result did not violate the rural floor (it does), the Secretary's policy would separately violate 42 U.S.C. § 1395ww(d)(8)(E)(i), which requires the Secretary to treat a hospital that has elected to reclassify as rural as rural for the purposes of the prospective payment system.
>
> For the forging reasons, the Provider requests that the Board reverse the Secretary's calculation of the rural floor for CY 2021 and direct the Secretary to recalculate [its OPPS] payments in the manner required by the statute.[38]

2. Providers' Requests for EJR

The Providers filed their Petitions for EJR to challenge CMS' new wage index rules as unlawful because it conflicts with the Medicare statute.[39] They argue that the FY 2020 rulemaking (1) does not treat reclassified "Section 401" hospitals as being located in a rural area, as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[40]

They seek to have their wage indices recalculated in compliance with the requirements of the Medicare statute.[41] The Providers are specifically seeking the Board hold that:

> CMS's calculation of the FFY 2020 rural floor is unlawful because CMS does not have statutory authority to exclude data of Section 401 hospitals from the calculation of the rural floor and CMS cannot assign a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state, and to compel CMS to pay the Providers reimbursement that was withheld as a result of that regulation during the years under appeal.[42]

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[38] Case No. 21-1373GC, Statement of the Issue (June 20, 2021).
[39] *E.g.*, Case Nos. 20-1659GC *et al.*, Consolidated Petition for Expedited Judicial Review at 1-2 (Jan. 5, 2026).
[40] *Id.* at 1, 5-6.
[41] *Id.* at 2.
[42] *Id.* at 7. The Petition for EJR for Case 21-1373GC is materially identical, but references FFY 2021.

The Providers insist they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[43]

3. Medicare Contractor's Position

On **January 12, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services, filed responses to the Consolidated Requests for Expedited Judicial Review. It took no position on the Request for EJR, but noted that it would be filing Substantive Claim Challenges in both case.

Substantive Claim Challenges were filed in Case 20-1662GC on **January 20, 2026**, and in Case 21-1373GC on **January 26, 2026**. The Substantive Claim Challenges are addressed below.

Decision of the Board:

The Providers participating in the group appeals included in this EJR request have filed their appeals involving FFYs 2020 and 2021 from policies established in the FFY 2020 and 2021 OPPS Final Rules published in the Federal Register.

1. Jurisdiction and Requests 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.

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[44] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[45] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board,

[43] *Id.* at 6-10.
[44] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[45] *Id.* at 70555.

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.

As previously noted, all of the participants in these group cases appealed from the FFY 2020 and 2021 OPPS Final Rules.[46] The Board has determined that (1) the participants' documentation in the group appeals show that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[47] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that amounts in controversy illustrate the difference between the "current rural floor calculation" and "if [the] rural floor were calculated correctly."[48] 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

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

[46] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[47] *See* 42 C.F.R. § 405.1837.
[48] *E.g.,* Case No. 21-1373GC, Reimbursement Impact, Morton Hospital (Provider Number 22-0073).

> 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.[49]

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-*
>
> ***

[49] (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**.[50]

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

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

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

> A party that questions whether the one or more participants in a group case (CIRP or optional) included an appropriate claim *on the cost report at issue* for the common issue being appealed in the group **must file a Substantive Claim**

[50] (Bold and underline emphasis added.)

> **Challenge sixty (60) days after the group files its final Schedule of Providers (SOP) unless the moving party's filing demonstrates good cause.**[51] The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the Substantive Claim Challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* sample language in Rule 44.2. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
>
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed per Board Rule 42*.---If the final SOP is filed concurrent with an EJR request or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then refer to Rule 44.6 for special instructions on deadlines for filing Substantive Claim Challenges and any response thereto.

On **February 3, 2026**, the Board issued a Scheduling Order explaining:

> In Case 20-1662GC, the Providers' Representative certified, pursuant to Board Rule 20 (2021), that all providers in each group were populated in OH CDMS, along with all supporting documentation, thus effectively certifying its final Schedule of Providers, on **July 28, 2022**. The Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Request for EJR on **January 12, 2026**, indicating it would be filing a Substantive Claim Challenges in this case, which was filed on **January 20, 2026**.
>
> In Case 21-1373GC, the Providers' Representative certified, pursuant to Board Rule 20 (2021), that all providers in each group were populated in OH CDMS, along with all supporting documentation, thus effectively certifying its final Schedule of Providers, on **June 17, 2022**. The Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Request for EJR on **January 12, 2026**, indicating it would be filing a Substantive Claim Challenges in this case, which was filed on **January 26, 2026**.
>
> In these Cases (20-1662GC and 21-1373GC), the Providers' representative acknowledged that the groups were complete and fully populated in OH CDMS pursuant to Board Rule 20, effectively finalizing the Schedule of Providers, on **July 28 and June 17, 2022,** respectively. Pursuant to Board Rule Board Rule 44.5.2 (2021), any Substantive Claim Challenges would have typically been due no later than **August 29 and July 18, 2022,** respectively. The deadlines to file these challenges, however, were indefinitely stayed via Board Alert 19 due to the public health emergency created by the COVID-19 pandemic. (*Available at*

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

> https://www.cms.gov/files/document/prrb-alerts.pdf). This indefinite stay was lifted effective December 7, 2022 via Board Alert 23, which stated "***Effective Wednesday, December 7, 2022***, Board Order No. 3 ceases suspension of deadlines and will hold parties to the deadline specified in: (1) *any* Board rule or instruction; and/or (2) *any* Board notice or correspondence issued ***on or after that date.***" (*Available at* https://www.cms.gov/medicare/regulations-guidance/providerreimbursement-review-board/current-prrb-alerts) (emphasis in original). There was no correspondence in Cases 20-1662GC and 21-1373GC, or any general notice applicable to this case, which re-established deadlines for Substantive Claim Challenges. As such, the stay for the deadlines for Substantive Claim Challenges was never lifted and FSS' filings were not untimely.[52]

i. *Substantive Claim Challenges*

In Case 20-1662GC, FSS filed a Substantive Claim Challenge on **January 20, 2026** arguing that the two Providers in this group "did not include an appropriate claim in their . . . cost reports, for the issue at hand – i.e., OPPS Section 401 Hospital Rural Floor."[53] For Leesburg Regional Medical Center (Provider No. 10-0084; FYE 06/30/2020 & 06/30/2021), FSS argues that "there is nothing in the record to demonstrate that the Provider sought to claim full reimbursement for the specific item in dispute."[54] For FYE 6/30/2020, FSS claims that this Provider filed its applicable cost report reflecting $0 in Part A protested amounts, meaning it failed to include a self-disallowed item for the specific issue on appeal.[55] For FYE 6/30/2021, FSS explains:

> Referring to 42 C.F.R. § 413.24(j)(1)(ii) and (j)(2), the MAC notes the Provider filed its FYE 06/30/2021 cost report identifying $0 in Part B protested amounts. As the issue under appeal is specifically identified as Outpatient Section 401 Hospital Rural Floor, the MAC contends there is nothing in record to demonstrate the Provider filed its cost report under protest for this issue. The MAC notes that the Provider filed its FYE 06/30/2021 cost report identifying $1,005,654 in Part A protested amounts. The Provider submitted a protested worksheet, which also identifies an impact of $1,005,654. While the protested worksheet includes inpatient and outpatient "Pre-Adjusted Wage Index" and "Post-Adjusted Wage Index" amounts, there is no explanation of the issue under protest. The Provider has not included a separate worksheet explaining why it self-disallowed the wage index issue instead of claiming full reimbursement in its cost report and describing how it calculated an estimated reimbursement amount for the wage index. The calculation of the estimated impact is not clear from the protested worksheet.[56]

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[52] Citations omitted.
[53] Case No. 20-1662GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Jan. 20, 2026).
[54] *Id.* at 4.
[55] *Id.*
[56] *Id.* at 5 (citing Ex. C-4 at 3-5).

For The Villages Regional Hospital (Provider No. 10-0290; FYEs 06/30/2020 & 06/30/2021), FSS also argues that "there is nothing in the record to demonstrate that the Provider sought to claim full reimbursement for the specific item in dispute."[57] For FYE 6/30/2020, FSS claims that this Provider filed its applicable cost report reflecting $0 in Part A protested amounts, meaning it failed to include a self-disallowed item for the specific issue on appeal.[58] For FYE 6/30/2021, FSS explains:

> Referring to 42 C.F.R. § 413.24(j)(1)(ii) and (j)(2), the MAC notes the Provider filed its FYE 06/30/2021 cost report identifying $0 in Part B protested amounts. As the issue under appeal is specifically identified as Outpatient Section 401 Hospital Rural Floor, the MAC contends there is nothing in record to demonstrate the Provider filed its cost report under protest for this issue. The MAC notes that the Provider filed its FYE 06/30/2021 cost report identifying $1,085,531 in Part A protested amounts. The Provider submitted a protested worksheet, which also identifies an impact of $1,085,531. While the protested worksheet includes inpatient and outpatient "Pre-Adjusted Wage Index" and "Post-Adjusted Wage Index" amounts, there is no explanation of the issue under protest. The Provider has not included a separate worksheet explaining why it self-disallowed the wage index issue instead of claiming full reimbursement in its cost report and describing how it calculated an estimated reimbursement amount for the wage index. The calculation of the estimated impact is not clear from the protested worksheet.[59]

In Case 21-1373GC, FSS filed a Substantive Claim Challenge on **January 26, 2026**, arguing that all the Providers in this appeal "failed to include an appropriate cost report claim for the appealed item in dispute – OPPS Section 401 Hospitals Rural Floor Wage Index."[60] FSS argues that, for its FYE 12/31/2021, Nashoba Valley Medical Center (Prov. No. 22-0098) filed its cost report "reflecting zero dollars ($0) in Part A protested amounts", and "did not submit any documentation with its filed cost reports to indicate that the OPPS Section 401 Rural Floor issue was protested on Worksheet E Part B."[61] The remaining six (6) providers in the group did have Part A protested amounts, but the supporting schedules do not establish that the appealed issue was self-disallowed.[62]

Based on the foregoing, the Medicare Contractor argues that none of the Providers outlined above ("the Challenged Providers") in these two cases included an appropriate cost report claim for the specific item in dispute.

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[57] *Id.* at 5.
[58] *Id.* at 5-6.
[59] *Id.* at 6 (citing Ex. C-6 at 3-5).
[60] Case No. 21-1373GC, Medicare Administrative Contractor's Substantive Claim Challenge at 2 (Jan. 26, 2026).
[61] *Id.* at 5.
[62] *Id.* at 6-6.

ii. Providers' Responses

In response to the Board's **February 3, 2026** Scheduling Order, the Providers filed responses to both Substantive Claim Challenges on **February 17, 2026**. The Providers do not dispute that the Challenged Providers 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*[63] and *Banner Heart Hospital v. Burwell*[64] in support of their position that these regulations are unlawful.[65]

iii. 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))"[66] 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 in both cases do not dispute that they failed to include an appropriate cost report claim for the OPPS Section 401 Hospital Rural Floor issue under appeal. The Board hereby finds that they did not.

3. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to (1) calculate the rural floor without including the wage data of urban hospitals reclassified as rural under . . .[42 U.S.C. § 1395ww(d)(8)(E)] . . . (as implemented at § 412.103)"; and (2) "for purposes of applying the provisions of . . . [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E). . . (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in section [1395ww](d)(8)(C)(iii). . . ."[67] was made through notice and comment in the form of an uncodified regulation.[68]

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

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[63] 485 U.S. 399 (1988).
[64] 201 F.Supp.3d 131 (D.D.C. 2016).
[65] *E.g.*, Case 20-1662GC, Response to MAC's Substantive Claim Letter at 2-3 (Feb. 17, 2026).
[66] (Emphasis added.)
[67] 84 Fed. Reg. 42044 at 42336.
[68] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section 1886(d)(8)(C)(iii) of the Act, to remove the wage data of urban hospitals reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented at § 412.103) from the calculation of "the wage index for rural areas in the State in which the county is located" referred to in section 1886(d)(8)(C)(iii) of the Act.[69]

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.[70]

While this appeal involves the FFY 2020 and 2021 OPPS Final Rules, CMS has adopted the FY 2020 IPPS Final Rule's policy in these OPPS Final Rules. This means that CMS will calculate the rural floor in a state without reference to the wage index that applies to any hospitals in that state which were reclassified as rural pursuant to Section 401 for both FFY 2020 and 2021 with regard to the OPPS.[71] Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FYs 2020 and 2021 with regard to the OPPS.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 and 2021 OPPS Final Rules and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural area, as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[72] As a

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[69] 84 Fed. Reg. at 42336.
[70] 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 . . . ."
[71] 84 Fed. Reg. 61142, 61187-61188 (Nov. 12, 2019) (stating "as proposed, we are finalizing the use of 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."); 85 Fed. Reg. 85866, 85916-17 (Dec. 29, 2020) ("FY2021 OPPS Rule") (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").
[72] Consolidated Petition for Expedited Judicial Review at 1, 5-6.

result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in the Cases 20-1662GC and 21-1373GC.

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 Cases 20-1662GC and 21-1373GC and that the Providers in each group appeal are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for all the Challenged Providers in Cases 20-1662GC and 21-1373GC 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) Based upon the Providers' assertions regarding the FFY 2020 and 2021 OPPS Final Rules, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 and 2021 OPPS Final Rules is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FY 2020 and 2021 OPPS Final Rules 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 cases, the Board hereby closes Cases 20-1662GC and 21-1373GC 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:

3/9/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Scott Berends, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: **Board Determination on Response to Show Cause Order**

Case Number: 25-1505GC - MultiCare Health CY 2008 Part C Days Retroactive Final Rule CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the correspondence filed by Quality Reimbursement Services, Inc. ("QRS") in response to the Show Cause Order issued in the subject common issue related party ("CIRP") group appeal. A summary of the pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **January 21**, **2025**, QRS formed the "MultiCare Health CY 2008 Part C Days Retroactive Final Rule CIRP Group" under Case No. 25-1505GC.[1]

On **January 22, 2025**, the Board acknowledged the case in a Case Acknowledgement and Critical Due Dates notification ("ACDD"). The Board's ACDD notice gave the Group Representative a **January 21, 2026** deadline to file the "Group's Comments Regarding Full Formation – The comments *must advise* the Board whether the group is complete, ***and if not***, *must specifically identify* which providers within the related party chain organization have not yet received a final determination for the appealed year. See Board Rule 19."[2, 3]

[1] The group was formed with two providers: MultiCare Good Samaritan Hospital (Provider Number 50-0079) and MultiCare Valley Hospital (Provider Number 50-0119).

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

[3] The Board is aware of the Office of Hearings Case & Document Management System ("OH CDMS") outage that occurred on Jan. 20-21, 2026. Pursuant to Board Rule 2.1.3, "To the extent the issue cannot be resolved by the Board-Set Deadline and the case representative makes a late filing, then the registered user should document their issues and submit their filing electronically within twenty-four (24) hours of the issue being resolved by the Help Desk. As part of this filing, the case representative must request an extension due to technical difficulties and provide satisfactory proof to establish good cause for the late filing. . . ."

On **January 29, 2026**, more than a week after the deadline had passed, the Board issued a determination deeming the group to be fully formed and ordering QRS to show cause why the group should not be dismissed for having missed the "Comments Regarding Full Formation" deadline.

On **February 5, 2026**, QRS filed its response to the Board's Show Cause Order. QRS maintains that on January 21, 2026, its staff timely responded to the Full Formation Comments question by:

- selecting the "Respond" box, and
- clicking "yes" to answer the question "Is the group fully formed?"[4]

According to QRS, the OH CDMS portal redirected the staff person to a page that indicated "No Actions Exist for This Case." In addition, QRS noted that no Confirmation of Correspondence ("COC") was received. QRS explained that it has experienced delayed COC's in the past so it presumed one would be forthcoming.[5]

In support of its claim, QRS provided a copy of its internal log to demonstrate its attempt to timely respond. In addition, it pointed to the fact that the OH CDMS portal has been experiencing technical issues over the last few weeks. QRS submitted a copy of a Help Desk email regarding issues it had encountered when trying to file responsive documents in various cases, including this one. The Help Desk "ServiceNow" email reflects a completed status as of January 21, 2026 at 1:03 p.m. but QRS alleges that technical issues continue to persist. Accordingly, QRS argues that dismissal is not appropriate in this case.[6]

Board Determination:

After a review of the facts, the Board finds dismissal of the group to be appropriate based on QRS' failure to timely respond to the "Group's Comments Regarding Full Formation" by the deadline. QRS has failed to meet its responsibilities per Board Rule 5.2, which require the representative to meet Board deadlines and respond timely to correspondence or requests from the Board. The Rule states that, "[F]ailure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines."

Although there were documented systems issues with OH CDMS on January 20 and 21, 2026, the Parties were advised in a January 21, 2026 email blast issued at 3:50 p.m., that "the issue had been resolved and the system is now fully operational."

Board Rule 2.1.3 indicates that:

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[4] Response to Board Show Cause at 1 (Feb. 5, 2026).
[5] *Id.*
[6] QRS used a similar argument in the "Health First FFY 2025 IPPS Understated Standardized Payment Amount CIRP Group" under Case No. 25-1356GC. In that case, not only did QRS provide a copy of the Help Desk ticket, but it sent follow-up correspondence to the Board (3 business days later) when it had not received the appropriate responses.

> To the extent the issue cannot be resolved by the Board-Set Deadline and the case representative makes a late filing, then the registered user should document their issues and ***submit their filing electronically within twenty-four (24) hours of the issue being resolved by the Help Desk***. As part of this filing, the case representative must request an extension due to technical difficulties and provide satisfactory proof to establish good cause for the late filing. In this regard, the request should:
>
> ▪ Describe the technical issue;
> ▪ Describe when it was identified;
> ▪ Describe their efforts to resolve the issue;
> ▪ Identify the OH CDMS Help Desk ticket number opened to address the issue;
> ▪ Include a copy of the notice from the OH CDMS Help Desk confirming that the technical issue was resolved; and
> ▪ Confirm whether there are any other registered users in the case representative's organization and, if so, explain why the other user(s) could not make the filing.[7]

In this case, when QRS failed to receive its COC for the "Group's Comments Regarding Full Formation" submission, it did not send a follow-up letter (as it did in Case No. 25-1356GC). In addition, QRS did not file a request for extension as indicated in Board Rule 2.1.3, nor is there evidence of a timely response in OH CDMS.

Considering the technical difficulties QRS experienced in this case, a logical course of action would be for QRS to examine other groups that had submissions filed during the same time period. In that regard, the Board notes, on January 21, 2026, after the system outage had been resolved, COCs were issued in at least five other QRS CIRP groups.[8] Instead, QRS waited for the Board to address the deficiency by issuing a Show Cause Order on January 29, 2026, more than a week after the deadline had passed and the OH CDMS systems issues had been fixed. Consequently, the Board finds this to be another case of administrative error and QRS not properly managing its docket. In addition, the Board has already afforded QRS a courtesy in Case No. 25-1356GC, and the facts in this case are less compelling. Further, QRS's ability to successfully manage other cases, as noted herein, indicates that this was likely an operator error, rather than system related. Finally, the Board notes that this is not the first instance where QRS has failed to meet the "Group's Comments Regarding Full Formation" deadline in a group due to its own oversight.[9]

Therefore, given its discretionary authority in 42 C.F.R. § 405.1868 and Board Rule 41.2, which states the Board may dismiss a case upon failure of the group to comply with Board procedures or filing deadlines, the Board dismisses Case No. 25-1505GC.

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[7] (Bold emphasis added.)
[8] Specifically, the COCs related to QRS submissions of Comments Regarding Full Formation in Case Nos. 25-1504GC and 25-1506GC and Direct Add requests in Case Nos. 25-0496GC, 26-0498GC and 26-0499GC.
[9] On July 22, 2025, the Board issued a decision dismissing Case Nos. 24-1484GC, 24-1549GC, 24-1366GC, 24-1406GC, 24-1367GC and 24-1409GC for failure to timely respond to the "Comments Regarding Full Formation." On December 16, 2025, it dismissed Case No. 25-0856GC for the same infraction.

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

Board Members Participating:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq. (dissent w/o comment)

For the Board:

3/11/2026

X Kevin D. Smith, CPA

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

cc: Dean Wolfe, Noridian Healthcare Solutions (J-F)
Wilson C. Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Leslie Goldsmith, Esq.
Bass, Berry & Sims, PLC
1201 Pennsylvania Avenue NW, Suite 300
Washington, DC 20004

Re: ***Determination to Expand Later Year CIRP Group to Allow Consolidation of CIRP Less than $50K & Disposition of Expedited Judicial Review Request***

Case Number: 25-3340GC - Virtua Health System CY 2008 DSH Calculation - Treatment of Medicare Part C Days CIRP Group

Case Number: 25-3337GC - Virtua Health System CY 2007 DSH Calculation - Treatment of Medicare Part C Days CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board (the "Board") has reviewed the March 11, 2026 correspondence from Bass, Berry & Sims, PLC ("Bass Berry") requesting to "merge" its calendar year ("CY") 2007 common issue related party ("CIRP") group with the subsequent CY appeal under Case No. 25-3340GC.[1,2] Bass Berry indicates that the CY 2007 CIRP group does not meet the minimum $50,000 jurisdictional threshold required for a group appeal.[3] In support of its request, Bass Berry certified that "there are no differences in relevant facts or laws between these two years that would support different decisions across these years."[4]

BOARD DETERMINATION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, 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. Further, 42 C.F.R. § 405.1839(b)(1) indicates that "[i]n order to satisfy the amount in controversy requirement under 42 C.F.R. § 405.1837(a)(3) . . . the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000."

After reviewing the facts in these group cases and based on Bass Berry's certifications that the issues in the two CIRP groups are identical and that there are no factual or regulatory changes for the issue

[1] On February 20, 2026, Bass Berry filed a consolidated request for Expedited Judicial Review ("EJR") which included the referenced group appeals.
[2] Case No. 25-3340GC was designated to be fully formed with two participants. The aggregate amount in controversy for the group is $244,337.
[3] The aggregate amount in controversy in Case No. 25-3337GC is $12,951.
[4] Response to MAC Jurisdictional Challenges and Request to Combine at 1-2 (Mar. 11, 2026).

between the two years, the Board is exercising its discretion and hereby:

1. Reopens the status of and expands the CY 2008 CIRP group under Case No. 25-3340GC to include CY 2007;
2. Consolidates Case No. 25-3337GC into the newly expanded group under Case No. 25-3340GC;
3. Modifies the case name for Case No. 25-3340GC to the "Virtua Health System CYs 2007 & 2008 DSH Calculation – Treatment of Medicare Part C Days CIRP Group;
4. Re-designates Case No. 25-3340GC to be fully formed; and
5. Closes Case No. 25-3337GC as there are no remaining participants.

EJR Determination in Case No. 25-3337GC:

With regard to the Provider's request for EJR, Rule 42.1 explains that

> A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request.
>
> . . .
>
> The Board will make an EJR determination within 30 days **after it determines whether it has jurisdiction** and the request for EJR is complete. See 42 C.F.R. § 405.1842. (Bold emphasis added)

As a prerequisite to rendering an EJR determination, 42 C.F.R. § 405.1842(b)(1), states the Board "must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question." In this instance, Case No. 25-3337GC is being closed as it does not meet the minimum amount in controversy threshold for a group appeal. Therefore, the Board finds it appropriate to **deny the Provider's request for EJR** in Case No. 25-3337GC. Bass Berry will receive the Board's determination regarding the consolidated EJR under separate cover in the lead case, Case No. 25-1278GC.

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

For the Board:

3/11/2026

X Kevin D. Smith, CPA

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

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

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Via Electronic Delivery

Leslie Goldsmith, Esq.
Bass, Berry & Sims, PLC
1201 Pennsylvania Avenue NW, Suite 300
Washington, DC 20004

Re: ***Determination to Expand Earlier Year CIRP Group to Allow Consolidation of CIRP Less than $50K & Disposition of Expedited Judicial Review Request***

Case Number: 25-3340GC - Virtua Health System CYs 2007- 2008 DSH Calculation – Treatment of Medicare Part C Days CIRP Group

Case Number: 25-3870GC - Virtua Health System CY 2009 DSH Calculation - Treatment of Medicare Part C Days CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board (the "Board") has reviewed the March 11, 2026 correspondence from Bass, Berry & Sims, PLC ("Bass Berry") requesting to "merge" its calendar year ("CY") 2009 common issue related party ("CIRP") group with its earlier CY2008 appeal under Case No. 25-3340GC.[1,2] Bass Berry indicates that the CY 2009 CIRP group does not meet the minimum $50,000 jurisdictional threshold required for a group appeal.[3] In support of its request, Bass Berry certified that "there are no differences in relevant facts or laws between these two years that would support different decisions across these years."[4]

BOARD DETERMINATION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, 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. Further, 42 C.F.R. § 405.1839(b)(1) indicates that "[i]n order to satisfy the amount in controversy requirement under 42 C.F.R. § 405.1837(a)(3) . . . the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000."

[1] On February 20, 2026, Bass Berry filed a consolidated request for Expedited Judicial Review ("EJR") which included the referenced group appeals.
[2] Case No. 25-3340GC was just expanded to include CY 2007 to allow the consolidation of Case No. 25-3337GC which did not meet the $50K threshold requirement for a group.
[3] The aggregate amount in controversy in Case No. 25-3870GC is $14,995.
[4] Response to MAC Jurisdictional Challenges and Request to Combine at 2 (Mar. 11, 2026).

After reviewing the facts in these group cases and based on Bass Berry's certifications that the issues in these CIRP groups are identical and that there are no factual or regulatory changes for the issue between the three years, the Board is exercising its discretion and hereby:

1. Reopens the status of and further expands the CYs 2007-2008 CIRP group under Case No. 25-3340GC to include CY 2009;
2. Consolidates Case No. 25-3870GC into the newly expanded group under Case No. 25-3340GC;
3. Modifies the case name for Case No. 25-3340GC to the "Virtua Health System CYs 2007 - 2009 DSH Calculation – Treatment of Medicare Part C Days CIRP Group;
4. Re-designates Case No. 25-3340GC to be fully formed; and
5. Closes Case No. 25-3870GC as there are no remaining participants.

EJR Determination in Case No. 25-3870GC:

With regard to the Provider's request for EJR, Rule 42.1 explains that

> A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request.
>
> . . .
>
> The Board will make an EJR determination within 30 days **after it determines whether it has jurisdiction** and the request for EJR is complete. See 42 C.F.R. § 405.1842. (Bold emphasis added)

As a prerequisite to rendering an EJR determination, 42 C.F.R. § 405.1842(b)(1), states the Board "must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question." In this instance, Case No. 25-3870GC is being closed as it does not meet the minimum amount in controversy threshold for a group appeal. Therefore, the Board finds it appropriate to **deny the Provider's request for EJR** in Case No. 25-3870GC. Bass Berry will receive the Board's determination regarding the consolidated EJR under separate cover in the lead case, Case No. 25-1278GC.

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

For the Board:

3/11/2026

X Kevin D. Smith, CPA

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

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

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Washington, DC 20006

RE: ***Board Determination on Expansion and Consolidation of CIRP Groups AND Disposition of Related Request for Expedited Judicial Review***

Case Number 25-4793GC - Tenet Healthcare CY 2006 DSH Medicare Part C Days CR #13294 CIRP Group

Case Number 25-5567GC - Tenet Healthcare CY 2005 DSH Medicare Part C Days CR #13294 CIRP Group

As it relates to:
Princeton Baptist Medical Center (Provider Number 01-0103), FYE 06/30/2005

Dear Ms. Webster:

The Provider Reimbursement Review Board (the "Board") is in receipt of correspondence from Ropes & Gray, LLP ("Ropes"), filed on March 10, 2026, in which it requests the sole provider in the calendar year ("CY") 2005 common issue related party ("CIRP") group be transferred to a later year CIRP group pending for the same issue under Case No. 25-4793GC.[1] Ropes certified that the issue under appeal in each group is the same and that there are no factual or regulatory differences between the Providers' appeal of this issue for CYs 2005 and 2006. Ropes also simultaneously filed a request for expedited judicial review ("EJR") in both groups.[2] The Board's determination is set forth below.

Board Determination:

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

[1] Case No. 25-4793GC was designated to be fully formed on March 6, 2026.
[2] Request to Transfer Sole Remaining Provider at 1 (Mar. 10, 2026).

Board Rule 12.6.1 stipulates that a "CIRP group may be initiated by a single provider under common ownership or control, **but at least two different providers must be in the group upon full formation**"[3] Further 42 C.F.R. § 405.1837(b) requires that a group appeal have two or more providers.

After review, the Board notes that the only participant in the CY 2005 group is Princeton Baptist Medical Center and that there are currently twelve other participants in the CY 2006 CIRP group, which was designated to be fully formed on March 6, 2026.[4] Therefore, the Board is exercising its discretion and hereby (*reopens the status of and*) grants the expansion of the CY 2006 Tenet Healthcare "DSH Medicare Part C Days CR #13294" CIRP Group, Case No. 25-4793GC, to include CY 2005. The Board is consolidating the sole provider in Case No. 25-5567GC into the expanded group. Since there are no remaining providers, after the consolidation of Case No. 25-5567GC into Case No. 25-4793GC, Case No. 25-5567GC is hereby closed and removed from the Board's docket. In addition, the Board is re-designating Case No. 25-4793GC to be fully formed as of the date of this notification and is modifying the group name to the "Tenet Healthcare CYs 2005-2006 DSH Medicare Part C Days CR #13294 CIRP Group."

Since Ropes has indicated that there are no other providers in the Tenet Healthcare organization appealing the issue for CY 2005, the Board will not allow any future additions of CY 2005 providers to the expanded CIRP Group, Case No. 25-4793GC, nor will it accept a new group filing for Tenet Health for the CY 2005 DSH Medicare Part C Days CR #13294 issue.

Change of Lead Medicare Contractor in Case No. 25-5567GC:

The Board notes that the lead Medicare Contractor in Case No. 25-5567GC was Palmetto GBA ("Palmetto"/J-J) and the lead Medicare Contractor in the surviving group, Case No. 25-4793GC, is Novitas Solutions, Inc. c/o GuideWell Source ("Novitas"/J-H). This is to advise the Parties that the lead Medicare Contractor in the consolidated group, Case No. 25-5567GC, has been changed from Palmetto (J-J) to Novitas (J-H). Since the consolidated cases are now one, the change is necessary to allow the Medicare Contractor of the surviving case to have access to the information that originated in the now closed case. This notification should allow the Medicare Contractors to update the CMS System for Tracking Audit and Reimbursement ("STAR").

EJR Determination in Case No. 25-5567GC:

With regard to the Provider's request for EJR, Rule 42.1 explains that

> A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling. Board jurisdiction must be established prior to granting an EJR request.
>
> . . .

[3] Board Rules v. 3.2 (Dec. 15, 2023) (Emphasis added).
[4] Princeton Baptist Medical Center is not one of the participants in the CY 2006 CIRP group.

> The Board will make an EJR determination within 30 days **after it determines whether it has jurisdiction** and the request for EJR is complete. See 42 C.F.R. § 405.1842. (Bold emphasis added)

As a prerequisite to rendering an EJR determination, 42 C.F.R. § 405.1842(b)(1), states the Board "must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question."

In this instance, the group appeal is being closed as it does not meet the minimum participant requirements. Therefore, the Board finds it appropriate to **deny the Provider's request for EJR** in Case No. 25-5567GC. Ropes will receive the Board's determination regarding EJR in the surviving group, Case No. 25-4793GC, where Ropes simultaneously filed for EJR.

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

For the Board:

3/11/2026

X Kevin D. Smith, CPA

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

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

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

Ms. Nicole Stoychev
Reimbursement Manager
West Virginia University Health System
One Medical Center Drive
P.O. Box 8261
Morgantown, WV 26506

RE: **Determination re: Filing Requirements**
Braxton County Memorial Hospital (51-1308)
Appealed Period: 12/31/2020
PRRB Case No.: 26-1949

Dear Ms. Stoychev:

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 subject appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

A. Prior Appeal, PRRB Case No. 25-4867

On **June 30, 2025**, West Virginia University Health System (hereafter "WVU Health") filed an appeal on behalf of the above-referenced Provider for Fiscal Year End ("FYE") 12/31/2020. The proceedings for the appeal indicated that the Provider was filing the appeal based on a **Notice of Program Reimbursement** ("NPR") dated August 25, 20**23**. The sole issue in dispute in that individual appeal was stated as *Material Errors*. Case number 25-4867 was assigned to the appeal.

In a letter dated **July 14, 2025**, the Board noted that although the Provider had indicated that the appeal was based on an NPR dated August 25, 2023, it did not upload a copy of that final determination as required. In lieu of the NPR, the Provider filed various worksheets and audit adjustment pages dated August 23, 2023.

In addition, the Board noted that the Provider failed to file a Representation Letter in accordance with Board Rule 5.4. In lieu of the Representation Letter, the Provider filed a Modification Request letter addressed to the Medicare Contractor ("MAC").

Because the appeal request for case number was untimely filed since it was filed on the 675th day past the final determination date of August 25, 2023, the Board *dismissed* case number 25-4867, in its entirety, and removed it from its docket.

B. Current Appeal, PRRB Case No. 26-1949

On **March 3, 2026**, WVU Health filed another appeal on behalf of the above-referenced Provider for the same FYE 12/31/2020 and based on the same NPR dated 8/25/2023 as case number 25-4867. The sole issue for the new appeal was identified as *Material Omissions*. As OH CDMS automatically assigns case numbers as they are entered, the new individual appeal was assigned case number 26-1949.

As in the earlier appeal (case number 25-4867), the Board notes that although the Provider had indicated that the appeal is based on an NPR dated August 25, 2023, it did not upload a copy of that required final determination for the new appeal (case number 26-1949). In lieu of the NPR, the Provider filed various worksheets and audit adjustment pages dated August 23, 2023.

In addition, the Board notes that the Provider, again, failed to file a Representation Letter, in case number 26-1949 in accordance with Board Rule 5.4. In lieu of the Representation Letter, the Provider filed a Modification Request letter addressed to the MAC.

The Board notes that the appeal request for case number 26-1949 is untimely since it was filed on the ***921 days*** past the final determination date of August 25, 2023.

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

Board Rule 4.4.1. states:

> **Due Dates for New Appeals** New appeals must be received by the Board ***no later than 180 days*** from the commencement of the appeal period as specified in Rule 4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states:

> **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5 states:

> **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).

Board Rule 4.6.3[1] states:

> **Issue Previously Dismissed or Withdrawn** Once an issue is dismissed or withdrawn, the provider may not appeal or pursue that issue in any other case. For example, if the provider has an issue dismissed from its individual appeal, it may not appeal or pursue that same issue in a group appeal covering the same time period. Refer to Rule 47 for motions for reinstatement.

Per Board Rule 6.1, 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:

As noted in the facts above, the appeal request states that the subject appeal is based on a **Notice of Program Reimbursement** dated August 25, 20**23**. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on February 24, 2024 (since this date was a Saturday, the Provider had until the following business day, February 26, 2024 to file the appeal). The date of delivery to the Board for case number 26-1949, as evidenced by the Confirmation of Correspondence generated by OH CDMS, is March 3, 2026. The subject appeal request was filed 921 days past the final determination date of August 25, 2023 and was, therefore, untimely filed.

In addition, the Board notes that the Provider failed to meet the minimum filing requirements by omitting a copy of the NPR and a Letter of Representation from the appeal request.

[1] Also see 42 C.F.R. § 405.1840(c)

As a result, the Board hereby dismisses case number 26-1949, in its entirety, since it failed to meet the minimum filing requirements pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 and Board Rules 4.4.1, 4.4.3, 4.4.5 and 4.6.3.

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:

3/11/2026

X Nicole E. Musgrave

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

cc: Wilson C. Leong, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Ms. Nicole Stoychev
Reimbursement Manager
West Virginia University Health System
One Medical Center Drive
P.O. Box 8261
Morgantown, WV 26506

RE: **Determination re: Filing Requirements**
Braxton County Memorial Hospital (51-1308)
Appealed Period: 12/31/2021
PRRB Case No.: 26-1973

Dear Ms. Stoychev:

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 subject appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

A. Prior Appeal, Case No. 25-4868

On **June 30, 2025**, West Virginia University Health System (hereafter "WVU Health") filed an appeal, on behalf of the above referenced Provider, for Fiscal Year End ("FYE") 12/31/2021. The proceedings for the appeal indicated that the Provider was filing the appeal based on a **Notice of Program Reimbursement** ("NPR") dated June 26, 20**24**. The sole issue in dispute in the subject individual appeal was stated as *Material Errors*. OH CDMS assigned case number 25-4868 to the appeal.

In a letter dated **July 14, 2025**, the Board noted that although the Provider had indicated that the appeal was based on an NPR dated June 26, 2024, it did not upload a copy of that final determination as required. In lieu of the NPR, the Provider filed various worksheets and audit adjustment pages dated June 26, 2024.

In addition, the Board noted that the Provider failed to file a Representation Letter in accordance with Board Rule 5.4. In lieu of the Representation Letter, the Provider filed a Modification Request letter addressed to the Medicare Contractor ("MAC").

Because the appeal request for case number 25-4868 was untimely filed since it was filed on the 369th day past the final determination date of June 26, 2024, the Board *dismissed* case number 25-4868, in its entirety, and removed it from its docket.

B. Current Appeal, Case No. 29-1973

On **March 5, 2026**, WVU Health filed another appeal, on behalf of the above referenced Provider, for the same Fiscal Year End ("FYE") 12/31/2021 and based on the same NPR dated June 26, 2024 as case number 25-4868. The sole issue for the new appeal was identified as *Material Omissions*. As OH CDMS automatically assigns case numbers as they are entered, the new individual appeal was assigned case number 26-1973.

As in the earlier appeal (case number 25-4868), the Board notes that although the Provider had indicated that the appeal is based on an NPR dated June 26, 2024, it did not upload a copy of that required final determination for the new appeal (case number 26-1973). In lieu of the NPR, the Provider filed various worksheets and audit adjustment pages dated June 20, 2024.

In addition, the Board notes that the Provider, again, failed to file a Representation Letter in case number 26-1973 in accordance with Board Rule 5.4. In lieu of the Representation Letter, the Provider filed a Modification Request letter addressed to the Medicare Contractor.

The Board notes that the appeal request for case number 26-1973 is untimely filed since it was filed ***617 days*** past the final determination date of June 26, 2024.

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 contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and ***the request for a hearing is filed within 180 days of receipt of the final determination***.[1]

Board Rule 4.4.1. states:

> **Due Dates for New Appeals** New appeals must be received by the Board ***no later than 180 days*** from the commencement of the appeal period as specified in Rule 4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states:

> **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

[1] Emphasis added.

Board Rule 4.5 states:

> **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).

Board Rule 4.6.3[2] states:

> **Issue Previously Dismissed or Withdrawn** Once an issue is dismissed or withdrawn, the provider may not appeal or pursue that issue in any other case. For example, if the provider has an issue dismissed from its individual appeal, it may not appeal or pursue that same issue in a group appeal covering the same time period. Refer to Rule 47 for motions for reinstatement.

Per Board Rule 6.1, 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:

As noted in the facts above, the appeal request states that the subject appeal is based on a **Notice of Program Reimbursement** dated June 26, 20**24**. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on December 28, 2024 (since this date was a Saturday, the Provider had until the following business day, December 30, 2024 to file the appeal). The date of delivery to the Board for case number 26-1973, as evidenced by the Confirmation of Correspondence generated by OH CDMS, is March 5, 2026. The subject appeal request was filed 617 days past the final determination date of June 26, 2024 and was, therefore, untimely filed.

In addition, the Board notes that the Provider failed, once again, to meet the minimum filing requirements by omitting a copy of the NPR and a Letter of Representation from the appeal request.

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[2] *See also* 42 C.F.R. § 405.1840(c).

As a result, the Board hereby dismisses case number 26-1973, in its entirety, since it failed to meet the minimum filing requirements pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 and Board Rules 4.4.1, 4.4.3 and 4.4.5 and 4.6.3.

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:

3/11/2026

X Nicole E. Musgrave

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

cc: Wilson C. Leong, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

RE: ***Notice of Dismissal***
Lake Granbury Medical Center (Provider No. 45-0596)
FYE 11/30/2018
Case No. 23-0512

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0512. Set forth below is the decision of the Board to dismissing the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background:

A. *Procedural History for Case No. 23-0512*

On **August 1, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end November 30, 2018.

On **January 12, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 7, 2023**, the Provider transferred Issues 2, 4 and 5

[11] On March 3, 2026 , this issue was withdrawn.
[2] On August 7, 2023, this issue was transferred to PRRB Case No. 21-1206GC.
[3] On August 7, 2023, this issue was transferred to PRRB Case No. 20-2149GC.
[4] On August 7, 2023, this issue was transferred to PRRB Case No. 21-0066GC.

to Community Health groups. Issue 1 was withdrawn on March 3, 2026. As a result, there is remaining issue in this appeal: Issue 3 (DSH Payment – Medicaid Eligible Days).

On **January 13, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **August 22, 2023**, the Provider timely filed its preliminary position paper.

On **October 31, 2023**, the Medicare Contractor filed a Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor formally requested that a listing of the Medicaid eligible days at issue plus supporting documentation be provided to the Medicare Contractor on or before December 15, 2023 (*i.e*., within 45 days). Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

On **December 14, 2023**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider did not file a response and the time for doing so has elapsed.

On **December 22, 2023**, the Medicare Contractor timely filed its preliminary position paper.

B. Description of Issue 3 in the Appeal Request

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

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

[5] (Emphasis added).

Statement of the Legal Basis

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

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

Audit Adjustment Number(s): 5,6,20,S-D

Estimated Reimbursement Amount: $29,112[6]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[7] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[8] The Provider then, for the first time in this appeal, states it is seeking reimbursement for section 1115 waiver days as a part of the Medicaid eligible day issue. Specifically, the Provider states:

> [M]edicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).[9]

MAC's Contentions

Issue 3 – DSH Payment – Medicaid Eligible Days

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

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[6] Appeal Request at Issue 3.
[7] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[8] Provider's Preliminary Position Paper at 9.
[9] *Id.* at 9-10.

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its 2018 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[10]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] The Provider failed to file a timely response to the Jurisdictional Challenge. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

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

A. DSH Payment – Medicaid Eligible Days

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

[10] *Id*. at 11-12.
[11] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

Statement of the Issue

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

Statement of the Legal Basis

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

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[12]

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See*

[12] Individual Appeal Request, Issue 3.

> subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[13]

Similarly, with regard to position papers, Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[14] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[15]

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

---

[13] (Emphasis added).
[14] (Emphasis added).
[15] (Emphasis added).

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

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

This appeal was initiated on January 12, 2023 (over 3 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[16] ***To-date, no listing has been provided***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[17] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[18]

B. 1115 Waiver Days

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

The appeal was filed with the Board in January of 2023 and the regulations required the following:

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[16] Provider's Preliminary Position Paper at 10.

[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.

[18] An example of a CHS individual provider case in which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing in the manner prescribed by the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[19]

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

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

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

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

[19] 42 C.F.R. § 405.1835(b).

- ***Section 1115 waiver days (program/waiver specific). . .***[20]

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

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

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

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

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

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

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan

[20] (Bold and italic emphasis added).
[21] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[22] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

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

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

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

Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[26] Here, the Board makes the same finding based on similarly *overly generalized language.*

****

In summary, the Board hereby dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 23-0512 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/11/2026

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

[26] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Case Number 24-1709GC: *CHS CY 2020 Wage Index CIRP Group*

Dear Ms. Williams:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on **January 8, 2026** concerning the above referenced common issue related party ("CIRP") group appeal. The Board's decision on jurisdiction and EJR for this case are set forth below.

Issue:

The Petition for EJR describes the issue as follows:

> The Providers contend that the Centers for Medicare and Medicaid Services (CMS) applied a wage index for each of the Providers' fiscal years ended during calendar 2020 that was improper because the wage index did not treat rural hospitals described in Section 401 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (generally referred to as "Section 401" hospitals) "as being located in the rural area," in contravention of 42 U.S.C. § 1395ww(d)(8)(E)(i).[1]

The Providers assert these wage indices "were calculated in violation of the Medicare statute's requirement that Section 401 hospitals be treated the same as hospitals that are rural based on geographic location" and seek to challenge these policies as arbitrary, capricious, unreasonable, and unlawful.[2]

[1] Providers' Petition for Expedited Judicial Review at 1 (Jan. 8, 2026).
[2] *Id.* at 12.

Statutory and Regulatory Background:

1. Wage Index; Rural and Urban Classification

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

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

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives "an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to 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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[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[4] The standardized amount is based on per discharge averages from a base period and is updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that affects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (Aug. 18, 2006).
[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 Mar. 12, 2026).
[8] *Id.*

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

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

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

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

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

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

2. Rural Floor Adjustment

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

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

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

3. Changes to the Wage Index Calculation

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

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

allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[21,22] The Secretary finalized without modification the proposals

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

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

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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.

pointed out that the "legislative intent of the rural floor was to correct the 'anomaly' of 'some urban hospitals being paid less than the average rural hospital in their States.'"[27]

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

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

Positions of the Parties:

1. Providers' Appeal Requests

The Board received a request to establish a Common Issue Related Party ("CIRP") group from Powers, Pyles, Sutter & Verville, PC on **March 19, 2024**. The Board thereafter created Case 24-1709GC, *CHS CY 2020 Wage Index CIRP Group*. The Board received another request to establish a CIRP group from King & Spalding, LLP on **September 9, 2024**. The Board then created Case 24-2454GC, *CHS CY 2020 412.103 Wage Index CIRP Group*. On **January 21, 2025**, King & Spalding notified the Board that these groups both concerned the calculation of the wage index for Community Health Systems, Inc. and requested they be consolidated. The Board granted this request on **March 4, 2025**, leaving the earlier established group in Case 24-1709GC open with Powers, Pyles, Sutter & Verville as the designated representative.

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

The Providers describe the appealed issue as follows:

> **Brief Description of Issue:** The Providers contend that the Centers for Medicare and Medicaid Services (CMS) calculated an invalid wage index for their fiscal years ended on December 31, 2020 because CMS failed to comply with 42 U.S.C. §§ 1395ww(d)(8)(C)(ii), (iii), 42 U.S.C. § 1395ww(d)(8)(E)(i), and the Balanced Budget Act of 1997 § 4410(a).
>
> **Statement of Legal Basis for Appeal:** . . . . Section 401 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 allows a hospital that is located in an urban CBSA to be treated as a rural hospital if the hospital meets certain criteria. . . . The Providers contend that the wage index that CMS applied for purposes of their IPPS payments for cost years ending on December 31, 2020 violated 42 U.S.C. § 1395(d)(8)(E)(i) because CMS did not treat Section 401 hospitals as being part of the rural area of the state.[34]

2. Providers' Request for EJR

The Providers filed their Petition for EJR to challenge CMS' decision "not treat rural hospitals described in Section 401 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (generally referred to as 'Section 401' hospitals) 'as being located in the rural area,' in contravention of 42 U.S.C. § 1395ww(d)(8)(E)(i)."[35] The underlying argument is that the Medicare Statute requires that Section 401 hospitals "be treated the same as hospitals that are rural based on geographic location."[36] They argue that this failure is arbitrary, capricious, unreasonable, and unlawful. They continue:

> More specifically, CMS violated 42 U.S.C. § 1395ww(d)(8)(E) because it treated Section 401 hospitals differently than other rural hospitals by: (1) excluding from the rural wage index calculation the wage data of Section 401 hospitals that had an MGCRB reclassification to a different geographic area when including the data would increase the rural wage index in contravention of 42 U.S.C. § 1395ww(d)(8)(C)(ii); and (2) excluding the wage data of Section 401 hospitals from the rural floor calculations in contravention of BBA § 4410 and 42 U.S.C. § 1395ww(d)(8)(C)(iii).[37]

The Providers argue they have met the criteria set forth in 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), namely that the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.[38]

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[34] Issue Statement at 1 (Mar. 19, 2024).
[35] Providers' Petition for Expedited Judicial Review at 1.
[36] *Id.* at 12 (citing 42 U.S.C. § 1395ww(d)(8)(E)(i)).
[37] *Id.* at 12-13.
[38] *Id.* at 13.

3. Medicare Contractor's Position

On **January 6, 2026**, the designated representative certified that the group was fully formed and populated in OH CDMS pursuant to Board Rule 20. The Providers filed a Petition for Expedited Judicial Review ("EJR") on **January 8, 2026**. On **January 13, 2026**, the Medicare Contractor's designated representative, Federal Specialized Servies ("FSS") filed a timely Response to the Petition for EJR, which simply stated:

> Federal Specialized Services ("FSS"), as representative for the Medicare Administrative Contractor ("MAC"), responds to the Providers' request for Expedited Judicial Review (EJR) and notes that the MAC **has filed**[39] a substantive claim challenge in this case.[40]

A review of the record did not reveal any Substantive Claim Challenge, but a Substantive Claim Challenge was filed on **January 21, 2026** alleging that nine (9) providers did not include an appropriate claim in the cost reports for the disputed issue. **On February 3, 2026**, the Board issued a Scheduling Order for the Provider to file a response no later than February 18.[41] On **February 11, 2026**, FSS filed an updated Substantive Claim Challenge, essentially withdrawing their previous challenge as to three (3) of the Providers. The Providers filed a Response on **February 17, 2026**, and filed a revised response on **February 18**.

Decision of the Board:

The participants that are included in the group appeal filing this EJR request have filed appeals involving FFY 2020 based on policies established in the FFY 2020 IPPS Final Rule published in the Federal Register.

1. Jurisdiction and Request for EJR

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[42] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an

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[39] (Emphasis added).
[40] Response to Provider's Request for Expedited Judicial Review at 1 (Jan. 13, 2026).
[41] The Board found that, while the language in the January 13, 2026 response to the Petition for EJR was misleading, it was sufficient to put the Board and Providers on notice that a challenge would be filed within the requirements of Board Rule 44.6, considering that the filing was within five (5) business days of the request for EJR and the Substantive Claim Challenge was ultimately filed within twenty (20) days of the request for EJR.
[42] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

appropriate cost report claim.[43] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). All of the participants in these cases have fiscal years that began on or after January 1, 2016, so the claim-specific dissatisfaction requirement is not applicable to the Board's analysis regarding jurisdiction.

As previously noted, all of the participants in this group case appealed from the FFY 2020 IPPS Final Rule.[44] The Board has determined that (1) the participants' documentation in the group appeals show that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[45] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that, while there is some variance in how the amounts in controversy were calculated, or at least how they were illustrated, one example notes the actual wage indices used, and compares them to "corrected" wage indices which "reflect what the hospital's wage index adjustment would have been . . . had CMS treated section 413.103 hospitals the same as geographically rural hospitals in calculating the wage index, as is required by the statute."[46] 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

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

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[43] *Id.* at 70555.
[44] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[45] *See* 42 C.F.R. § 405.1837.
[46] Reimbursement Impact, Shands Lake Shore Regional Medical Center (Provider Number 10-0102).

> 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.[47]

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.

[47] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[48]

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

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

[48] (Bold and underline emphasis added.)

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

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

> A party that questions whether the one or more participants in a group case (CIRP or optional) included an appropriate claim *on the cost report at issue* for the common issue being appealed in the group **must file a Substantive Claim Challenge sixty (60) days after the group files its final Schedule of Providers (SOP) unless the moving party's filing demonstrates good cause**.[49] The moving party must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the Substantive Claim Challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* sample language in Rule 44.2. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
>
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed per Board Rule 42*.---If the final SOP is filed concurrent with an EJR request or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then refer to Rule 44.6 for special instructions on deadlines for filing Substantive Claim Challenges and any response thereto.

As previously noted, a Substantive Claim Challenge was filed in this case, and a timely Response was filed by the Providers following the Board's February 3, 2026 Scheduling Order.

i. *Substantive Claim Challenge*

The Medicare Contractor is challenging whether the following six (6) Providers ("the Challenged Providers") included an appropriate claim on the cost reports for the disputed issue:

- Lutheran Hospital of Indiana Provider No. 15-0017 FYE 6/30/2020 ("Lutheran")
- Shore Point Health Punta Gorda, Provider No. 10-0047, FYE 9/30/2020 ("Shore Point")
- Lower Keys Medical Center, Provider No. 10-0150, FYE 9/30/2020 ("Lower Keys")
- Shands Lake Shore Regional Medical Center, Provider No. 10-0102, FYE 8/30/2020 ("Shands")
- Lafolette Medical Center Provider No. 44-0033, FYE 9/30/2020 ("Lafolette")

[49] (Bold and underline emphasis added.)

- Flowers Hospital, Provider No. 01-0055, FYE 9/30/2020 ("Flowers")[50]

For Lutheran, the Medicare Contractor claims no audit adjustment was cited as the basis for its dispute, and that while the Provider did include a protested amount on its cost report, no protest schedule was submitted with the as-filed cost report, which would identify what items were being protested, the basis for the protest, and the dollar amount attributable to each protested item.[51]

For Shore Point, the Medicare Contractor notes that an audit adjustment is cited which does adjust the wage index, but that this "does not indicate that the Provider sought to claim reimbursement for the [appealed issue].[52] Additionally, while this Provider did include a protested amount on its cost report, no protest schedule was submitted with the as-filed cost report, which would identify what items were being protested, the basis for the protest, and the dollar amount attributable to each protested item.[53]

For Lower Keys, the Medicare Contractor notes that an audit adjustment is cited which does adjust the wage index, but that this "does not indicate the Provider sought to claim reimbursement for the [appealed issue].[54] Additionally, while this Provider identified protested amounts on its cost report, the accompanying protested schedules do not include the appealed wage index issue.[55]

For Shands, the Medicare Contractor notes that two audit adjustments are cited which do adjust the wage index, but that these "do not indicate the Provider sought to claim reimbursement for the [appealed issue]."[56] Additionally, while this Provider identified protested amounts on its cost report, the accompanying protested schedules do not include the appealed wage index issue.[57]

For Lafolette, the Medicare Contractor claims no audit adjustment was cited as the basis for its dispute, and while this Provider identified protested amounts on its cost report, the accompanying protested schedules do not include the appealed wage index issue.[58]

Finally, for Flowers, the Medicare Contractor claims no audit adjustment was cited as the basis for its dispute, and while it identified protested amounts on its cost report, the accompanying protested schedules do not include an item related to the appealed wage index issue.[59]

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[50] Medicare Administrative Contractor's Amended Substantive Claim Challenge at 1 (Feb. 11, 2026).
[51] *Id.* at 5 and Ex. C-3.
[52] *Id.* at 5.
[53] *Id.* and Ex. C-4.
[54] *Id.* at 5-6.
[55] *Id.* and Ex. C-5.
[56] *Id.* at 6.
[57] *Id.* and Ex. C-6.
[58] *Id.* at 6-7 and Ex. C-7.
[59] *Id.* at 7 and Ex. C-8.

ii. Providers' Response

The Providers' response emphasizes 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] They also argue that Shore Point, Shands, Lower Keys, and Lutheran met the requirements set forth in 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873 because their NPRs included adjustments to the wage index.[63] Their Response argues:

> For ShorePoint, the MAC made Adjustment No. 26, which it described as "Provider's requested revisions to the wage index data." Exhibit P-2. For Shands, the MAC made Adjustment Nos. 5 and 7. The MAC described the purpose of Adjustments No. 5 and 7 as "To adjust Wage Index to agree to the Provider's revision request." Exhibit P-3. For Lower Keys, the MAC made Adjustment No. 14, which the MAC described as "Provider's requested revisions to the wage index data." Exhibit P-4. For Lutheran, the MAC made Adjustment Nos. 9 through 11. The MAC described the purpose of Adjustment No. 9, 10 and 11 as "Provider's requested revisions to the wage index data"
>
> The descriptions of these audit adjustments demonstrates that ShorePint, Shands, Lower Keys and Lutheran each made a request for an adjustment to its wage data. Therefore, ShorePoint, Shands, Lower Keys and Lutheran met the requirements of 42 C.F.R. § 413.24(j)(1) because their "cost report[s] included an appropriate claim for the specific item." Furthermore, the MAC actually adjusted the Providers' wage data. Therefore, ShorePoint, Shands, Lower Keys and Lutheran are "dissatisfied with a final determination" of their MAC and are entitled to appeal the determination and to receive the appropriate Medicare payments.[64]

Finally, the Providers' Response expresses a desire to challenge the validity of 42 C.F.R. § 413.24(j).[65] Indeed, they filed an additional, separate Request for EJR for this issue on **February 23, 2026**.

iii. 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))"[66]

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[60] 485 U.S. 399 (1988).
[61] 201 F.Supp.3d 131 (D.D.C. 2016)
[62] REVISED Providers' Response to Substantive Claim Challenge, 6-10 (Feb. 18, 2026).
[63] *Id.* at 10.
[64] *Id.* at 11.
[65] *Id.* at 11-12.
[66] (Emphasis added.)

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 Medicare Contractor has alleged that six (6) Providers have failed to satisfy the requirements set forth in 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873. Compliance with 42 C.F.R. § 413.24(j)(1) can be achieved by ***either*** claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy ***or*** self-disallowing the specific item. The Providers have not alleged that any of the six (6) challenged Providers have properly self-disallowed the specific item under appeal in their respective cost reports. Nor do they allege that Lafolette or Flowers have claimed full reimbursement in their cost reports for the specific item under appeal in accordance with Medicare Policy.

They do, however, argue that Shore Point, Shands, Lower Keys, and Lutheran each made a request for an adjustment to its wage data and therefore met the requirements of 42 C.F.R. § 413.24(j)(1) because their "cost report[s] included an appropriate claim for the specific item."

These four (4) Providers' wage data was, in fact, adjusted. But 42 C.F.R. § 413.24(j)(1) does not merely require that a Provider request **some** additional reimbursement, or that an adjustment be made to the NPR. It requires the Provider to claim **full** reimbursement for a specific item. These four (4) Providers' adjustments were to change the wage data to what the Provider asked for. They received adjustments to match what they claimed was the correct wage data, representing full reimbursement on this issue. On appeal, they are seeking additional reimbursement beyond what they claimed in their cost reports, suggesting the amount they originally sought from the Medicare Contractor did not represent **full** reimbursement for the alleged deficiencies in the wage index data. If the request had included reimbursement for the appealed issue, and the adjustment was to change the data, per the Provider's request, there would be no need for these appeals.

Based on the foregoing, the Board finds that all six (6) of the Challenged Providers failed to make an appropriate cost report claim for the appealed issue.

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). . . .”[67] was made through notice and comment in the form of an uncodified regulation.[68]

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.[69]

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.[70]

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 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).[71] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in Case 24-1709GC.

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[67] 84 Fed. Reg. 42044 at 42336.
[68] *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.”
[69] 84 Fed. Reg. at 42336.
[70] 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 . . . .”
[71] *See* Providers’ Petition for Expedited Judicial Review at 1, 12-14.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject year in Case No. 24-1709GC and that the Providers in the group appeal are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for six (6) Providers (the Challenged Providers) and the Board specifically finds that the six (6) Challenged Providers failed to include "an appropriate claim for the specific item" that is the subject of this group appeal as required under 42 C.F.R. § 413.24(j)(1);

3) Based upon the Providers' assertions regarding the FFY 2020 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 IPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 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 this case, the Board hereby closes Case 24-1709GC 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:

3/12/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
Case Numbers: 24-2543GC *et al*. (11 Cases – *See* **Appendix A**)

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed between **February 13 and 19, 2026** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Providers in these Common Issue Related Party ("CIRP") group appeals are all appealing from original and revised Notices of Program Reimbursement ("NPRs/RNPRs"), **some**[1] of which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[2] as it pertains to the Providers' Fiscal Year Ends ("FYEs") in calendar years spanning 2004 to 2013.

The issue in these appeals is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[3] 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.[4]

[1] As explained *infra*, the record for some Providers does not substantiate the claim that the RNPRs are actually implementing the June 2023 Final Rule, but instead suggest they were issued to implement some other adjustment to the cost report.
[2] 88 Fed. Reg. 37772 (June 9, 2023).
[3] *E.g.,* Case No. 24-2543GC, Statement of Group Issue at 1 (Sept. 18, 2024).
[4] *Id.* at 2-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[5] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[7] 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.[8]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[9] 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.[10] The DPP is defined as the sum of two fractions expressed as percentages.[11] 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 . . . .[12]

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.[13]

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[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(2)-(3).

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[14]

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.[15]

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[16] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[17]

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[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).
[16] of Health and Human Services.
[17] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[18]

With the creation of Medicare Part C in 1997,[19] 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.[20] 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."[21] 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.[22]

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.[23] 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."[24] In response to a comment regarding this change, the Secretary explained that:

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

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[18] *Id.*
[19] 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.
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[21] *Id.*
[22] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[23] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[24] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[25]

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.[26] 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).[27] 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."[28]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[29]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[30] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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[25] *Id.* (emphasis added).
[26] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[27] *Id*. at 47411.
[28] 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).
[29] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[30] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[31] 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.[32] 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.[33] 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.[34] A number of hospitals appealed this action.[35] In *Azar v. Allina Health Services* ("*Allina II*"),[36] 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.[37] 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."[38] 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.[39]

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.[40] 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

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[31] *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.").
[32] *Id.* at 2011.
[33] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[34] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[35] 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)).
[36] 139 S.Ct. 1804 (2019).
[37] *Id.* at 1817.
[38] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[39] 139 S.Ct. at 1814.
[40] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> 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.[41]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[42] 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.[43]

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

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

[41] CMS Ruling 1739-R at 1-2.
[42] 88 Fed. Reg. 37772 (June 9, 2023).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

fractions for ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[44]

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**."[45]

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."[46]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[47]

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.[48] It ruled,

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[44] 88 Fed. Reg. at 37774-75 (emphasis added).
[45] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[46] *Id.* at 37788 (emphasis added).
[47] *Id.* (emphasis added).
[48] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

however, that the June 9, 2023 Final Rule is both impermissibly retroactive[49] and arbitrary and capricious.[50] The court has ordered the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[51]

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[52]

The "Statement of Group Issue" included with the group appeal requests state that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[53] 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.[54]

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[55]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been

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[49] *Id.* at *12-19.
[50] *Id.* at *19-22.
[51] *Id.* at *23.
[52] *E.g.,* Case No. 24-2543GC, Appeal Request, Statement of Jurisdiction (citations omitted).
[53] *E.g.,* Case No. 24-2543GC, Appeal Request, Statement of Group Issue at 1.
[54] *Id.*
[55] *Id.* (citing to 139 S. Ct. at 1816).

vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[56]

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."[57]

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.[58] 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.[59] "The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the NPR[s] 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."[60] Since the Board is bound by this regulation,[61] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

The Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed timely responses to all eleven (11) Petitions for EJR in these cases. In Case 25-1298GC, FSS indicated it would be filing a jurisdictional challenge as to Provider 45-0651, but the Providers' Representative withdrew that provider the following day making FSS' potential challenge moot. In each remaining case, FSS' response simply noted "that the MAC will not file a jurisdictional challenge in this case, the MAC will not file a substantive claim challenge in this case."[62]

Decision of the Board:

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

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[56] *Id.*
[57] *Id.* (citing 4 U.S.C. § 706(2)).
[58] *E.g.*, Case No. 25-2543GC, Providers' Petition for Expedited Judicial Review at 13 (Feb. 13, 2026).
[59] *Id.* at 16-17.
[60] *Id.* at 1-2.
[61] 42 C.F.R. § 405.1867.
[62] *E.g.*, Case No. 25-2543GC, Response to Provider's Request for Expedited Judicial Review at 1 (Feb. 20, 2026).

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [63]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[64]

For these eleven (11) appeals listed in **Appendix A,** the Board finds that the Providers were directly added to the groups within 180 days of the issuance of their NPRs and/or RNPRs and the amount in controversy exceeds $50,000 in each case. ***Most*** of the providers 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. RNPRs in those cases are typically for $0 and specifically reference CR13294 or *Allina v. Sebelius* in the actual RNPR or in a cover letter accompanying the RNPR. Others have a Notice of Reopening included with the RNPR or a specific audit adjustment which makes a similar reference. The records for the following providers, however, do ***not*** have ***anything*** in the record which demonstrates that that the RNPRs were issued to implement the new, retroactive Part C days rule. The Providers outlined below shall be collectively referred to as the "improper RNPR Providers."

I. Case 24-2543GC

Trident Medical Center (Provider No. 42-0079, FYE 3/31/2013) is appealing from an RNPR dated June 11, 2025. The RNPR **specifically** addressed a realignment request and was issued because the Medicare Contractor "received a Medicare Part A/SSI Percentage Realignment Request for the above provider and fiscal year end on 09/05/2024." The request was processed and a new SSI percentage was applied, resulting in in a payment due to the Provider in the amount of $238,351. The audit adjustments submitted with the appeal request specifically reference the SSI realignment. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated June 11, 2025, was issued as a result of this remand.

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[63] 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).
[64] 42 U.S.C. § 1395oo(a) and (b); 42 C.F.R. §§ 405.1835 – 1840.

II. Case 25-1298GC

Central Florida Lake Monroe Hospital (Provider No. 10-0161, FYE 5/31/2005) is appealing from an RNPR dated March 19, 2025. The RNPR resulted in a payment due to the Provider in the amount of $11,144. The audit adjustments reference updating the cost report to the published SSI percentage and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 19, 2025, was issued as a result of this remand.

Corpus Christi Medical Center (Provider No. 45-0788, FYE 8/31/2005) is appealing from an RNPR dated March 21, 2025. The RNPR resulted in a payment due to the Program in the amount of $440,125. The audit adjustments reference updating the cost report to the published SSI percentage and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 21, 2025, was issued as a result of this remand.

East Houston Medical Center (Provider No. 45-0126, FYE 2/28/2005) is appealing from an RNPR dated March 21, 2025. The RNPR resulted in a payment due to the Provider in the amount of $29,160. The audit adjustments reference updating the cost report to the published SSI percentage and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 21, 2025, was issued as a result of this remand.

HCA Florida Capital Hospital (Provider No. 10-0254, FYE 4/30/2005) is appealing from an RNPR dated March 24, 2025. The RNPR resulted in a payment due to the Program in the amount of $63,888. The audit adjustments reference updating the cost report to the published SSI percentage and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 24, 2025, was issued as a result of this remand.

HCA Florida Mercy Hospital (Provider No. 10-0167, FYE 8/31/2005) is appealing from an RNPR dated March 24, 2025. The RNPR resulted in a payment due to the Program in the amount of $34,549. The audit adjustments reference updating the cost report to the published SSI percentage and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 24, 2025, was issued as a result of this remand.

HCA Florida Palms West Hospital (Provider No. 10-0269, FYE 5/31/2005) is appealing from an RNPR dated March 24, 2025. The RNPR resulted in a payment due to the Program in the amount of $15,532. The audit adjustments reference updating the cost report to the published SSI percentage and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 24, 2025, was issued as a result of this remand.

HCA Florida Trinity Hospital (Provider No. 10-0191, FYE 6/30/2005) is appealing from an RNPR dated March 19, 2025. The RNPR resulted in a payment due to the Program in the amount of $13,696. The audit adjustments reference updating the cost report to the published SSI percentage and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 19, 2025, was issued as a result of this remand.

HCA HealthONE Presbyterian St. Luke's (Provider No. 06-0014, FYE 8/31/2005) is appealing from an RNPR dated March 25, 2025. The RNPR resulted in a payment due to the Provider in the amount of $309,200. The audit adjustments reference updating the cost report to the **realignment** SSI percentage, and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 25, 2025, was issued as a result of this remand.

Medical Center of McKinney (Provider No. 45-0403, FYE 8/31/2005) is appealing from an RNPR dated May 30, 2025. The RNPR resulted in a payment due to the Program in the amount

of $44,053. The audit adjustments reference updating the cost report to the published SSI percentage, and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated May 30, 2025, was issued as a result of this remand.

Medical City Dallas Hospital (Provider No. 45-0647, FYE 5/31/2005) is appealing from an RNPR dated March 24, 2025. The RNPR resulted in a payment due to the Provider in the amount of $326,954. The audit adjustments reference populating the correct CBSA code, updating the cost report to the published SSI percentage, and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 24, 2025, was issued as a result of this remand.

Methodist Hospital (Provider No. 45-0388, FYE 6/30/2005) is appealing from an RNPR dated May 30, 2025. The RNPR resulted in a payment due to the Program in the amount of $297,193. The audit adjustments reference updating the cost report to the published SSI percentage, and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated May 30, 2025, was issued as a result of this remand.

OU Medical Center (Provider No. 37-0093, FYE 8/31/2005) is appealing from an RNPR dated March 14, 2025. The RNPR resulted in a payment due to the Provider in the amount of $133,173. The audit adjustments reference implementing an SSI percentage realignment and to properly state the allowable DSH adjustment factor. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 14, 2025, was issued as a result of this remand.

III. Case 25-4994GC

East Jefferson General Hospital (Provider No 19-0176, FYE 12/31/2006) is appealing an RNPR dated March 25, 2025. The RNPR was **specifically** issued based on a provider request for an SSI realignment. Indeed, the appeal contains a Notice of Realignment dated August 26, 2022, which references the Provider's Request for SSI Realignment dated August 2, 2022. The RNPR

resulted in a payment due to the Provider of $89,705. The audit adjustments submitted with the appeal request specifically reference the SSI realignment. The appeal request also includes an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 25, 2025, was issued as a result of this remand.

IV. Case 25-0808GC

Singing River Gulfport (Provider No. 25-0123, FYE 12/31/2007) is appealing from an RNPR dated February 28, 2025. The RNPR resulted in a payment due to the Provider in the amount of $48,713. The audit adjustments reference updating SSI and DSH percentage related to a realignment. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated February 28, 2025, was issued as a result of this remand.

V. Case 24-2542GC

Medical City North Hills (Provider No. 45-0087, FYE 5/31/2012) is appealing from two different RNPRs. One is dated March 6, 2025, and **was** issued to implement the retroactive Part C Days Rule. It is also appealing an RNPR dated October 2, 2024 which resulted in a payment due to the Provider in the amount of $310. The audit adjustments reference including additional Medicaid eligible days. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated October 2, 2024, was issued as a result of this remand.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the Cases listed in **Appendix A**, and that, except for the Improper RNPR Providers, the Providers in each appeal are entitled to a hearing before the Board;

2) For the Improper RNPR Providers, these Providers did not appeal from a final determination which specifically adjusted the issue in these appeals, since there is nothing in the records for those Providers to show that the RNPRs being appealed were

issued to implement the June 2023 Final Rule and, as a result, the Board hereby ***dismisses*** these Providers from their respective appeals;

3) 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;

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 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, except with regard to the Improper RNPR Providers which are hereby dismissed from Case Nos. 24-2543GC, 25-1298GC, 25-4994GC, 25-0808GC, and 24-2542GC.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in the eleven (11) Cases listed in **Appendix A**, the Board hereby closes these eleven (11) cases and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/12/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Judith Cummings, CGS Administrators (J-15)
Scott Berends, Federal Specialized Services

Appendix A

PRRB Case Number	PRRB Case: Case Name
24-2543GC	*HCA CY 2013 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*
24-2541GC	*HCA CY 2011 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*
25-3837GC	*HCA CY 2004 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*
25-0303GC	*HCA CY 2009 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*
25-0240GC	*HCA CY 2010 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*
24-2542GC	*HCA CY 2012 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*
25-1298GC	*HCA CY 2005 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*
25-4313GC	*Kettering Health Network CY 2013 Post-Allina II DSH Part C Days CIRP Group*
25-0082GC	*HCA CY 2014 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*
25-4994GC	*HCA CY 2006 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*
25-0808GC	*HCA CY 2007 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Avenue NW
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RE: ***Expedited Judicial Review Determination***
Case Number: 24-2539GC *HCA CY 2008 Medicare Care Advantage Pre 10-1-13 Part C Days CIRP Group*

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on **February 20, 2026** in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Providers in this Common Issue Related Party ("CIRP") group appeal are all appealing from original and/or revised Notices of Program Reimbursement ("NPRs"), **some**[1] of which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[2] as it pertains to the Providers' Fiscal Year Ends ("FYEs") in calendar year 2008.

The issue in these appeals is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[3] 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.[4]

[1] As explained *infra*, the record for some Providers does not substantiate the claim that the RNPRs are actually implementing the June 2023 Final Rule, but instead suggest they were issued to implement some other adjustment to the cost report.
[2] 88 Fed. Reg. 37772 (June 9, 2023).
[3] *E.g.,* Case No. 24-2539GC, Statement of Group Issue at 1 (Sept. 18, 2024).
[4] *Id.* at 2-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[5] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[7] 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.[8]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[9] 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.[10] The DPP is defined as the sum of two fractions expressed as percentages.[11] 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 . . . .[12]

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.[13]

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[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(2)-(3).

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[14]

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.[15]

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[16] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[17]

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[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).
[16] of Health and Human Services.
[17] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[18]

With the creation of Medicare Part C in 1997,[19] 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.[20] 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."[21] 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.[22]

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.[23] 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."[24] In response to a comment regarding this change, the Secretary explained that:

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

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[18] *Id.*
[19] 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.
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[21] *Id.*
[22] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[23] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[24] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[25]

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.[26] 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).[27] 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."[28]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[29]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[30] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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[25] *Id.* (emphasis added).
[26] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[27] *Id*. at 47411.
[28] 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).
[29] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[30] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[31] 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.[32] 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.[33] 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.[34] A number of hospitals appealed this action.[35] In *Azar v. Allina Health Services* ("*Allina II*"),[36] 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.[37] 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."[38] 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.[39]

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.[40] 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

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[31] *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.").
[32] *Id.* at 2011.
[33] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[34] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[35] 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)).
[36] 139 S.Ct. 1804 (2019).
[37] *Id.* at 1817.
[38] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[39] 139 S.Ct. at 1814.
[40] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> 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.[41]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[42] 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.[43]

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

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

[41] CMS Ruling 1739-R at 1-2.
[42] 88 Fed. Reg. 37772 (June 9, 2023).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

*fractions for **each** applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[44]

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**."[45]

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."[46]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[47]

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.[48] It ruled,

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[44] 88 Fed. Reg. at 37774-75 (emphasis added).
[45] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[46] *Id.* at 37788 (emphasis added).
[47] *Id.* (emphasis added).
[48] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

however, that the June 9, 2023 Final Rule is both impermissibly retroactive[49] and arbitrary and capricious.[50] The court has ordered the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[51]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal request includes a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[52]

The "Statement of Group Issue" included with the group appeal request states 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."[53] 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.[54]

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[55]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been

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[49] *Id.* at *12-19.
[50] *Id.* at *19-22.
[51] *Id.* at *23.
[52] *E.g.,* Case No. 24-2539GC, Appeal Request, Statement of Jurisdiction (citations omitted).
[53] *E.g.,* Case No. 24-2539GC, Appeal Request, Statement of Group Issue at 1.
[54] *Id.*
[55] *Id.* (citing to 139 S. Ct. at 1816).

vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[56]

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."[57]

B. Providers' Petition for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[58] 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.[59] "The Provider[s] contend that the new, post-*Allina* retroactive part C days rule, applied in the NPR[s] 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."[60] Since the Board is bound by this regulation,[61] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

The Medicare Contractor's representative, Federal Specialized Services, filed a response to the Request for EJR on **February 27, 2026** simply noting "that the MAC will not file a jurisdictional challenge in this case, the MAC will not file a substantive claim challenge in this case."[62]

Decision of the Board:

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

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[56] *Id.*
[57] *Id.* (citing 4 U.S.C. § 706(2)).
[58] *E.g.*, Case No. 24-2539GC, Providers' Petition for Expedited Judicial Review at 13 (Feb. 13, 2026).
[59] *Id.* at 16-17.
[60] *Id.* at 1-2.
[61] 42 C.F.R. § 405.1867.
[62] *E.g.*, Case No. 24-2539GC, Response to Provider's Request for Expedited Judicial Review at 1 (Feb. 27, 2026).

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [63]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[64]

The Providers in this case were directly added to the group within 180 days of the issuance of their NPRs and/or RNPRs and the amount in controversy exceeds $50,000. ***Most*** of the providers 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. Those RNPRs are typically for $0 and specifically reference CR13294 or *Allina v. Sebelius* in the actual RNPR or in a cover letter accompanying the RNPR. Others have a Notice of Reopening for the cost report or a specific audit adjustment which makes a similar reference. The records for the following providers, however, do ***not*** have ***anything*** in the record demonstrate that that the RNPRs were issued to implement the new, retroactive Part C days rule. The Providers outlined below shall be collectively referred to as the "improper RNPR Providers."

Central Florida Lake Monroe Hospital (Provider No. 10-0161, FYE 5/31/2008) is appealing from an RNPR dated August 23, 2024. The RNPR resulted in a payment due to the Provider in the amount of $156,044. The only specific audit adjustment is listed "to properly include the last settlement on the reopened cost report." There is a document included which shows a reopening was granted on September 18, 2013, with a stated "issue type" of "DSH/SSI%" that resulted in this RNPR. Nothing in that request confirms the reopening request was related to Part C days. The appeal does not include an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply includes an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated August 23, 2024, was issued as a result of this remand.

Corpus Christi Medical Center (Provider No. 45-0788, FYE 8/31/2008) is appealing from an RNPR dated June 30, 2025. The RNPR resulted in a payment due to the Provider in the amount of $3,328. The audit adjustments reference properly stating the allowable DSH adjustment

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[63] 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).
[64] 42 U.S.C. § 1395oo(a) and (b); 42 C.F.R. §§ 405.1835 – 1840.

factor and including the last settlement on the reopened cost report. No adjustment to the SSI percentage (not even a zero adjustment) is made in the submitted adjustment report. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated June 30, 2025, was issued as a result of this remand.

HCA Florida Gulf Coast Hospital (Provider No. 10-0242, FYE 1/31/2008) is appealing from an RNPR dated March 25, 2025. The RNPR resulted in a payment due to the Provider in the amount of $54,806. The audit adjustments reference updating the SSI% and the allowable DSH %, per CMS CR 13413, as well as recording settlement amounts per the most recent NPR'd cost report. CMS CR 13413 is specific to realignment, and the filename for these adjustments **specifically** references "SSI Realignment." The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 25, 2025, was issued as a result of this remand.

Spring Branch Medical Center (Provider No. 45-0630, FYE 6/30/2008) is appealing an RNPR dated June 17, 2025. The RNPR resulted in a payment due to the Program in the amount of $1,771. The audit adjustments reference properly stating the allowable DSH adjustment factor and including the last settlement on the reopened cost report. No adjustment to the SSI percentage (not even a zero adjustment) is made in the submitted adjustment report. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated June 17, 2025, was issued as a result of this remand.

Women and Children's Hospital (Prov. No. 19-0205, FYE 8/31/2008) is appealing an RNPR dated March 24, 2025. The RNPR resulted in a payment due to the Provider in the amount of $522,973. The audit adjustments reference properly stating the allowable DSH adjustment factor and including the last settlement on the reopened cost report. An email, sent by the Provider's Managing Director of Appeals was sent to the MAC, but includes no response from the MAC which would verify that this was a part C remand RNRP. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor, as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated March 24, 2025, was issued as a result of this remand.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the Case 24-2539GC, and that, except for the Improper RNPR Providers, the Providers in each appeal are entitled to a hearing before the Board;

2) For the Improper RNPR Providers, the Board finds that these Providers did not appeal from a final determination which specifically adjusted the issue in these appeals, since there is nothing in the records for those Providers to show that the RNPRs being appealed were issued to implement the June 2023 Final Rule and, as a result, the Board hereby ***dismisses*** these Providers from their respective appeals;

3) 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;

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 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' request for EJR for the issue and the subject year, except with regard to the Improper RNPR Providers which are hereby dismissed.

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 Case 24-2539GC, the Board hereby closes this case and will remove it from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/16/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Leslie Goldsmith
Bass, Berry & Sims, PLC
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Washington, DC 20004

RE: ***Expedited Judicial Review Determination***
Case Numbers: 25-4641G *et al.* (16 cases – *see* **Appendix A**)
Bass, Berry Sims Treatment of Medicare Part C Days Groups

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Consolidated Petition for Expedited Judicial Review ("EJR") filed on **February 20, 2026** in the above-referenced group appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

Between **January 3 and June 6, 2025**, the Board received sixteen (16) requests to establish Common Issue Related Party ("CIRP") and optional groups. The Providers in all sixteen (16) groups are appealing from original and revised Notices of Program Reimbursement ("NPRs" and "RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYEs") spanning from 2005 to 2012.

The issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days"). The Providers contend that "Medicare Part C days should be included in the numerator of the Medicaid fraction (if the inpatient day is attributable to an individual who is also eligible for Medicaid) (also referred to as the Medicaid percentage) and excluded from the numerator and denominator of the Supplementary Security Income ("SSI") fraction."[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 25-4641G, Issue Statement and Jurisdictional Statement at 1 (June 6, 2025).
[3] *Id.* at 1-2.

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 impermissibly retroactive[48] and arbitrary and capricious.[49] The court has ordered the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[50]

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests argue that Medicare Part C days should be included in the Medicaid fraction rather than the Medicare/SSI Fraction.[51] They seek to invalidate the NPRs and DSH adjustments made pursuant to the Final Rule published on June 9, 2023, arguing the rule is "procedurally and substantively invalid under the Medicare statute and the APA."[52]

The Providers recount how, prior to 2004, CMS did not include Part C Days in the SSI Ratio, along with the subsequent rulemaking and litigation which can be outlined as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. This decision was affirmed by the Supreme Court in 2019.[53]

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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. 25-4641G, Issue Statement and Jurisdictional Statement at 1.
[52] *Id.* at 3.
[53] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).

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.[54]

Based on the above, the Providers argue that "[t]he Final Rule is arbitrary and capricious, not in accordance with law, and/or procedurally invalid."[55] They claim the rule is impermissibly retroactive and "violates the plain wording of the Medicare statute."[56] They also note that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[57]

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their NPRs and/or RNPRs, all of which implemented the June 2023 Final Rule; that the amount in controversy exceeds $50,000; that they challenge the validity of the June 2023 Final Rule;[58] and that the Board cannot grant this relief because it is bound by the policy.[59] They note that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[60]

The Petition for EJR originally contained eighteen (18) cases. The Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed a response to the Petition for EJR on **February 27, 2026**. It objected to the inclusion of one Provider in Case 25-1278G, but that provider was subsequently withdrawn making the objection moot. It also challenged the Board's jurisdiction in Case 25-3337GC because it did not meet the $50,000 amount in controversy threshold, but that case was subsequently consolidated with Case 25-3340G to meet that threshold so that challenge is also moot. The Provider also conceded that Case 25-3870GC did not meet the $50,000 amount in controversy threshold when the Petition for EJR was filed, but that case was also subsequently consolidated into Case 25-3340G to meet that threshold. For the remaining sixteen (16) cases in the Request for EJR, FSS indicated that "[t]he MAC will not file jurisdictional challenges in the remainder of the cases."[61]

Decision of the Board:

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

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[54] *E.g.*, Case No. 25-4641G, Issue Statement and Jurisdictional Statement at 1-3.
[55] *Id.* at 3.
[56] *Id.*
[57] *Id.* at 3-4 (citing 88 Fed. Reg. 37772, 37787-37788 (June 9, 2023)).
[58] Case Nos. 25-4641GC *et al.*, Providers' Petition for Expedited Judicial Review at 11-13 (Feb. 20, 2026).
[59] *Id.* at 15.
[60] *Id.* at 13-14.
[61] AMENDED Response to Provider's Request for Expedited Judicial Review at 2 (Feb. 27, 2026).

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; [62]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[63]

For these sixteen (16) 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 RNPRs. Finally, the amount in controversy exceeds $50,000 in each case.

The Board finds that the Providers in the sixteen (16) cases listed in **Appendix A** have filed timely appeals from their original and revised NPRs concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs and RNPRs. The Board also finds that the amount in controversy exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the sixteen (16) cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;

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[62] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[63] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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 the sixteen (16) 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:

3/16/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

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

Appendix A

25-3682GC	*Virtua Health System CY 2011 DSH Calculation - Treatment of Medicare Part C Days CIRP Group*
25-3344GC	*Virtua Health System CY 2010 DSH Calculation - Treatment of Medicare Part C Days CIRP Group*
25-3340GC	*Virtua Health System CY 2007-09 DSH Calculation - Treatment of Medicare Part C Days CIRP Group*
25-3758GC	*Capital Health CY 2012 DSH Calculation - Treatment of Medicare Part C Days CIRP Group*
25-3757GC	*Capital Health CY 2011 DSH Calculation - Treatment of Medicare Part C Days CIRP Group*
25-3755GC	*Capital Health CY 2010 DSH Calculation - Treatment of Medicare Part C Days CIRP Group*
25-3753GC	*Capital Health CY 2009 DSH Calculation - Treatment of Medicare Part C Days CIRP Group*
25-3751GC	*Capital Health CY 2007 DSH Calculation - Treatment of Medicare Part C Days CIRP Group*
25-3749GC	*Capital Health CY 2006 DSH Calculation - Treatment of Medicare Part C Days CIRP Group*
25-3587G	*Bass, Berry & Sims, PLC CY 2012 DSH Calculation - Treatment of Medicare Part C Days Group*
25-3573G	*Bass, Berry & Sims, PLC CY 2011 DSH Calculation - Treatment of Medicare Part C Days Group*
25-1814G	*Bass, Berry & Sims, PLC CY 2010 DSH Calculation - Treatment of Medicare Part C Days Group*
25-1392G	*Bass, Berry & Sims, PLC CY 2009 DSH Calculation - Treatment of Medicare Part C Days Group*
25-1278G	*Bass, Berry & Sims, PLC CY 2008 DSH Calculation - Treatment of Medicare Part C Days Group*
25-3141G	*Bass, Berry & Sims, PLC CY 2006 DSH Calculation - Treatment of Medicare Part C Days Group*
25-4641G	*Bass, Berry & Sims, PLC CY 2005 DSH Calculation - Treatment of Medicare Part C Days Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Mark Polston
King & Spalding, LLP
1700 Pennsylvania Avenue NW
Washington, D.C. 20006

RE: ***EJR Determination***

Case Number: 26-1613GC - *Univ of KS Health Sys FFY 2026 Reasonable Cost-To-IPPS BNA CIRP Group*

Dear Mr. Polston:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request and Petition for Expedited Judicial Review ("EJR") filed by the Providers in the above-referenced Common Issue Related Party ("CIRP") group case. In this case, the Providers challenge their FFY 2026 inpatient prospective payment system ("IPPS") payments, arguing that CMS "unlawfully applied a pair of budget neutrality adjustments that by statute could only apply to the IPPS rates for FY 1985."[1] The Providers have requested EJR to challenge the FFY 2026 IPPS rates, and the decision of the Board ***GRANTING*** the Request is set forth below.

BACKGROUND:

A. Group Issue – Alleged 1985 Budget Neutrality Adjustment Carryforward

1. Initial Appeal and Issue Statement

This Common Issue Related Party ("CIRP") group is appealing from the Federal Register published on August 4, 2025. The Providers' designated representative filed a certification that the group was complete pursuant to Board Rule 20 on **February 20, 2026**, and it filed a request for EJR the same day. The Medicare Contractor ("MAC") has filed a response arguing (1) the legal question posed "misrepresents and oversimplifies the Secretary's legal justification for setting the standardized amounts used for FFY 1986 at essentially the FFY 1985 rates"; (2) the request for EJR "fails to adequately develop the facts related to the purported '1.05 reduction error' and appears to improperly raise more than one legal question"; (3) the Providers have not established "that the legal question posed for the FFY 1986 standardized amounts has any

[1] Issue Statement at 1 (Jan. 30, 2026).

relevance to the FFY 2025 standardized amount"; and (4) the "amount in controversy is unclear and additional briefing is necessary."[2]

The Providers' appeal challenges their FY 2026 IPPS payments, arguing that CMS "unlawfully applied a pair of budget neutrality adjustments that by statute could only apply to the IPPS rates for FY 1985."[3] They note that 42 U.S.C. § 1395ww(d)(3)(C) directed CMS' predecessor, the Health Care Financing Administration ("HCFA"), "to adjust the 'average standardized amounts as may be required under subsection [§ 1395ww](e)(1)(B) for that fiscal year.'"[4] 42 U.S.C. § 1395ww(e)(1)(B) reads:

> For discharges occurring in FY 1984 or 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment in each of the average standardized amounts otherwise computed for that fiscal year as may be necessary to assure that--
>
> (i) The aggregate payment amounts provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals . . . ,
>
> Are not greater or less than –
>
> (ii) . . . the payment amounts which would have been payable for such services for those same hospitals for that fiscal year under this section under the law as in effect before April 20, 1983. . . .

Pursuant to his authority at 42 U.S.C. §§ 1395ww(d)(3)(C) and (e)(1)(B), the Secretary implemented two adjustments that the Providers contend resulted in a reduction of IPPS payments by 5.59% in FY 1985.[5] The Providers argue that these budget neutrality adjustments "were not to be applied in future years", and that the statute at 42 U.S.C. § 1395ww(d)(3) "includes instructions for calculating the standardized amount for FY 1986 and all years thereafter."[6] For FY 1986, the amount was to start with the "average standardized amount computed for the previous fiscal year under [§ 1395ww(d)(3)(A)]."[7] The Providers claim that the standardized amount computed under this section is the amount *after* it was adjusted for inflation but before it was adjusted under §§ 1395ww(d)(3)(B) (for outliers), 1395ww(d)(3)(C) and (e)(1)(B) (for budget neutrality).[8]

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[2] MAC Response to Provider's Request for Expedited Judicial Review at 2 (Feb. 27, 2026) ("EJR Response").
[3] Issue Statement at 1.
[4] *Id.*
[5] *Id.* (citing 49 Fed. Reg. 34728, 34771, 34796, (Aug. 31, 1984)).
[6] *Id.*
[7] 42 U.S.C. § 1395ww(d)(3)(A).
[8] Issue Statement at 1.

The Providers continue by explaining that "for FY 1986, HCFA decided that the 'budget-neutrality adjusted rates for FY 1985 are…to be used as the basis for the determination of rates for later years.'"[9] They argue that calculating FY 1986 by preserving these FY 1985 budget neutrality adjustments is unlawful and has been carried forward every year since, resulting in a present day IPPS payment understatement of 0.9441, "which could be corrected by an adjustment of 5.92% . . . ."[10] They "challenge the continued application of these budget neutrality adjustment because the statute says that they should have sunset at the end of FY 1985."[11]

2. *Petition for EJR*

The Providers' **February 20, 2026** Petition for EJR makes the same arguments found in their Issue Statement, with some elaboration. They discuss how the FY 1984 standardized amount was set using FY 1981 data. They also note that this amount was later adjusted pursuant to 42 U.S.C. § 1395ww(d)(2)(E) to account for outliers, and again pursuant to § 1395ww(d)(2)(F) to adjust the standardized amount "as may be required under subsection (e)(1)(B)." This budget neutrality adjustment adjusted the FY 1984 standardized amount "by a factor of 0.97, which translated to a 3 percent decrease."[12] The Request for EJR indicates that this "second adjustment required the Secretary to ensure that aggregate payments for FY 1984 did not exceed aggregate payments for services had he continued to make them under the prior reasonable cost payment system."[13]

The Providers then repeat the same arguments found in their Issue Statement with regard to the FY 1985 rate setting being unlawfully carried forward into FY 1986 and beyond.[14] The Petition for EJR claims that "the FY 2026 rates continue to include the 0.954 adjustment to the standardized amount and the 1.05 percent adjustment to the DRG weights from FY 1985, effectively reducing those rates by a factor of 0.9441."[15]

The Providers request the Board grant EJR in this case, first noting the D.C. District Court's decision in *St. Mary's Regional Medical Center v. Becerra ("St. Mary's")*.[16] They note that the Court stated that there was "no basis for carrying forward budget-neutralized standardized amounts from 1985 to 1986," and that "the Court also ruled that the provision precluding review of the 1985 budget neutrality adjustment does not also preclude review of the inaugural

[9] *Id.* at 2 (citing 50 Fed. Reg. 35646, 35695 (Sept. 3, 1985)).
[10] *Id.*
[11] *Id.*
[12] Petition for Expedited Judicial Review ("Petition for EJR") at 3-4 (Feb. 20, 2026) (citing 49 Fed. Reg. 234, 334 (Jan 1. 1984)).
[13] *Id.* at 3.
[14] *Id.* at 4-6.
[15] *Id.* at 8.
[16] Memorandum Opinion, No. 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024).

standardized amount."[17] They also point out that the Board recently acquiesced to the holding in *St. Mary's* when it granted EJR in Cases 25-1782GC and 26-0941GC.[18]

The Petition for EJR then discusses the merits of the case, arguing that the decision to apply FY 1985 budget neutrality adjustments to FY 2026 rates is unlawful, repeating the arguments made in *St. Mary's* and the Court's decision therein.[19] They conclude their Petition by requesting the Board grant EJR in this case, first noting the Board has jurisdiction over the appeal. They claim that each Provider is "dissatisfied with the Secretary's final payment determination in the FY 2026 IPPS final rule – specifically the Secretary's refusal to correct the rates to remove the budget neutrality adjustments he adopted in FY 1985."[20] They also argue that the challenge is not precluded from administrative and judicial review (specifically 42 U.S.C. § 1395ww(d)(7)(A)), but acknowledge that the Board has previously found that it lacked subject matter jurisdiction over an appeal brought by a different group of providers challenging the same issue.[21] The Providers argue that "the Board interpreted [§] 1395ww(d)(7)(A) too broadly" because the action challenged in this appeal is not the type of action shielded from review in that statue.[22] The Providers contend that "Section 1395ww(d)(7)(A) bars review of 'adjustments effected pursuant to [42 U.S.C. § 1395ww] (e)(1)," which does not encompass the Secretary's decision to base the 1986 standardized amounts based on the prior year's budget-neutralized rates.[23] They also discuss the Board's rationale that the decision to carry forward the FY 1985 budget neutrality adjustment to FY 1986 and onward was "inextricably intertwined" to the original calculation and application of that adjustment in FY 1985, but note that the Court in *St. Mary's* rejected this proposition.[24] The Providers conclude that 42 U.S.C. § 1395ww(d)(7)(A) was intended "to preclude review of the Secretary's application of the budget neutrality adjustments in FYs 1984 and 1985 and nothing more."[25]

The Provider's position with regard to the Request for EJR, is since the Board is bound to "comply with all provisions of Title XVIII of the [Social Security] Act and regulations issued thereunder,"[26] the Board is bound by the rates published in the FY 2026 IPPS final rule and cannot declare them unlawful. Thus, the Providers contend the Board does not have authority to resolve this dispute and as a result, EJR is appropriate.[27]

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[17] Petition for EJR at 9.
[18] *Id.* at 9-10.
[19] *Id.* at 10-14.
[20] *Id.* at 15.
[21] *Id.* at 16 (quoting Case No. 25-1141GC, EJR Determination and Notice of Dismissal (Jan. 17, 2025) (copy at Ex. P-8)).
[22] *Id.* at 16-17 (citing *St. Mary's Regional Medical Center v. Becerra*, 2024 WL 5186641 (D.D.C. 2024)).
[23] *Id.* at 17.
[24] *Id.* at 20-21.
[25] *Id.* at 18, n. 6.
[26] 42 U.S.C. § 405.1867.
[27] Petition for EJR at 23-24.

B. Board Jurisdiction

1. St. Mary's Regional Medical Center v. Becerra

The Board Majority has historically found that the Board lacks substantive jurisdiction over the issue presented in these [*St. Mary's*] appeals relying on a statutory review preclusion provision. Accordingly, on appeal of such findings, the D.C. District Court's decision in *St. Mary's Regional Medical Center v. Becerra*,[28] concerned a similar substantive issue to the one presented in the instant group appeal – namely whether the Secretary miscalculated the standardized amount in FY 1984 by including transfer cases in the denominator – and the Court decided whether section 1395ww(d)(7)(A) bars review of this issue. The instant case concerns a different issue – whether CMS unlawfully applied a pair of budget neutrality adjustments that could only apply to IPPS rates for FY 1985 – but the Board Majority previously found that it lacked subject matter jurisdiction over that issue because the bar on administrative review at 42 U.S.C. § 1395ww(d)(7)(A) was applicable to the standardized amount calculations being challenged.

Here, relative to a challenge relating back to FY 1986, it is important to note that while there are time limits on when a provider can challenge their payment determinations, providers are generally permitted to challenge "predicate facts." Specifically, courts have permitted providers to modify "predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[29] Predicate fact challenges are permitted "no matter how long ago the facts were established, so long as the providers raise their challenge in a timely administrative appeal and seek damages only for underpayment during an open cost year."[30]

Accordingly, in *St. Mary's*, a group of providers challenged their FY 2019 IPPS payments, alleging that when calculating "allowable operating costs per discharge" in calculating the IPPS, "the Secretary erroneously counted inter-hospital transfers as 'discharges,' . . . [which] depressed the inaugural standardized amounts and, . . . has perpetuated chronic underpayment up to the present day."[31] In April 2023, the Board dismissed the underlying providers' appeals in *St. Mary's* for lack of subject matter jurisdiction, finding the standardized amounts at issue were inextricably intertwined with the budget neutrality adjustments which were precluded from administrative review.[32] With regard to whether the providers had standing to bring their case before the Board, the Court in *St. Mary's* addressed the Board's findings and rejected them all.

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[28] 2024 WL 5186641 (D.D.C. 2024).
[29] *Id.* (citing *Kaiser Found. Hosps. v. Sebelius*, 708 F.3d 226, 232-233 (D.C. Cir. 2013)).
[30] *Id.* (citing *St. Francis Med. Ctr. v. Azar*, 894 F.3d 290, 294 (D.D.C. 2018)).
[31] *St. Mary's.* at *4.
[32] Case No. 19-1723GC *et al.*

Where the Board opined that the original standardized amount calculations were actually inflated, rather than deflated, the Court found that this had "no bearing on the independent, judicially cognizable injury which the plaintiffs now allege—to wit, that the Secretary's supposedly unlawful categorization of transfers as discharges exerted downward pressure on their compensation."[33] The Court went on to hold that the injury alleged by St. Mary's was not erased by "some unrelated benefit of equal or greater value" claimed to be conferred by the Secretary.[34] Moreover, the summation of the gravity of the alleged errors would be relevant to the issue of damages during the litigation phase, if reached, but irrelevant to the ponderance of jurisdiction.[35]

The Court also rejected the Board's acceptance of the notion that other adjustments to the standardized amount "between 1985 and 1997 may have broken the chain between the inaugural calculations and the allegedly depressed 2019 standardized amounts."[36] The Court seemed skeptical,[37] and while it did not outright reject this argument, it found that the argument was not sufficiently explored to defeat the Provider's jurisdictional claim of standing.

The Court then looked to whether the statutory preclusion provisions actually precluded review of the 1984 standardized amounts. Contrary to the Board's finding, the Court held that the statutes did not explicitly preclude review,[38] and also found that the calculation of the 1984 standardized amounts is not "inexplicably intertwined" with the budget neutrality adjustments, especially in light of the Administrative Procedure Act's strong presumption of judicial review.[39]

Ultimately, the Court remanded the case for further proceedings.[40] The Secretary then filed a motion for clarification or partial reconsideration of the Court's decision. On September 26, 2025, the Court issued a Memorandum & Order granting the Secretary's motion to confirm that the Court's holdings are limited to the Board's subject matter jurisdiction over the dispute relative to reviewing the matter absent the purported statutory review preclusion, and denying the motion for partial reconsideration.[41] The cases have been remanded to the Board and are currently pending on the Board's docket.

2. Jurisdictional and Substantive Claim Challenges

Board Rule 44.6 (2023) governs the timing of Jurisdictional and Substantive Claim Challenges in cases where a Request for EJR is filed less than sixty (60) days from the filing of a Final

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[33] *St. Mary's* at *7.
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.* ("[T]he Secretary himself reiterated that the current standardized amount is the result of adjusting and updating the original standardized amounts, necessarily—if implicitly—disclaiming the possibility that subsequent statutory or regulatory changes have washed away any trace of the inaugural calculations.") (citing 83 Fed. Reg. 41144, 41713 (Aug. 17, 2018)).
[38] *Id.* at *11-12.
[39] *Id.* at *13-17.
[40] *Id.* at *19.
[41] *St. Mary's Reg'l Med. Ctr. v. Kennedy*, No. 1:23-cv-01594-RCL (Sept. 26, 2025).

Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP ("Schedule of Providers") which certifies that the group is complete and fully populated in the Board's case management system, OH CDMS). In such instances, Board Rule 44.6 requires any party questioning either the Board's jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. If the MAC files a certification that a challenge is forthcoming, it must file its challenge no later than twenty (20) days following the filing of the EJR Request.

On **February 20, 2026,** the Providers certified that this group case was fully formed. On the same day, the Petition for EJR was filed. On **February 27, 2026**, the MAC's designated representative, Federal Specialized Services ("FSS") filed a timely Response to the Petition for EJR on behalf of the MAC. As previously noted, the MAC's response argues (1) the legal question posed "misrepresents and oversimplifies the Secretary's legal justification for setting the standardized amounts used for FFY 1986 at essentially the FFY 1985 rates"; (2) the request for EJR "fails to adequately develop the facts related to the purported '1.05 reduction error' and appears to improperly raise more than one legal question"; (3) the Providers have not established "that the legal question posed for the FFY 1986 standardized amounts has any relevance to the FFY 2025 standardized amount"; and (4) "the amount in controversy is unclear and additional briefing is necessary."[42]

First, the MAC discusses the accuracy of the legal question posed. The Providers claim that, pursuant to his authority at 42 U.S.C. §§ 1395ww(d)(3)(C) and (e)(1)(B), the Secretary implemented two adjustments that resulted in a reduction of IPPS payments by 5.59% in FY 1985.[43] The Petition for EJR claims that "the FY 2026 rates continue to include the 0.954 adjustment to the standardized amount and the 1.05 percent adjustment to the DRG weights from FY 1985, effectively reducing those rates by a factor of 0.9441."[44] They argue that the applicable statute prohibits applying the FY 1985 adjustments to any fiscal year after 1985.[45] The MAC notes that, while the Secretary acknowledged that 42 U.S.C. § 1395ww(e)(1) provided the authority to carry forward these adjustments (which the Providers believe is inaccurate and unlawful), this is irrelevant because there was a separate, independent basis to carry them forward in 42 U.S.C. § 1395ww(e)(4).[46] The MAC claims that "*the Secretary specifically confirmed that she would end up in the same place* ***even if the FFY 1985 budget neutrality adjustment was factored out***."[47] Without exploring the full justification(s) for the Secretary's actions, the MAC argues the case "is not yet ripe for EJR and that additional briefing is needed for the Parties to develop the relevant and material facts surrounding the Secretary's adoption of the FFY 1986 standardized amounts."[48]

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[42] EJR Response at 2.
[43] Issue Statement at 1 (citing 49 Fed. Reg. 34728, 34771, 34796, (Aug. 31, 1984)).
[44] Petition for EJR at 8.
[45] *Id.* at 1.
[46] EJR Response at 3-4.
[47] *Id.* at 4 (citing 50 Fed. Reg. 35646, 35697-35698 (Sept. 4, 1985) (emphasis in original).
[48] *Id.* at 5.

Second, the MAC argues that the Petition for EJR does not adequately develop the facts and appears to raise more than one legal question:

> The purported application of the FFY 1985 budget neutrality rates to the FFY 1986 rates appears to be one issue for which the Providers maintain there is a 0.954 adjustment as set forth in the FFY 1984 IPPS final rule at 49 Fed. Reg. 34,728, 34,796 (Aug. 31, 1984). However, the Providers also appear to raise a separate issue concerning DRG weighting and case mix and appear to assert that the Secretary inappropriately applied a "1.05 reduction error" purportedly made to the FFY 1986 standardize[d] amount.[49]

The MAC's EJR Response claims that the material facts related to the "1.05 percent reduction" are insufficiently developed, and that this is also a separate legal question which is prohibited by 42 C.F.R. § 1837(a)(2) (limiting group cases to one issue of law or fact).[50]

Third, the MAC maintains that the Providers have not established that the legal question posed for the FFY 1986 standardized amounts has any relevance to the FFY 2025 standardized amounts. It notes that 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842(a)(1) both permit a provider to seek EJR over a legal question relevant to the matter(s) in controversy or matter(s) at issue.[51] The MAC also cites *Mercy General Hospital v. Becerra*,[52] which affirms the notion that EJR is only appropriate for legal questions relevant to the matters in controversy or matters at issue. The case also suggests the Board is within its authority to deny EJR, or request more information before granting EJR, if it is unable to determine whether it has jurisdiction or authority, including when the Board is unable to determine whether a legal question or challenge is relevant.[53] This argument ultimately concerns whether there is a causal link between the FFY 1986 standardized amounts and the FFY 2026 standardized amounts at issue, and suggests the causal link has been broken by numerous adjustments to the standardized amounts that have been made across the intervening 40+ years.[54] The MAC states that this argument was generally supported by the Board Majority's "Appendix A" in previous decisions on this issue where the Board Majority found it lacked subject matter jurisdiction over this issue.[55]

Finally, the MAC argues that the amount in controversy is unclear. It disputes the assertion that the 0.954 adjustment to the standardized amount and the 1.05 percent adjustment to the DRG weights (with a combined effect of reducing IPPS payments by a factor of 0.9441) results in "a straight-line 0.9441 factor across the intervening nearly 40 FFYs as the Providers baldly

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[49] *Id.*
[50] *Id.* at 5-6.
[51] *Id.* at 6-7. The MAC also cites *Mercy General Hospital v. Becerra*, 643 F.Supp.3d 16 (D.D.C. 2022) (included as EJR Response Exhibit C-1).
[52] 643 F.Supp.3d 16 (D.D.C. 2022).
[53] *Id.* at *28.
[54] EJR Response at 9.
[55] *See, e.g.*, Case Nos. 25-3211GC and 25-3212GC, EJR Determination (Sept. 25, 2025).

assert."[56] Once again, it points to the many adjustments to the standardized rate since 1986, including discretionary adjustments under 42 U.S.C. § 1395ww(e)(4), to demonstrate the fact-specific and complex nature of this issue.[57] It urges the Board to require additional briefing to substantiate the application of the 0.9441 factor so the Board can definitively determine "whether the jurisdictional minimum amount in controversy has been met", which is a prerequisite for EJR.[58]

3. Board Findings on Jurisdiction and Appropriate Cost Report Claims

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

a. Preliminary and Subject Matter Jurisdiction

Pursuant to 42 C.F.R. § 405.1840(a)(2)(i), the Board must make a preliminary jurisdictional determination "(that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the matters at issue in the appeal before [] determining its authority to decide a legal question relevant to a matter at issue [when evaluating a request for EJR]."

The MAC "does not dispute that the Board has substantive jurisdiction over this appeal."[59] All of the participants in this group case made timely appeals from the FFY 2026 IPPS Final Rule.[60] The Board also finds that the participants' documentation in the group appeal shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[61] In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that amounts in controversy are calculated by applying a correction factor of 0.9441%.[62] Accordingly, the Board finds that the amounts claimed were made in good faith and are sufficient to meet the

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[56] EJR Response at 11.
[57] *Id.* at 11-17.
[58] *Id.* at 17.
[59] *Id.* at 6 ("As a result of the recent decisions in *St. Mary's Regional Medical Center v. Becerra* (*St. Mary's*), the MAC does not dispute that the Board has substantive jurisdiction over this appeal.").
[60] The CMS Administrator confirmed that, consistent with the D.C. Circuit's decision in *Washington Hosp. Ctr. v. Bowen*, 795 F.3d 139 (D.C. Cir. 1986, a wage index notice published in the Federal Register is a final determination from which a provider may appeal to the Board within the meaning of 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[61] *See* 42 C.F.R. § 405.1837.
[62] *E.g.*, Impact Calculation, Paola Hospital (Provider Number 17-0109, aka Miami County Medical Center) (estimated reimbursement impact calculated by removing the alleged 5.92% reduction from the 1985 budget neutrality adjustment). *See also* Petition for EJR at 10 ("To correct for his error, the Secretary must increase the FFY 2026 rates by 5.92 percent [1 ÷ 0.9441 = 1.0592].").

jurisdictional threshold required for the Providers to be entitled to a hearing on the issue presented.[63]

As to any concerns about the accuracy of these estimates or any questions of whether the Providers would ultimately be able to prove actual damages, the Board acknowledges that such concerns involve *underlying factual matters* that would be addressed during a case on the merits and damages, *if reached*. But the foregoing are not to be used as blocks to a jurisdictional finding for purposes of determining a right to a hearing or the appropriateness of EJR for a legal challenge outside of the Board's authority.

The MAC's third point in its Response to the Petition for EJR focuses on whether the causal link between the FFY 1986 standardized amounts to the FFY 2026 standardized amounts at issue was broken. The Court in *St. Mary's* seemed skeptical of this argument, as discussed *supra.*[64]

The MAC's fourth argument specifically urges the Board to more definitively determine the amount in controversy in this case. As previously noted, however, the Board finds that the proposed calculations were made in good faith based on a reasonable theory, which is sufficient for the amount in controversy inquiry.[65] Moreover, the Court in *St. Mary's* ultimately found that the Providers' theory of injury satisfied the case or controversy requirement to establish standing, which is equivalent to the Board's inquiry for its amount in controversy.[66]

Next, the Board recognizes that in its prior decisions, the Board found that the issue in this appeal was "*inextricably* tied with the FFY 1985 [budget neutrality adjustment ("BNA")] to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years." Further, in those cases, the Board found that "42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[67]) prohibit administrative and judicial review of those BNAs." Based on those findings, the Board concluded that it did not have substantive jurisdiction over the issue in those group cases and denied the providers' requests for EJR, and further, dismissed the cases.[68]

The Court in *St. Mary's* held that Board review of the matter in that appeal (the challenge to the inaugural standardized amount) was not precluded by statute or regulation, and thus, the Board

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[63] *See Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111, *3 (N.D. OK 2011). *Compare Beacon Healthcare Svcs., Inc. v. Leavitt*, 629 F.3d 981, 984 (9th Cir. 2010) (distinguishing the amount in controversy, which is typically determined from the face of the pleadings, from the remedy sought).
[64] *See supra* n. 37.
[65] *See supra* n. 63 and accompanying text.
[66] *St. Mary's* at *11.
[67] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).
[68] *See, e.g.*, Case Nos. 25-3211GC and 25-3212GC.

has subject matter jurisdiction over such appeals.[69] However, *St. Mary's* holding is "'confin[ed]' to reviewing the 'validity of th[at] ground[]'"[70] and does not make a dispositive determination regarding the appropriateness of EJR for the instant matter or the like.

Based on the foregoing, the Board acknowledges that it has jurisdiction over the Providers' above-captioned appeal.

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

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

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

[69] *See St. Mary's* at 17.
[70] *St. Mary's* Memorandum and Order on Motion for Clarification at 5 (quoting *SEC v. Chenery Corp.*, 318 U.S. 80, 88 (1943)).

> ***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***.[71]

These substantive claim regulations are applicable to the cost reporting periods under appeal for all the participants in the instant case, which all have cost reporting periods ending on or after December 31, 2016. The regulation at 42 C.F.R. § 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 42 C.F.R. § 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"[72] 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. [73]

The MAC did not file any substantive claim challenges in response to the Providers' Petition for Expedited Judicial Review. Pursuant to 42 C.F.R. § 405.1873(a) and in compliance with the Board's Rules, since no party to the appeal has questioned whether an appropriate claim was

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[71] (Bold italics and underline emphasis added.)
[72] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[73] *See* 42 C.F.R. § 405.1873(a).

made,[74] Board review under 42 C.F.R. § 405.1873(b) ***has not been triggered***. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request, pursuant to 42 C.F.R. § 405.1873(d). for the participants in this CIRP group.

BOARD DECISION:

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[75] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[76]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[77] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain base period cost data be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[78] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the "base period" operating cost per discharge.[79] The Secretary then *updated* the per discharge amount by an inflationary factor.[80]

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v.*

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[74] 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."
[75] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[76] *Id.*
[77] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[78] *Id*.
[79] *Id.*
[80] *Id*. at 39764.

Azar ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[81] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e) provides for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
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> (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[82]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 and 1985 rate years, respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) Maintaining budget neutrality. (1) CMS adjusts each of the *reduced standardized amounts* determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of

[81] 894 F.3d 290, 291 (D.C. Cir. 2018). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.
[82] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).

> certain classes of hospitals for Federal fiscal year 1984) *is not greater or less than 25 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1984 under the Social Security Act as in effect on April 19, 1983.*
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[83]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) Maintaining budget neutrality for fiscal year 1985. (1) For fiscal year 1985, CMS will adjust each of the *reduced standardized amounts* determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is *not greater or less than 50 percent of the payment amounts that would have been payable for the inpatient operating costs for those same hospitals for fiscal year 1985 under the law as in effect on April 19, 1983.*
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[84]

B. Board's Decision Regarding the EJR Request

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), the Board must grant a request for EJR if it has jurisdiction over the appealed issue and lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling. Having already found that it has jurisdiction over these appeals, the Board must determine whether it has the authority to decide the legal question relevant to the matter at issue.

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[83] (Italics and underline emphasis added.)
[84] (Italics and underline emphasis added.)

1. Factual Disputes and Board Record Development

At the outset of its analysis, the Board acknowledges that Board Rule 42.3 requires a Request for EJR to demonstrate that there are "no factual issues in dispute." Here, it is important to note that the duty to establish whether there are factual disputes first lies with the parties to the appeal. Although Board Rule 42.3 requires a demonstration that there are "no factual issues in dispute," such is not to be interpreted as any and all facts must be resolved to pursue expedited review of a ***legal question*** outside of the Board's authority, which is distinguished from a question of fact. Moreover, from a purely legal perspective, a Request for EJR is akin to a motion for summary judgment in trial court where to prevail, the moving party must show there are no genuine disputes of ***material fact.***[85] The Board recognizes that "material" is not used as an adjective that modifies the noun "fact" to specify the significance of the facts to be discerned versus trivial ones.[86] However, in its prior dismissals of issues similar to the one presented herein, even the Board acknowledged that "no factual issues in dispute" in Board Rule 42.3 is with reference to "material" facts, not merely any facts that have no dispositive impact on the matter.[87]

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[85] *See e.g.* Federal Rules of Civil Procedure, 56.

[86] Even if the reference to "no factual issues in dispute" in Board Rule 42.3 is taken at face value, a historical review of 42 C.F.R. § 405.1842(g)(2) reveals that, prior to 2008, versions of the regulation specified that:

> If there are factual or legal issues in dispute on an issue ***within the authority of the Board to decide***, the Board will not make an expedited review determination on the particular issue but will proceed with a hearing. The Board has the authority to decide when two or more issues are sufficiently related to preclude separation for purposes of an expedited review determination on one or more of them and a hearing on the other or others.

See 48 Fed. Reg. 22920, 22925 (May 23, 1983). However, by May 23, 2008, 405.1842 had been overhauled and all references to the words "factual" or "fact" were removed from the regulation in an effort to clarify that EJRs were specific to legal questions over which the Board had no authority to resolve. *See* 73 Fed. Reg. 30190, 30214-30215 (May 23, 2008):

> Under section 1878(f)(1) of the Act, a provider in certain situations may immediately seek judicial review of an action of the intermediary involving a question of the statute or regulations whenever the Board determines that it is without authority to decide the issue. If the Board determines that it has jurisdiction over the issue, but it lacks the authority to decide the issue, the provider may obtain expedited judicial review (EJR). The intent of this provision is to eliminate undue delays resulting from a requirement that providers pursue time-consuming and unproductive administrative reviews before they could obtain judicial review of a Board determination. We proposed several changes to § 405.1842 to clarify any confusion surrounding the procedures and the types of cases to which EJR applies.

[87] *See* Case No. 19-1723GC, Dismissal Based on Lack of Substantive Jurisdiction at 10-11 (Apr. 6, 2023) ("Similarly, the Board notes that consideration of expedited judicial review is not appropriate if there are ***material*** facts in dispute. Accordingly, the Board's RFI was designed to further develop the record regarding both the highly complex nature of the Providers' dispute as it relates to whether the Board has jurisdiction to hear the Providers' dispute and whether EJR is appropriate (including whether there are ***material*** factual disputes)."); *see id.* at 3 (where

Additionally, in accordance with 42 C.F.R. § 405.1865, the Board recognizes the importance of developing a sufficient record for review by the CMS Administrator or the district courts.[88] Here too, however, the initial responsibility to develop the record lies with the parties in either the pursuit or defense of the appeal. For instance, 42 C.F.R. § 1865(a)(2) states, "For proceedings before the Board, ***the administrative record consists of all evidence, documents and any other tangible materials submitted by the parties to the appeal and by any nonparty*** (as described in §§ 405.1853(e)(4) and 405.1857(c)(3) of this subpart), along with all Board correspondence, rulings, subpoenas, orders, and decisions." With respect to EJR, the record is limited to the documentary evidence produced by the parties in support of or opposition to the legal question or challenge posed by the appellant.[89]

2. Providers' legal challenge and whether EJR is appropriate.

Courts have unequivocally held that the Board "lacks the power to adjudicate direct challenges to existing CMS regulations, such as IPPS rules."[90] Moreover, pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program.

In this case, the Providers challenge their FY 2026 IPPS payments based on the rates published in the FFY 2026 IPPS Final Rule,[91] arguing that CMS "unlawfully applied a pair of budget neutrality adjustments that by statute could only apply to IPPS rates for FY 1985."[92] As set forth above, to support its challenge of the validity of the FY 2026 IPPS rates based on a budget neutrality adjustment carryforward error, Providers argue the applicable statute required the Secretary to calculate the FY 1986 standardized amount using "the 1985 standardized amount *after* it was adjusted for inflation but *before* it was adjusted under [§] 1395(d)(3)(B) for outliers and under [§§] 1395(d)(3)(C) and (e)(1)(B) to offset the budgetary impact of IPPS."[93] They argue that calculating FY 1986 by preserving these FY 1985 budget neutrality adjustments is unlawful and has been carried forward every year since, resulting in a present day IPPS payment understatement of 0.9441, "which could be corrected by an adjustment of 5.92%."[94] The Secretary disagreed that the FY 1986 rates should be based on the FY 1984 and 1985 standardized amounts prior to the adjustment of these amounts for budget neutrality.[95]

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the Board discusses a prior denial of EJR and requested additional information "to allow the Board to determine whether…(3) there are ***material*** factual disputes,"); *see id* at 30, Fn. 63 (where the Board pondered that additional input from the parties could lead to a determination "that ***material*** factual disputes exist").

[88] *See also* 42 C.F.R. § 405.1875 and § 405.1877.

[89] *See e.g.*, 42 C.F.R. § 405.1842(d)(2) and (e)(2)(ii).

[90] *See St. Mary's Regional Medical Center v. Becerra*, 2024 WL 5186641, *5 (D.D.C. Dec. 20, 2024) (citing *Bayshore Cmty. Hosp. v. Azar*, 325 F. Supp. 3d 18, 21 (D.D.C. 2018)).

[91] 90 Fed. Reg. 36536 (Aug. 4, 2025).

[92] Issue Statement at 1.

[93] *Id.*

[94] *Id.* at 2.

[95] 50 Fed. Reg. 35646, 35703-35704 (Sept. 3, 1985).

Whether the FY 1986 standardized amounts should have been computed using a base rate from previous year before or after they were adjusted for outliers or budget neutrality is, without doubt, a legal question. Even if the Board had the authority to find that the Providers' interpretation is correct, the Board lacks the authority to order the removal or to order the invalidation and recalculation of IPPS rates based on such a finding.[96] Further, the parties argue that different statutes dictate that the Secretary did or did not have the ability to decide whether to use the base rate before or after the BNA.[97] As such, if both were true, the Board would be bound by conflicting statutory provisions, and still without the authority to rectify (either way) the situation. Therefore, the Board finds that EJR is appropriate.

The Board acknowledges that if the Providers prevail in this legal challenge at the district court level, they must then prove the impact of any alleged errors in setting the FY 1986 IPPS standardized amounts on present day rates with the presentation of evidence. Moreover, in *St. Mary's,* the Court signaled that EJR is appropriate as to the legal question presented and that the Board's lack of authority to resolve the matter:

> If the plaintiffs cannot establish *ultra vires* jurisdiction, the appropriate next step is to remand the case to the agency, which will likely result in certification for expedited judicial review. *See Bayshore Cmty. Hosp*, 325 F. Supp. 3d at 21 (citing 42 C.F.R. § 405.1867). Remanding for this purpose may seem like a pointless formality, but as another court in this District has concluded, the statutory scheme appears to condition the district court's jurisdiction on the plaintiffs' receipt of expedited judicial review certification. *[citations omitted]*.
>
> Additionally, if and when the case returns to federal court, the parties' briefs will be focused on the merits of the dispute, rather than the jurisdictional questions addressed herein.
>
> ***
>
> As for the second element [of the *ultra vires* review], the Court has already clarified that the PRRB has subject matter jurisdiction to entertain the plaintiffs' challenge and certify it for judicial review, affording an "alternative procedure for review of the [plaintiffs'] statutory claim ...." [citation omitted].[98]

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[96] 42 C.F.R. § 405.1867.
[97] Providers' argument is that the Secretary was bound by 42 U.S.C. § 1395ww(e)(1)(B) to only apply the BNA in fiscal years 1984 or 1985. The MAC's argument is that 42 U.S.C. § 1395ww(e)(4) is a different controlling authority that gave the Secretary authority to carry forward the FFY 1985 BNA.
[98] *St. Mary's* at 17-18.

Next, the Board will address the MAC's two remaining points in its Response to the Petition for EJR. The MAC's first point is that while the Secretary acknowledged that 42 U.S.C. § 1395ww(e)(1) provided the authority to carry forward these adjustments (which the Providers believe is inaccurate and unlawful), this is irrelevant because there was a separate, independent basis to carry them forward in 42 U.S.C. § 1395ww(e)(4).[99] This is an argument related to the merits of the legal challenge posed by Providers. The MAC essentially asks the Board to find that the Secretary acted in accordance with the applicable statute when setting the FY 1986 IPPS rates. As noted above, the Board lacks the authority to order the removal or to order the invalidation and recalculation of IPPS rates based on a finding that the rates are invalid, and likewise, the Board lacks the authority to determine that the Secretary's actions in carrying forward the budget neutrality adjustments under 42 U.S.C. § 1395ww(e)(4) were in accordance with the law. These findings would be conflicting, and the Board is "bound" by both.

Moreover, in *St. Mary's*, as it applies to the 1985 standardized amount calculations, the Court held that: "Taken together [1395ww(d)(2)(D) and subsection (b)(3)(B)] dictates that the Secretary had no authority to carry forward the 1984 budget-neutralized amounts to 1985; he was to base his 1985 calculations on the unadjusted 1984 average standardized amounts."[100] In discussing the 1986 standardized amount calculations, the Court held:

> The only discretion that the Secretary had in calculating the 1986 standardized amounts is that provided **"under subsection (e)(4),"** which authorizes the Secretary to determine, beginning in fiscal year 1986, the "applicable percentage increase ... for discharges in that fiscal year ...." 97 Stat. at 159–60. But this grant of authority merely gives the Secretary discretion to determine *how much* the standardized amounts should be increased from one year to the next; it does not authorize to the Secretary to ignore Congress's express directive that the prior year's average standardized amounts, unadjusted for budget neutrality, must serve as the base amount to be increased. It should also be noted that the methodology for calculating the 1986 average standardized amounts omits any reference to subsection (b)(3)(C) which, again, is the statutory provision that authorizes the 1985 budget neutrality adjustments. The statute simply supplies no basis for carrying forward the budget-neutralized standardized amounts from 1985 to 1986; to the contrary, it forbade the Secretary from doing so. As the plaintiffs argue in their Reply brief, by carrying forward the 1985 budget neutrality adjustment into the following year's standardized amounts, he patently violated this statutory requirement.[101]

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[99] EJR Response at 3-4.
[100] *St. Mary's* at 10.
[101] *Id.* (Italic emphasis in original, Bold emphasis added).

Additionally, while the Secretary may have asserted an independent basis for setting the standardized rates by relying on 42 U.S.C. § 1395ww(e)(4), that still does not make its additional reliance on 42 U.S.C. § 1395ww(e)(1) irrelevant as such is also to be determined upon judicial review of whether the Secretary's actions were in accordance with the law or outside of his statutory authority.

Finally, the Board will address the MAC's argument that this appeal presents two separate issues. The Providers frame their issue in the Petition for EJR as:

> The question presented in this appeal is whether the payment rates published in the fiscal year ("FY") 2026 inpatient prospective payment system final rule are understated as a result of the Secretary of Health and Human Services (the "Secretary") unlawfully applying budget neutrality adjustments that by statute he could only apply "in fiscal year 1984 or fiscal year 1985." 42 U.S.C. § 1395ww(e)(1)(B).[102]

The MAC argues that the Petition for EJR actually concerns two issues:

> The purported application of the FFY 1985 budget neutrality rates to the FFY 1986 rates appears to be one issue for which the Providers maintain there is a 0.954 adjustment as set forth in the FFY 1984 IPPS final rule at 49 Fed. Reg. 34,728, 34,796 (Aug. 31, 1984). However, the Providers also appear to raise a separate issue concerning DRG weighting and case mix and appear to assert that the Secretary inappropriately applied a "1.05 reduction error" purportedly made to the FFY 1986 standardize[d] amount.[103]

These two combined errors are what results in the Providers' requested 0.9441 correction factor.[104] The Board finds that these are two aspects of a single issue, namely how the FY IPPS rates were calculated, which is the underlying challenge in this case. Should the Providers prevail in their arguments, the proper calculation of the rates would be undertaken at that time and is not before the Board at this time, as it deals with the relief to be granted, if any. Based on the foregoing, the Board finds that:

1) It has jurisdiction over the challenges to the calculation of the standardized amounts used in federal rates for the IPPS during FFY 1986 as it allegedly impacts the Providers' FFY 2026 IPPS rates and that the Providers in this group appeal are entitled to a hearing before the Board;

---

[102] Petition for EJR at 1.
[103] Response to EJR at 5.
[104] Petition for EJR at 5-6 ("The combined effect of these adjustments was a reduction factor of 0.9441 [0.954 x (1 ÷ 1.0105)], which reduced IPPS payments by 5.59 percent [1 – 0.9441] in FY 1985.").

2) While the Providers appealed cost reporting periods beginning after January 1, 2016, no substantive claim challenges[105] have been filed pursuant to 42 C.F.R. § 405.1873(a) to trigger Board review under 42 C.F.R. § 405.1873(b) or reporting under 42 C.F.R. § 405.1873(d)(2);

3) Based upon the Providers' uncontested assertions regarding the calculation of the standardized amounts used in federal rates for the IPPS during FFY 1986 and its alleged impact on the Providers' FFY 2026 IPPS rates, 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 lacks the authority to decide the legal question of whether the Providers' FFY 2026 IPPS rates are understated because CMS unlawfully applied a pair of budget neutrality adjustments that could only apply to IPPS rates for FY 1985.

Accordingly, the Board concludes that the question of whether the Providers' FFY 2026 IPPS rates are understated falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and in accordance with 42 C.F.R. §405.1842(f)(1) 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 Case 26-1613GC, the Board hereby closes it 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:

3/17/2026

X Kevin D. Smith, CPA

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

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Scott Berends, FSS

[105] 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."

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd.
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Los Angeles, CA 90064-1582

RE: ***Expedited Judicial Review Determination***
Case Numbers: 25-3464GC *et al.* (22 cases – *see* **Appendix A**)
Blumberg Ribner CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Groups

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed between **February 21 and 25, 2026** in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

Between **March 1 and August 15, 2025**, the Board received twenty-two (22) requests to establish Common Issue Related Party ("CIRP") groups. The Providers in all twenty-two (22) groups are appealing from revised Notices of Program Reimbursement ("RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYEs") spanning from 2005 to 2013.

The issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days"). The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.*, Case No. 25-3464GC, Statement of Issue at 1-2 (Mar. 1, 2025).
[3] *Id.* at 2-5.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

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

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

> included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

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

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

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

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

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

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

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

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[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

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

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

> notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court has ordered the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[50]

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests argue that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[51] They seek to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[52] The Providers argue that the Final Rule is contrary the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[53]

The Providers recount how, prior to 2004, CMS did not include Part C Days in the SSI Ratio, along with the subsequent rulemaking and litigation which can be outlined as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment

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[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.*, Case No. 25-3464GC, Statement of Issue at 1.
[52] *Id.* at ¶ 3.
[53] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).

rulemaking.

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

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

B. Providers' Petitions for EJR

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

The Medicare Contractor's representative, Federal Specialized Services ("FSS"), has filed timely responses to the Requests for EJR in each case simply advising that "the MAC will not file a jurisdictional challenge in this case, the MAC will not file a substantive claim challenge in this case."[57]

Decision of the Board:

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

A. Jurisdiction

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

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

[54] *Id.* at ¶¶ 6-18.
[55] *E.g.*, Case No. 25-3464GC, Providers' Petition for Expedited Judicial Review at 1-4 (Feb. 21, 2026).
[56] *Id.* at 11.
[57] *E.g.*, Case No. 25-3464GC, Response to Provider's Request for Expedited Judicial Review at 1 (Feb. 28, 2026).

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

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

42 C.F.R. § 405.1835(b)(3) requires that a provider's request for a Board hearing **must** include "[a] copy of the final contractor or Secretary determination under appeal." Board Rule 6.1.1 specifically states that "[t]he Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b)[.]" Board Rule 7.1.1 reiterates that a copy of the final determination under appeal must be included as support for an appeal, and Board Rule 16.2 explains that the filing requirements found in these Rules are also applicable to requests to join a group appeal from a final determination.

In Case 25-5172GC, Iowa Lutheran Hospital (Provider Number 16-0024, FYE 12/31/2008) did not include a copy of its RNPR with its appeal request. Instead, the document submitted in OH CDMS and labeled as the final determination is a copy of numerous worksheets from its cost report. Pursuant to Board Rule 6.1.1, the Board hereby ***dismisses*** this provider from the appeal for failing to meet the filing requirements set forth in 42 C.F.R. § 405.1835(b)(3) and Board Rule 7.1.1.

For the remaining providers in these twenty-two (22) groups, the providers all appealed from revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers were directly added to their respective groups within 180 days of the issuance of their RNPRs. Finally, the amount in controversy exceeds $50,000 in each case.

Except for Iowa Lutheran Hospital in Case 25-5172GC, the Board finds that the Providers in the twenty-two (22) cases listed in **Appendix A** have filed timely appeals from their revised NPRs concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

[58] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[59] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) Except for Iowa Lutheran Hospital in Case 25-5172GC (which is hereby dismissed from Case 25-5172GC), it has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the twenty-two (22) cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;

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

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

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

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years, except Iowa Lutheran Hospital in Case 25-5172GC.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes the twenty-two (22) 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:

3/17/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

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

Appendix A

25-3464GC	*East Texas Regional HS CY 2012 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3598GC	*East Texas Regional HS CY 2011 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3729GC	*East Texas Regional HS CYs 2008 & 2009 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3808GC	*CHSLI CYs 2005 & 2007 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Part C Days CIRP Group*
25-3618GC	*CHSLI CY 2011 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3622GC	*CHSLI CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3594GC	*CHSLI CY 2013 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3655GC	*Bon Secours Charity CY 2012 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3640GC	*Bon Secours Charity CY 2013 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3658GC	*Bon Secours Charity CY 2011 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3662GC	*Bon Secours Charity CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3667GC	*Bon Secours Charity CY 2009 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3632GC	*Health Alliance CY 2012 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3688GC	*Health Alliance CY 2011 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3700GC	*Health Alliance CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3683GC	*Health Alliance CY 2009 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3711GC	*Health Alliance CY 2008 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-3714GC	*Health Alliance CY 2007 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*

25-5175GC	*UnityPoint Health CY 2007 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-5172GC	*UnityPoint Health CY 2008 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-5430GC	*UnityPoint Health CY 2009 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
25-5115GC	*SSM Health CY 2007 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Jurisdiction in Part – Dismissal of Medicaid Eligible Days (1115 Waiver Days) Issue***
Stormont Vail Hospital (Provider Number 17-0086)
FYE: 09/30/2016
Case Number: 20-1619

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-1619. Set forth below is the decision of the Board to dismiss one of the two remaining issues in this appeal challenging the Provider's Medicaid Eligible Days *(including Section 1115 Waiver Days)*.

Background

On **November 14, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year ended September 30, 2016.

On **May 1, 2020**, Quality Reimbursement Services, Inc. ("QRS") filed the Provider's individual appeal request. The initial Individual Appeal Request included two (2) issues:

1. DSH SSI (Provider Specific)[1]
2. DSH Payment – Medicaid Eligible Days

On **July 7, 2020**, QRS added a third issue: Bad Debts.

On **May 4, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (hereinafter "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim,

[1] After a March 30,2021 Jurisdictional Challenge was filed over the SSI P/S issue, QRS eventually withdrew the issue on February 29, 2024.

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

On **December 27, 2020**, the Provider timely filed its PPP.

On **February 19, 2021** and **January 10, 2023**, the Medicare Contractor ("MAC") filed copies of its requests to the Provider for Medicaid days support.

On **April 23, 2021**, the MAC timely filed its PPP. With respect to Issue 2, the MAC again detaild all documentation requested from the Provider that was necessary to resolve the issue in dispute.[3]

On **April 26, 2024**, the MAC filed a jurisdictional challenge over the Provider's untimely and improper attempt to add a new issue, section 1115 waiver days, to its Medicaid eligible days issue.

On **August 7, 2025**, the Board issued a Notice of Hearing and Critical Due Dates, scheduling the case for a hearing on February 18, 2026. Among other things the Notice provided the filing deadlines for the parties' final position papers.

On **November 19, 2025**, the Provider filed its final PP.

On **December 4, 2025**, the MAC filed its final PP. In it the MAC challenges jurisdiction over the Medicaid Eligible Days issue in its entirety.

On **February 12, 2026**, the Board issued a notice rescheduling the hearing in this case to a video hearing to be held on **April 2, 2026**.

B. Description of Issue 2 in the Appeal Request

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider describes Issue 2 as:

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

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[2] (Emphasis added).
[3] MAC's Preliminary Position Paper ("MAC's PPP") at 20 (April 23, 2021).

Statement of the Legal Basis

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

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

Audit Adjustment Number(s): 8, 22, 31, 34, 39, 40, s-d
Estimated Reimbursement Amount: $602,006[4]

In its PPP, the Provider argues that, pursuant to the Jewish Hospital case[5] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[6] The Provider's final PP reiterates its arguments and indicates that a Medicaid Eligible days listing, which included Section 1115 Waiver days, was being sent to the MAC under separate cover. Although the Provider also indicated a redacted listing was included with its final PP, it was not part of the Final PP exhibits.

MAC's Jurisdictional Challenge Over Section 1115 Waiver Days

The MAC disputes the Provider's attempt to untimely and improperly add the issue of Section 1115 Waiver days as a sub-issue via its submission of a redacted Medicaid Eligible Days listing. The listing, which was apparently filed on February 10, 2023, was uploaded to the MAC's secure portal, two and a half years after the filing deadline to add an issue. The MAC issued the Provider's NPR on November 14, 2019. In accordance with 42 C.F.R. § 415.1835(e), the deadline for adding issues to the appeal was July 11, 2020.[7]

In addition, the MAC maintains that the Section 1115 Waiver days issue is one component of the DSH issue that must be appealed as a separate issue. The MAC notes that Board Rule 8 explains that one issue can have multiple components. Within Board Rule 8, some of the disproportionate

[4] Appeal Request at Issue 2.
[5] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[6] Provider's PPP at 12 (Dec. 27, 2020).
[7] MAC Jurisdiction Challenge at 6 (Apr. 26, 2024).

share hospital (DSH) components are identified. Specifically, the Board identifies Section 1115 Waiver days as a distinct DSH component that the Provider must separately appeal.[8]

MAC's Challenge Over Medicaid Eligible Days

In its final PP, the MAC contends that the Board should deny jurisdiction over the Medicaid Eligible Days issue. The MAC argues that the Provider failed to substantiate its entitlement to additional days, filed a perfunctory PPP that violated Rule 25 and did not timely submit a non-redacted version of a Medicaid Eligible days listing showing the additional days. According to the MAC, the amount in controversy for the Medicaid Eligible Days issue was based on an increase of 998 Medicaid eligible days, but the listing submitted with the Provider's final PP totaled 3,936 days, which may not even include Medicaid Eligible Days.[9]

Provider's Jurisdictional Response regarding Section 1115 Waiver Days

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] Board Rule 44.4.3 specifies: "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

In this case, the Provider filed its response to the jurisdiction challenge over a year later. Therefore, the Board will not consider the Provider's argument.

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 Medicaid Eligible Days (including Section 1115 Waiver Days) issue in the appeal.

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, the PPP or the final PP.

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[8] MAC Jurisdictional Challenge at 7 (April 26. 2024).
[9] MAC final PP at 8 (Dec. 4, 2025).
[10] Board Rule 44.4.3, v.2. (Aug. 29, 2018).

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, at 7.3.2:

> **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.[11]

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

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

[11] (Bold emphasis added.)

Rule 25 - Preliminary Position Papers[12]

> **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.

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

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

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The May 4, 2020 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25. Moreover, in connection with Issue 2, Medicare regulations specifically place responsibility 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)(2019) 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.[13]

Relatedly, 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 December 27, 2020, 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.[14] 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 $602,006 based on an estimated 998 days). The Provider's complete briefing of this issue in its PPP is as follows:

> 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

[13] (Emphasis added.)
[14] Provider's PPP at 13 (Dec. 27, 2020).

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

In its December 4, 2025 Final PP, the MAC requested the Board deny jurisdiction of the Medicaid Eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a non-redacted listing of additional Medicaid days in support of its claim (or explain why such documentation is unavailable); and (2) the Provider did not fully address the issue in its final PP, nor did it clarify the estimated 998 days appealed are accurate. The MAC asserts that the PPs are perfunctory and clearly violate Board Rules 25 and 27, as well as 42 C.F.R. § 405.1835 (b)(2) as they fail to "set forth a fully developed narrative with relevant arguments, controlling authorities, and facts regarding the merits of the provider's claims on the Medicaid eligible days issue, and did not include all exhibits related to the issue."[15] Therefore, 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

[15] MAC Final PP at 8 (Dec. 4, 2025).

documents, as required by the Board Rules.[16] In addition, the MAC again argued the Provider was attempting to untimely, and improperly, add the Section 1115 waiver days issue by including it in its PP submission.

DSH Payment – Medicaid Eligible Days ~ Section 1115 Waiver Days

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

The appeal was filed with the Board in May of 2020 and the regulations required the following:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> * * *
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[17]

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

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - the controlling authority,

[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.
[17] 42 C.F.R. § 405.1835(b).

- why the adjustment is incorrect,
- how the payment should be determined differently,
- the reimbursement effect, and
- the basis for jurisdiction before the [Board].[18]

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

> Several examples are identified below, but these examples are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include…***Section 1115 Waiver days (program/waiver specific)***[19]

Effective August 21, 2008, following the appropriate notice and comment period, regulations went into effect that limited the addition of issues to appeals.[20]

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

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

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

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,

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[18] v. 2.0 (Aug. 2018).
[19] (Bold and italic emphasis added).
[20] *See* 73 Fed. Reg. 30190 (May 23, 2008).

2000.[21] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 Waiver days. In fact, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with a beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

Because the Provider did not raise the Section 1115 Waiver days prior to the deadline to add issues, and the fact that 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,

[21] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000).

would make them an unclaimed cost and provide an independent basis for dismissal. It was not until February 10, 2023, that the Provider filed a listing of days including the 1115 Waiver days.[22] This submission was sent years after the Provider would have needed to submit its as-filed cost report for FYE 09/30/2016 and more than three years after the Provider had received its NPR.

The Board regulations at 42 C.F.R. § 405.1835(e)(2016) provide the following with respect to adding issues:

> **Adding issues to the hearing request**. After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if—
>
> (1) The request to add issues complies with the requirements of paragraphs (a) and (b), or paragraphs (c) and (d), of this section as to each new specific item at issue.
> (2) The specific items raised in the initial hearing request and the specific items identified in subsequent requests to add issues, when combined, satisfy the amount in controversy requirements of paragraph (a)(2) or paragraph (c)(3) of this section.
> (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.[23]

Similarly, Board Rule 6.2.1 (Aug. 2018) states:

> **Request and Supporting Documentation**
>
> . . . an issue may be added to an individual appeal if the provider:
>
> - timely files a request with the Board to add issues to an open appeal no later than 60 days after the expiration of the applicable 180 days period for filing the initial hearing request. . .

Here, the Provider was issued its final determination on November 14, 2019, and had until May 17, 2020 to file its appeal request. The Provider had an additional 60 days, or until July 11,

[22] The listing was not filed in the Office of Hearings Case & Document Management System ("OH CDMS"). It was filed only in the MAC's secure portal according to the MAC's Jurisdictional Challenge.
[23] Emphasis added.

2020, to add any additional issues to its appeal.[24] The Provider did not mention the 1115 Waiver days in its PPP. According to the MAC, the first time the Provider referenced the 1115 Waiver days was in its February 10, 2023 submission, where it filed a listing of Eligible days included on the as-filed cost report and an updated listing including Section 1115 Waiver days (which was not copied to the Board). Thus, the Section 1115 Waiver days issue was not appealed or timely added and the Provider failed to develop its PPP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25, as applied via Board Rule 27.2.

The Board's finding that neither the appeal request, nor the PPs, met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[25] In that case, the provider's issue was tied to improper calculation to the DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[26] 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."[27] The Court found that this description of the issue was a violation of Board rules and a proper basis for the Board to dismiss the appeal.[28] Here, the Board makes the same finding based on similar *overly generalized language*.

Based on the above, the Board finds that the appeal did not include the *alleged* Section 1115 Waiver days sub-issue consistent with 42 C.F.R. §§ 405.1835(b)(2)-(3), 412.106(b)(4)(iii), and 405.1871(a)(3) and Board Rules 7.1, 8, 25, and 27.2.[29] Even if it had been included as part of the appeal, ***which it was not***, the issue was not properly developed in the PP process.

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[24] 42 C.F.R. § 405.1801(d)(3)(2016) states: "If the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days. " Therefore, the due date for the appeal and added issues would fall to the following business day.

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

[26] *Id*. at *5.

[27] *Id.*

[28] *Id.*

[29] If section 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the section 1115 waiver days. For example, the Board has found that when a class of days (*e.g*., 1115 waiver days) is excluded due to choice, error, and/or inadvertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).

Consequently, the Board dismisses Issue 2 - Medicaid Eligible days (including the Section 1115 Waiver days issue), from this case. As there is one remaining issue (Bad Debts), Case No. 20-1619 remains pending. **The case remains scheduled for a video hearing on April 2, 2026.**

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

Board Members Participating:

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

For the Board:

3/23/2026

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Mark Polston, Partner
King & Spalding, LLP
1700 Pennsylvania Avenue
Washington, DC 20006

Re: ***Determination on Reopening Status of Optional Group to Transfer Sole Participant from CIRP Group***

Case Number: 25-2673G - King & Spalding CY 2007 Reasonable Cost-to-IPPS BNA Group

Case Number: 25-3424GC - Tenet Healthcare CY 2007 Reasonable Cost-to-IPPS BNA CIRP Group

Dear Mr. Polston:

The Provider Reimbursement Review Board (the "Board") has reviewed King & Spalding, LLP's ("K&S") March 19, 2026 correspondence which was filed in response to the Board's Rule 18 Request for Information ("RFI"). The background of the cases and the Board's determination are set forth below.

Background:

On **February 24, 2026**, K&S designated the Tenet Healthcare CY 2007 Reasonable Cost-to-IPPS BNA CIRP Group, Case No. 25-3424GC to be fully formed with only a single participant - Saint Francis Bartlett Medical Center ("St. Francis Bartlett"/Provider Number 44-0228).

On the same date, K&S simultaneously filed a Motion, requesting the expansion of a pending optional calendar year ("CY") 2008 group for the Reasonable Cost-to-IPPS BNA issue under Case No. 25-3420G. K&S noted that its CY 2007 optional group under Case No. 25-2673G was already fully formed. The proposed expansion would allow the "group to group" transfer of St. Francis Bartlett's CY 2007 appeal from Case No. 25-3424GC.

On **March 4, 2026**, before deciding on K&S' Motion regarding its *multi-year* optional group request, the Board issued a Rule 18 RFI requesting comments on two alternative proposals regarding the disposition of the single participant CIRP group under Case No. 25-3424GC. The Board proposed either:

1) The expansion of the later year CY 2018 Tenet CIRP group for the Reasonable Cost-to-IPPS BNA issue, under Case No. 25-1021GC, to include CY 2007;[1]
   OR
2) The reopening of the status of K&S' CY 2007 Reasonable Cost-to-IPPS BNA optional group, under Case No. 25-2673G.

On **March 19, 2026**, K&S responded to the Board's proposed actions. K&S advised that, although the issues in the CY 2007 and 2018 groups (Case Nos. 25-3424GC and 25-1021GC) are the same and there are no factual or regulatory differences between the years, it was their preference to adopt the Board's second proposition to reopen the status of its optional CY 2007 group, Case No. 25-2673G. K&S advised that allowing St. Francis Bartlett to be transferred from the CY 2007 CIRP group to the reopened CY 2007 optional would be in the interest of judicial economy and convenience and would allow it to keep the CY

[1] Case No. 25-1021GC had not yet been designated to be fully formed.

2007 appeals together in a single group.

Board Determination:

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

After reviewing the facts in these groups and K&S' March 19, 2026 request and representations, the Board agrees to use its discretion to reopen the status of the CY 2007 optional group to allow the "group to group" transfer of St. Francis Bartlett, the sole participant from Case No. 25-3424GC to Case No. 25-2673G. After the transfer of St. Francis Bartlett to Case No. 25-2673G, there are no remaining participants in Case No. 25-3424GC, which is hereby closed and removed from the Board's docket. Case No. 25-2673G is being re-designated to be fully formed as of the date of this determination.

Finally, since K&S has attested that there are no other related providers appealing the Reasonable Cost-to-IPPS BNA issue for CY 2007, the Board will not entertain future requests for the addition or transfer of any other Tenet Healthcare CY 2007 providers to the optional group, nor will it allow the establishment of a new CIRP group for the CY 2007 Reasonable Cost-to-IPPS BNA issue.

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

For the Board:

3/24/2026

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Paul Zarling, Novitas Solutions Inc. c/o GuideWell Source (J-H) (MAC for CIRP groups)
Danelle Decker, National Government Services, Inc. (J-K) (MAC for optional groups)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

Re: ***Denial of Good Cause for Late Filing and Dismissal of Issues from CIRP Groups***

As it relates to: Carolinas Medical Center Northeast (Provider Number 34-0001)
Case Number: 25-4260, FYE 06/30/2007
and
Case Number; 25-4261, FYE 12/31/2007

As a Participant in Atrium Health/Advocate Health CY 2007 CIRP Groups:
Case Numbers: 25-5140GC, 26 -0566GC, 26-0567GC and 26-0568GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced individual appeals and related group cases. After reviewing the facts outlined below, the Board has determined that the individual appeal requests were untimely filed and consequently, the subsequent transfers of issues to group appeals must be denied. The Pertinent Facts, the Board's review and its determination are set forth below.

Pertinent Facts:

On **April 8, 2025,** Quality Reimbursement Services, Inc. ("QRS") filed separate individual appeals for Carolinas Medical Center Northeast ("CMC Northeast"/Prov. No. 34-0001) for its fiscal year ends ("FYEs") 6/30/2007 and 12/31/2007 under Case Nos. 25-4260 and 25-4261, respectively. Both Provider's Notices of Program Reimbursement ("NPRs") were issued on **September 25, 2024**. Because the two appeals were being filed beyond the regulatory filing deadline, QRS simultaneously filed a Request for Good Cause Extension with its appeals.

QRS' entire justification for good cause is set forth below:

> In January of 2025, QRS headquarters was subject to emergency evacuation orders due to the Eaton fire disaster. Additionally, the disaster resulted in employees having to flee their homes, with one key employee's home being destroyed by the conflagration.
>
> Due to the emergency conditions created by the fire disaster and its extensive impact on operations, manual operations recovery procedures caused several Board-issued deadlines to be missed, including the filing of the appeal. QRS apologizes for any

> inconvenience and respectfully requests that the Board accept this appeal as timely under the good cause provisions pursuant to 42 C.F.R. § 405.1836, and PRRB Rule 2.1.4. QRS believes that allowing the Provider to file an appeal under these provisions would be a reasonable remedy to these extraordinary circumstances.[1]

Both CMC Northeast's individual appeals included the following issues:

- DSH Medicaid Eligible Days
- DSH SSI Unduly Narrow Definition of SSI Entitlement ("Unduly Narrow")
- DSH SSI & MCD Fractions Medicare Managed Care Part C Days ("Part C Days")
- Improper Rulemaking- DSH SSI Fraction Dual Eligible Days (SSI Fr. DE Days")
- Improper Rulemaking- DSH Medicaid Fraction Dual Eligible Days (Mcaid Fr. DE Days")

On **October 13, 2025**, QRS withdrew the Medicaid Eligible Days issues from both cases.

On **December 1, 2025**, QRS transferred the following issues from Case Nos. 25-4260 and 25-4261 to common issue related party ("CIRP") groups:

Issue	Case No.	Group Name
Unduly Narrow	26-0566GC	Atrium Health CY 2007 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group
SSI Fr. DE Days	26-0567GC	Atrium Health CY 2007 Improper Rulemaking - DSH SSI Fraction Dual Eligible Days CIRP Group
Mcaid Fr. DE Days	26-0568GC	Atrium Health CY 2007 Improper Rulemaking-DSH Medicaid Fraction Dual Eligible Days CIRP Group

On **January 14, 2026,** QRS transferred the last remaining issue, Part C Days, in both individual appeals to the "Advocate Health CY 2007 DSH Part C Days RNPR CIRP Group," Case No. 25-5140GC.[2]

On **January 16, 2026 and January 21, 2026**, respectively, prior to the Board rendering a determination on the Request for Good Cause Extension, Case Nos. 25-4260 and 25-4261 were closed as no issues remained in either case.

Board Review:

In the subject individual cases, CMC Northeast's individual appeal filing deadline expired 185 days after issuance of the NPR, which fell on Saturday, March 29, 2025. Based on the Rules of

[1] Appeal Filed Under Good Cause Extension at 1 (Apr. 8, 2025).
[2]With respect to varying parent organizations in the CIRPs to which the provider transferred (i.e, Atrium Health vs. Advocate Health), based on an internet search, in December 2022, Advocate Health was formed by the merger of Advocate Aurora Health and Atrium Health.

Civil Procedure, the filing deadline was extended to the next business day, which was March 31, 2025. Case Nos. 25-4260 and 25-4261 were filed on April 8, 2025**, which was 195 days after the issuance of the NPR.**

The Eaton fire, which was the basis of QRS' Request for Good Cause Extension, was almost 3 months prior to the filing deadline in Case Nos. 25-4260 and 25-4261.

42 CFR 405.1836(b) states:

> The Board may find good cause to extend the time limit **only if the provider demonstrates in writing it [could] not reasonably be expected to file timely due to extraordinary circumstances beyond its control** (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in § 405.1835(a)(3) . . . .[3]

On April 21, 2025, the Board issued a determination regarding a request for Good Cause Extension in sixty-two cases where QRS filed a similar justification. In that determination, the Board indicated that,

> . . . while the requests for good cause extension refer generally to the California wildfires, the requests fail to provide any specific "relevant information and documents 'demonstrat[ing] . . . [the provider] could not be expected to file timely due to extraordinary circumstances beyond its control.'" There is a dearth of "relevant information" or "documents" accompanying the requests; in fact, there are no documents accompanying the requests, not even an official emergency declaration, news report, or map.[4]

The Board's determination went on to note that QRS' requests were devoid of detail regarding the operational challenges, in that they lacked specifics about how the QRS office was affected by the wildfires (e.g., building damage, power outages, access to the site). The Board also pointed out that QRS has various office locations in areas that were not impacted by the wildfire, so it was unclear why an employee in one of the other offices couldn't have filed the appeal or requested an extension while the California-based employees were unavailable.[5] The Board also questioned why QRS "was able to complete some of its work and file some appeals timely, but was unable to file all appeals timely."[6]

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[3] (Bold emphasis added.)
[4] Board Determination in 25-3081GC et. al. at 7-8 (April 21, 2025).
[5] *Id*. at 8.
[6] *Id.*

Similarly, in Case Nos. 25-4260 and 25-4261, QRS indicated that the fire disaster had an "extensive impact on operations, [*and that*] manual operations recovery procedures caused several Board-issued deadlines to be missed, including the filing of the appeal."[7] However, QRS' Request for Good Cause Extension in the current appeals still lacked relevant documents or specific information related to how the fire impacted QRS' office(s) or why another office couldn't have assumed responsibility for assuring the timely filing of these appeals three months after the fire.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final 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.

With respect to Case Nos. 25-4260 and 25-4261, the Board finds that the rationale it set forth in its April 21, 2025 Denial of Good Cause letter in Case Nos. 25-3081GC *et. al*. is applicable here. QRS again relied on the "generic fire explanation" as the basis for its Request for Good Cause Extension and again the Board finds this not to be an adequate justification. As in its prior determination, the Board bases its determination on the fact that QRS was able to accomplish its operations in numerous other cases during the time-period in question. QRS has six other offices that are NOT located in the fire zone and, QRS has provided no documentation of the actual disruption to its Arcadia office caused by the fire or any explanation as to how operations in its other offices were disrupted.[8]

Indeed, both individual appeals are for CMC Northeast, which is located in Concord, North Carolina -NOT California. It is not clear how a fire near one of the eight QRS locations (six of which are in other states), could make its entire operation unable to continue working, nor is there sufficient explanation for such an argument.

Consequently, although Case Nos. 25-4260 and 25-4261 have been in a closed status as of January 16 and 21, 2026, respectively (after the last issue in each was transferred to a group), the Board finds CMC Northeast's individual appeals were untimely filed and denies QRS' Request for Good Cause Extension. The cases remain in a closed status, but now, in light of the Good Cause denial, the previous transfers of issues from Case Nos. 25-4260 and 25-4261 to the following groups are found to be invalid and are hereby denied:

- Case No. 26-0566GC -Unduly Narrow SSI Entitlement
- Case No. 26-0567GC – Improper Rulemaking -SSI Fr. DE Days
- Case No. 26-0568GC – Improper Rulemaking -M'caid Fr. DE Days

[7] Filing of an appeal is a regulatory deadline, not a Board issued deadline.

[8] QRS' website shows that, in addition to the location in Arcadia, California, it has offices in Colorado Springs, Colorado; Spokane, Washington; Los Angeles, California; Chicago, Illinois; Detroit, Michigan; Guttenberg, New Jersey and Birmingham, Alabama.

- Case No. 25-5140GC – Part C Days

As CMC Northeast (for both years) is the sole participant in Case Nos. 26-0566GC through 26-0568GC, the Board dismisses the three group appeals and removes them from the docket. Case No. 25-5140GC remains pending as there are other timely filed participants.

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:

3/24/2026

X Kevin D. Smith, CPA

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

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

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

Ms. Heather Walters
Chief Nursing Officer
El Campo Memorial Hospital
303 Sandy Corner Road
El Campo, TX 77437

RE: Determination re: Filing Requirements
El Campo Memorial Hospital (45-0694)
Period Ended: Federal Fiscal Year (FFY) 2026
PRRB Case No.: 26-2036

Dear Ms. Walters:

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 subject 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 March 11, 2026, the Provider filed an appeal for the Federal Fiscal Year ("FFY") 2026. The proceedings for the appeal indicate that the Provider is filing the appeal based on a Notice of Quality Reporting Program Noncompliance Decision Upheld dated August 5, 2025. The appeal request identified a sole issue in dispute:

Quality Reporting Program Payment Reduction

The total controversy amount was stated as $255,546.

As set forth below, the appeal was untimely filed since it was filed on the 218th day passed the final determination date of August 5, 2025.

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

Board Rule 4.1 states: **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.

Board Rule 4.4.1. states: **Due Dates for New Appeals** New appeals must be received by the Board *no later than 180 days* from the commencement of the appeal period as specified in Rule 4.3. See Rule 2.1.4 for instructions on requesting an extension under 42 C.F.R. § 405.1836 "due to extraordinary circumstance beyond [the party's] control."

Board Rule 4.4.3 states: **Due Date Exceptions** If the due date falls on a Saturday, a Sunday, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

Board Rule 4.5 states: **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).

Per PRRB Rule 6.1, the Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b). **(Emphasis added.)**

BOARD DETERMINATION:

As noted in the facts above, the appeal request states that the subject appeal is based on a Notice of Quality Reporting Program Noncompliance Decision Upheld dated August 5, 2025. Allowing for the 180-day appeal period and a five-day presumption for mailing, the 185th day fell on February 6, 2026. The date of delivery to the Board, as evidenced by the Confirmation of Correspondence generated by OH CDMS, was March 11, 2026. The subject appeal request was filed 218 days past the final determination date of August 5, 2025 and was, therefore, untimely filed.

As a result, the Board hereby dismisses case number 26-2036, in its entirety, since it failed to meet the minimum filing requirements pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 and Board Rules 4.4.1, 4.4.3 and 4.4.5.

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:

3/24/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Houston Methodist St. John Hospital (Prov. No. 45-0709), FYE 12/31/2017
Case No. 22-1346

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1346. 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 (Provider Specific) issue.

Background:

A. ***Procedural History for Case No. 22-1346***

On **February 25, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017. The Provider is commonly owned by Houston Methodist Hospital System ("Houston Methodist").

On **August 23, 2022**, Houston Methodist filed the Provider's individual appeal request which included eight (8) issues:

1. DSH Payment (Provider Specific)
2. DSH Payment (SSI Systemic Errors)[1]
3. DSH Payment (Medicare Part C Days)[2]
4. DSH Payment (Medicare Dual Eligible Days)[3]
5. DSH Payment (Additional Days Including 1115 WD)[4]
6. DSH Payment (Medicaid Part C Days)[5]
7. DSH Payment (Medicaid Dual Eligible Days)[6]
8. Standardized Payment Amount[7]

[1] On March 27, 2023, this issue was transferred to PRRB Case No. 20-1609GC.
[2] On March 27, 2023, this issue was transferred to PRRB Case No. 20-1610GC.
[3] On March 27, 2023, this issue was transferred to PRRB Case No. 20-1611GC.
[4] On October 6, 2022, the Provider withdrew this issue pursuant to reopening. The withdrawal was acknowledged on October 26, 2022.
[5] On March 27, 2023, this issue was transferred to PRRB Case No. 20-1610GC.
[6] On March 27, 2023, this issue was transferred to PRRB Case No. 20-1613GC.
[7] On March 27, 2023, this issue was transferred to PRRB Case No. 20-1614GC.

As the Provider is commonly owned/controlled by Houston Methodist, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 27, 2023**, the Houston Methodist transferred Issues 2, 3, 4, 6, 7 and 8 to Houston Methodist CIRP groups. As a result of the transfers, and after the withdrawal of Issue 5, there is one (1) remaining issue in this appeal: Issue 1 - DSH Payment (Provider Specific).

On **August 23, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **April 19, 2023**, the Provider timely filed its preliminary position paper (*hereinafter* "PPP").

On **August 4, 2023**, the MAC timely filed its PPP.

On **May 10, 2024**, the Representative for Case No. 22-1346 was changed to Quality Reimbursement Services, Inc. ("QRS").

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 21-1206GC

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

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

[8] (Emphasis added).

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[9]

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue 2 (the SSI Percentage), reads in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and

[9] Issue Statement at 1 (Aug. 23, 2022).

6. Failure to adhere to required notice and comment rulemaking procedures.[10]

On April 19, 2023, the Board received the Provider's PPP in Case No. 22-1346. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. See 42 U.S.C. 1395 (d)(5)(F)(i).[11]

The amount in controversy in the Provider's individual appeal request for Issue 1 is $10,011 and for Issue 2 is $10,010.

MAC's Contentions in PPP – DSH Payment (Provider Specific)

Although a formal challenge has not yet been filed, in its PPP filing the MAC argues that there is an impediment over the Board's jurisdiction of the DSH Payment (Provider Specific) issue. First, the MAC contends that the issue is duplicative of the DSH Payment (SSI Systemic Errors) issue (#2) which was transferred to a CIRP group. Second, the MAC argues that the realignment component is premature, as the Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Therefore, the Provider has not exhausted all available remedies with regard to this component of the issue.

[10] Group Issue Statement, Case No. 21-1206GC.
[11] Provider's PPP at 2 (April 19, 2023).

Board Analysis and Decision:

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

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

A. DSH Payment (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 21-1206GC.

The SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[12] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14]

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case No. 21-1206GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Percentage (Provider Specific) issue in Case No. 22-1346 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[15], the Board dismisses this aspect of the DSH Payment (Provider Specific) issue.

---

[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 3.1 (Nov. 2021).

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[17]

The Board notes that there have been developments on the availability of data underlying the SSI fraction, such as MEDPAR data. For example, as noted in the FY 2006 IPPS Final Rule:

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MEDPAR LDS data for a hospital's patients eligible for both SSI

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

> and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[18]

This CMS webpage describes access to DSH data and instructs providers to send a request via email to access their DSH data.

Accordingly, *based on the record before it*, the Board finds that DSH Payment (Provider Specific) issue in the instant appeal and the group issue in Case No. 21-1206GC are the same issue.[19] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

[18] Last modified on March 17, 2026.
[19] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Houston Methodist Hospital System CIRP group per 42 C.F.R. § 405.1837(b)(1).

MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

****

Based on the foregoing, the Board is dismissing the last remaining issue in this case: DSH Payment (Provider Specific) - Issue No. 1. As no issues remain, the Board hereby closes Case No. 22-1346 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:

3/24/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Barbara Williams
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1250 Connecticut Avenue NW, 8th Floor
Washington, DC 20036

RE: ***Notice of Reopening and Expedited Judicial Review Determination***
Case Number: 24-1709GC: *CHS CY 2020 Wage Index CIRP Group*

Dear Ms. Williams:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on **February 23, 2026** concerning the above referenced common issue related party ("CIRP") group appeal. Since the case was closed on **March 12, 2026**, pursuant to an earlier EJR request, the Board is issuing this decision as a Notice of Reopening and also issuing its decision on jurisdiction and EJR as set forth below.

Issue:

On **March 12, 2026**, the Board granted EJR over the Providers' challenge to the treatment of Section 401 hospitals in the calculation of the rural wage index. That same decision also found that six (6) providers failed to make an appropriate cost report claim pursuant to 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873.

On **February 23, 2026**, while the original Petition for EJR was pending, the Providers filed a second Petition for EJR to challenge the validity of 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873. The Petition for EJR is challenging the "validity of the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 imposing the requirement for a provider to claim reimbursement, or submit a "protest" statement, for "a specific item" as a condition of receiving payment for that item."[1]

The Providers provide a history of the requirement to present issues on the cost report prior to appeal. They explain how the Supreme Court rejected the notion that 42 U.S.C. § 1395oo(a) contains an exhaustion requirement that precluded appealing issues not presented to the Medicare contractor in *Bethesda Hops. Ass'n v. Bowen*.[2] They recount how, in response to *Bethesda*, CMS finalized a "self-disallowance" regulation in 2008 at 42 C.F.R. § 405.1835(a)(1)(ii) that required providers to file the cost report "under protest" when challenging a CMS regulation.[3] The Providers note that this regulation was found to conflict with the plain

[1] Providers' Petition for Expedited Judicial Review of the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873 at 1 (Feb. 23, 2026) ("Petition for EJR").
[2] 485 U.S. 399 (1988). Petition for EJR at 5-6.
[3] Petition for EJR at 3-4, 6.

text of § 1395oo in *Banner Heart Hosp. v. Burwell*,[4] but note that the protest requirement in the self-disallowance regulation was removed prior to that decision. Instead, the same requirement is now one related to reimbursement, and not the Board's jurisdiction, and can be found at 42 C.F.R. § 413.24(j), with implementation regulations regarding Board action at 42 C.F.R. § 405.1873.[5] The Providers argue that "[m]oving the regulation from one section of the C.F.R. to another and retitling it as a "payment requirement" does not alter the substance of the regulation, which is an exhaustion requirement constraining Board authority, contrary to 42 U.S.C. § 1395oo, *Bethesda*, and *Banner Heart Hospital*."[6]

On **March 2, 2026**, FSS filed a response to the Petition for EJR that simply noted a substantive claim challenge had been filed, but this was referring to the challenge filed over the wage index petition for EJR (for which the Board issued a timely decision on March 12, 2026).

Statutory and Regulatory Background:

I. Board Reopenings

The Board, as a reviewing entity as described in 42 C.F.R. § 405.1801(a), may reopen its decisions "with respect to specific findings on matters at issue in a determination or decision."[7] In exercising its authority to reopen a decision, the Board "must provide written notice to all parties to the determination or decision that is the subject of the reopening."[8] Upon receipt of this notice, "the parties to the prior . . . determination or decision . . . must be allowed a reasonable period of time in which to present any additional evidence or argument in support of their positions."[9]

For group cases where an EJR Request is filed within 60 days of the Final Schedule of Providers, Board Rule 44.6 (2023) governs. In those instances:

> [T]he Medicare contractor . . . has five (5) business days to either:
>
> 1. File any jurisdictional and/or Substantive Claim Challenge(s) related to the group appeal (or participants therein, as relevant); or
> 2. Submit a filing wherein the Medicare contractor certifies that it will, *in fact*, be filing a challenge(s) (whether to a Jurisdictional or Substantive Claim Challenge) related to the group appeal (or participants therein, as relevant) but it has not yet had an opportunity to complete its review of the final schedule of providers and to finalize the filing for the challenge(s).
>
> If the Medicare contractor files the certification described above in No. 2, then the Medicare contractor must file the challenge(s) ***no later than twenty (20) days following the filing of the EJR request***.

[4] 201 F.Supp.3d 131 (2016). Petition for EJR at 6-7.
[5] Petition for EJR at 7.
[6] *Id.* at 8.
[7] 42 C.F.R. § 405.1885(a)(1).
[8] 42 C.F.R. § 405.1887(a).
[9] 42 C.F.R. § 405.1887(b).

II. *EJR and compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873*

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.

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[10] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[11] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement").

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

[10] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[11] *Id.* at 70555.

> 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.[12]

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

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

[12] (Bold and underline emphasis added.)

> 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**.[13]

Decision of the Board:

I. Reopening

The Board is reopening its **March 12, 2026** EJR decision to incorporate its decision on the Second Petition for EJR related to the validity of 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873 filed on **February 23, 2026**. The regulations require that, following a Notice of Reopening, the Board give the parties a "reasonable period of time" to present additional evidence or argument. The Board finds, however, that the Parties have already had a "reasonable period of time" to present their arguments on the matter since each party has been briefed and/or responded to the Petition for EJR within the timelines prescribed by the Board's Rules.

On **January 6, 2026**, the designated representative in Case 24-1709GC certified that the group was fully formed and populated in OH CDMS pursuant to Board Rule 20.[14] The instant Petition for EJR was filed on **February 23, 2026**. Any Substantive Claim or Jurisdictional Challenges (or certifications that such a challenge was forthcoming) were due no later than **March 2, 2026**. FSS filed its Response to this Petition simply noting that a substantive claim challenge had already been filed, but this was referring to the challenge filed over the wage index petition for EJR. It did not express any intent to challenge the Petition for EJR related to the validity of 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873.

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[13] (Bold and underline emphasis added.)

[14] Rule 20 instructs a Provider's Representative:

> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation.

Based on the foregoing, the Board is not soliciting additional arguments or evidence on this petition because the (1) Provider already made its arguments in the petition, and (2) FSS already responded to the Petition and did not voice any objection thereto.

II. EJR on the validity of 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873

As noted, *supra*, 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.

While the validity of 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873 was not presented in the Providers' original appeal request, it was not **relevant** to the specific matter at issue until the Medicare Contractor alleged that the Providers failed to comply with these regulations. Once such a challenge was made, the validity of 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873 became relevant to the specific matter at issue in the Providers' appeal for the following six (6) Providers challenged by the Medicare Contractor (the "Challenged Providers"):

- Lutheran Hospital of Indiana Provider No. 15-0017 FYE 6/30/2020 ("Lutheran")
- Shore Point Health Punta Gorda, Provider No. 10-0047, FYE 9/30/2020 ("Shore Point")
- Lower Keys Medical Center, Provider No. 10-0150, FYE 9/30/2020 ("Lower Keys")
- Shands Lake Shore Regional Medical Center, Provider No. 10-0102, FYE 8/30/2020 ("Shands")
- Lafolette Medical Center Provider No. 44-0033, FYE 9/30/2020 ("Lafolette")
- Flowers Hospital, Provider No. 01-0055, FYE 9/30/2020 ("Flowers")[15,16]

Thus, the Board must grant EJR over this issue if it finds it has jurisdiction over the Providers' appeal.

In its **March 12, 2026** decision on the Providers' **January 8, 2026** Petition for EJR, the Board found that it had jurisdiction over the appealed issue and that the Providers in the group appeal were entitled to a hearing before the Board. 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 provisions of 42 C.F.R. § 413.24(j) and 42 C.F.R.

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[15] Medicare Administrative Contractor's Amended Substantive Claim Challenge at 1 (Feb. 11, 2026).

[16] The Board recognized that this question relates only to some of the participants in this group and, as such, does not apply to the group as a whole. 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. § 405.1873(a) *as a procedural matter in the proceedings before the Board*, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Judicial review remains available on appeal for these discreet group participation issues regardless of whether they relate to the jurisdiction or claims-filing requirements under § 405.1840 or the substantive claims requirements under § 413.24(j).

§ 405.1873, as it did in its **March 12, 2026** EJR Decision. The Board is without the authority to grant the relief sought by the Providers in the current Petition for EJR, namely invalidating 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873 as contrary to 42 U.S.C. § 1395oo, *Bethesda*, and *Banner Heart Hospital*. As a result, the Board finds that EJR is appropriate for this issue for the Challenged Providers for the fiscal year under appeal in Case 24-1709GC.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the validity of 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873 as it relates to the Challenged Providers for the subject year in Case 24-1709GC and that the Providers in the group appeal are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the validity of 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873, 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 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873 are contrary to 42 U.S.C. § 1395oo, *Bethesda*, and *Banner Heart Hospital*.

Accordingly, the Board finds that the question of whether 42 C.F.R. § 413.24(j) and 42 C.F.R. § 405.1873 are contrary to 42 U.S.C. § 1395oo, *Bethesda*, and *Banner Heart Hospital* properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Challenged Providers' request for EJR for the issue and the subject year.

The Challenged Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Case 24-1709GC has been reopened, but the Board will now close it as no additional issues or motions remain in the case.

Board Members Participating:

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

FOR THE BOARD:

3/24/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
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Via Electronic Delivery

James Ravindran
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150 N. Santa Anita Avenue, Suite 570A
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RE: **EJR Determination QRS LSU Outlier Threshold CIRP Groups**
Case Numbers: 14-3220GC *et al.* (20 Cases – *See* **Appendix A**)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Requests for Expedited Judicial Review ("EJR") filed **February 26, 2026** in the above-referenced appeals. The Board's decision with respect to EJR is set forth below.

I. Background

These twenty (20) appeals were filed between **September, 2013** and **July, 2017**. The issue statements in each case are materially identical. The Statement of the Group Issues for Case No. 14-3774GC provides the following "Brief Description of the Issue":

> This group appeal concerns the determination of the Providers' outlier payments for high cost cases under the prospective payment system ("PPS") for operating and capital-related costs of inpatient hospital services. The common issue for the group is whether the Centers for Medicare & Medicaid Services ("CMS") has correctly determined the outlier payment thresholds for the federal fiscal years covering the Providers' fiscal years under appeal in calculating the Providers' outlier payments. The Providers contend that their outlier payments are erroneous because of systemic flaws in the data and methodology used by CMS in determining the outlier payment thresholds.[1]

[1] Case No. 14-3774GC, Issue Statement at 1 (Jul. 14, 2014).

Case Nos. 15-0383GC and 15-3375GC describe the group issue as:

Group Issue: Outlier Payments - Fixed Loss Threshold (5.1% Withheld Issue)

Statement of Issue

Whether the Providers received the reimbursement Congress intended under the Medicare Act for treating certain cases that incurred extraordinarily high costs? Was the cost outlier threshold set improperly?

Statement of the Legal Basis

The Provider contends the Secretary's final determination of outlier payments was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. Section 706(2)(A), and is short of statutory rights within the meaning of 5 U.S.C. Section 706(2)(c), because the Secretary acted in an arbitrary and capricious manner and abused her discretion when setting the outlier threshold and calculating outlier payments. The Secretary failed to consider relevant factors and data which should have been taken into account when setting the criteria, failed to consider alternative methodologies when establishing the outlier thresholds and failed to demonstrate a reasonable connection between the thresholds and the factors considered. Among other things, the Secretary failed to consider relevant data which showed that the rate of increase in hospital costs per discharge was trending downward and that the relationship of hospital costs to hospital charges was changing. The Secretary thus failed to take into account the established pattern of declining cost-to-charge ratios, which play a significant part in the calculation of outlier payments, despite this problem being repeatedly pointed out in comments and despite proposed methods to account for this phenomenon and to more accurately estimate outlier payments so that thresholds could be set more accurately. Further, the Secretary failed to consider use of the "cost methodology," rather than the "charge methodology," in setting the outlier thresholds, despite the fact that the cost methodology had been more accurate in predicting outlier payments in prior years. Finally, the Secretary failed to require mid-year adjustments and failed to consider adjustments to the reconciliation process. These deficiencies in the Secretary's methodology were identified in the rulemaking comments. By ignoring the flaws in her methodology, the Secretary failed to act reasonably in calculating the amounts of outlier payment to which hospitals are entitled. As a result of

> these arbitrary and capricious actions, the threshold was set too high, the resulting amount of outlier payments fell short of the percentage required by the Medicare Act and hospitals did not receive the amount of outlier payments that Congress intended.[2]

Though the Board notes that they ***incorrectly*** assert that they are appealing their outlier threshold payments for ***fiscal year 2004*** while they actually concern fiscal years ending between 2008 and 2013, the remaining seventeen (17) Cases describe the group issue as:

> **Group Issue: Outlier Payments - Fixed Loss Threshold**
>
> **Statement of Issue**
>
> Whether the Provider received the reimbursement Congress intended under the Medicare Act for treating certain cases that incurred extraordinarily high costs? Was the cost outlier threshold set improperly?
>
> **Statement of the Legal Basis**
>
> The Provider contends the Secretary's final determination of outlier payments for the fiscal year 2004 was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of 5 U.S.C. Section 706(2)(A), and is short of statutory rights within the meaning of 5 U.S.C. Section 706(2)(c), because the Secretary acted in an arbitrary and capricious manner and abused her discretion when setting the outlier threshold and calculating outlier payments for federal fiscal year 2004. The Secretary failed to consider relevant factors and data which should have been taken into account when setting the criteria, failed to consider alternative methodologies when establishing the outlier thresholds and failed to demonstrate a reasonable connection between the thresholds and the factors considered. Among other things, the Secretary failed to consider relevant data which showed that the rate of increase in hospital costs per discharge was trending downward and that the relationship of hospital costs to hospital charges was changing. The Secretary thus failed to take into account the established pattern of declining cost-to-charge ratios, which play a significant part in the calculation of outlier payments, despite this problem being repeatedly pointed out in comments and despite proposed methods to account for this phenomenon and to more accurately estimate outlier payments so that thresholds could be set more accurately. Further, the Secretary failed to consider use of the "cost methodology," rather than the "charge

[2] *E.g.*, Case No. 15-0383GC, Group Issue Statement at 1 (Nov. 14, 2014).

> methodology," in setting the outlier thresholds, despite the fact that the cost methodology had been more accurate in predicting outlier payments in prior years. Finally, the Secretary failed to require mid-year adjustments and failed to consider adjustments to the reconciliation process. These deficiencies in the Secretary's methodology were identified in the rulemaking comments. By ignoring the flaws in her methodology, the Secretary failed to act reasonably in calculating the amounts of outlier payment to which hospitals are entitled. As a result of these arbitrary and capricious actions, the threshold was set too high, the resulting amount of outlier payments fell short of the percentage required by the Medicare Act and hospitals did not receive the amount of outlier payments that Congress intended.[3]

The parties have filed preliminary position papers in all twenty (20) cases, and final position papers in Case 14-3220GC. Each group is fully formed and the Providers' representative has confirmed, pursuant to Board Rule 20, that the group is fully populated in OH CDMS, or has submitted a hard copy of the Schedule of Providers pursuant to Board Rule 20.1.[4] On **February 26, 2026**, the Providers filed identical requests for Expedited Judicial Review ("EJR") in each case.

II. Relevant Law – Outlier Threshold

Part A of the Medicare Act covers "inpatient hospital services." Originally, Medicare reimbursed hospitals based on the "reasonable costs" of these services.[5] Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7] These predetermined, standardized amounts are calculated by the Secretary first determining a nationwide average allowable cost per discharge,[8] which is then further adjusted based on a wage index specific to the locality of the hospital.[9] Each discharge is also adjusted based on the severity of illness, which are classified as distinct diagnosis-related groups ("DRGs").[10] These DRGs are intended to weight the reimbursement based on "the relationship between the cost of treating patients within that group and the average cost of treating all Medicare patients."[11]

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[3] *E.g.*, Case No. 14-3220GC, Group Issue Statement at 1 (Apr. 16, 2014).
[4] Cases 16-0920GC and 14-3220GC.
[5] *See* 42 U.S.C. § 1395f(b)(1).
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] 42 U.S.C. § 1395ww(d)(2)(A)-(C).
[9] 42 U.S.C. § 1395ww(d)(2)(H).
[10] 42 U.S.C. § 1395ww(d)(4).
[11] *See Cape Cod Hosp. v. Sebelius*, 630F.3d 203, 205-206 (D.C. Cir. 2011).

While the IPPS provides a fixed amount of reimbursement per patient regardless of actual costs incurred in rendering services,[12] Congress also authorized supplemental "outlier payments," or additional reimbursement for patients' care if the cost was atypically high.[13] Hospitals may request outlier payments "in any case where charges, adjusted to cost, exceed . . . the sum of the applicable DRG prospective payment rate . . . plus a fixed dollar amount determined by the Secretary."[14]

Ensuring that costs are "adjusted to cost" involves evaluating a hospital's "cost-to-charge ratio," which represents the hospitals "average markup" of inpatient hospital services.[15] Outlier payments may be requested if the adjusted costs exceed the DRG rate plus a "fixed dollar amount" – commonly referred to as the "fixed loss threshold."[16] This amount essentially makes a hospital responsible for a portion of the treatment's excessive costs.[17] The Secretary is mandated to ensure that the fixed loss threshold for a given fiscal year results in outlier payments between five (5) and six (6) percent of total payments projected or estimated to be made under the IPPS.[18] The sum of the DRG rate plus the fixed loss threshold is known as the "outlier threshold."[19] Hospitals are typically paid 80% of the costs above the applicable outlier threshold.[20]

As noted by the United States District Court for the District of Columbia, basing outlier payment eligibility on a hospital's own cost-to-charge ratio "led to rampant inflation of hospital charges, a problem that came to be known as 'turbo-charging.'"[21] To combat turbo-charging, the Secretary began using more recent data and also reserved the right to recalculate a hospital's eligibility for outlier payments using actual cost data at the time of settlement, a process known as reconciliation.[22]

III. Positions of the Parties

As noted above, the Providers' group issue statements outline a number of challenges to their outlier payments, claiming the process was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law within the meaning of the Administrative Procedure Act.[23] They take issue with the outlier thresholds set by the Secretary because they argue that she failed

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[12] *See Sebelius v. Auburn Reg'l Med. Ctr.*, 133 S.Ct 817, 822 (2013).
[13] *See County of L.A. v. Shalala*, 192 F.3d 1005, 1009 (1999); 42 U.S.C. § 1395ww(d)(5)(A).
[14] 42 U.S.C. § 1395ww(d)(2)(A)(ii).
[15] *See Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 49-50 (D.C. Cir. 2015) (citing *Appalachian Reg'l Healthcare, Inc. v. Shalala*, 131 F.3d 1050, 1052 (D.C. Cir. 1997)); 42 C.F.R. § 412.84(i).
[16] *See Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d at 50.
[17] *See Boca Raton Comm. Hosp., Inc. v. Tenet Health Care Corp.*, 582 F.3d 1227, 1229 (11th Cir. 2009).
[18] 42 U.S.C. § 1395ww(d)(2)(A)(iv).
[19] *See Banner Health v. Price*, 867 F.3d 1323, 1329 (D.C Cir. 2017) (citing *Boca Raton v. Tenet Health*, 582 F.3d at 1229); 42 U.S.C. § 1395ww(d)(2)(A)(ii).
[20] 42 C.F.R. § 412.84(k).
[21] *Billings Clinic v. Azar*, 901 F.3d 301, 306 (D.C. Cir. 2018) (citing *Banner Health v. Price*, 87 F.3d at 1333).
[22] *Id.* (citing 68 Fed. Reg. 34494, 34499 (June 9, 2003)).
[23] 5 U.S.C. § 706(2).

to consider relevant data which would have impacted their cost-to-charge ratios; failed to consider use of the more accurate "cost methodology" versus the "charge methodology"; and failed to require mid-year adjustments to the threshold or adjustments to the reconciliation process.

The Providers have filed Preliminary Position Papers in each of the twenty (20) cases which are materially identical. They allege that CMS set the cost outlier threshold too high, meaning all acute hospitals participating in the IPPS received a 5.1% reduction in payment for each case, which reduction was used to fund extraordinarily high cost patient stays.[24] They essentially argue that the Secretary's methodology in calculating the outlier cost threshold invited the abusive turbo-charging carried out by some hospitals, and that the use of this methodology persisted "[d]espite multiple warnings from providers, and red flags raised by the data on which the Secretary relied, and without valid justification[.]"[25]

The Providers note that, for the fiscal years at issue in these appeals, outlier payments were set at 5.1 percent of operating DRG payments, but outlier payments ultimately totaled less than this.[26] They argue the outlier payments at issues are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."[27] They claim that the Secretary failed to consider relevant data and consider alternative methodologies when establishing outlier thresholds, despite these deficiencies being identified in rulemaking comments.[28]

The Medicare Contractor argues that substantially identical arguments were considered, and rejected, by the D.C. District Court in *District Hosp. Partners, L.P. v. Sebelius*.[29] It asks the Board to adopt the reasoning of the court and affirm the adjustments to outlier payments or, in the alternative, allow the Providers to seek expedited judicial review in accordance with 42 C.F.R. § 405.1842.[30]

The Providers filed Petitions for EJR in all twenty (20) of these cases on **February 26, 2026**. The Medicare Contractor filed timely response in each case noting that it would not be filing jurisdictional or substantive claim challenges in these cases.

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[24] *E.g.*, Case No. 14-3220GC, Provider's Preliminary Position Paper at 1, 11 (Nov. 23, 2023).
[25] *Id.* at 12.
[26] *Id.* at 15.
[27] *Id.* at 16.
[28] *Id.*
[29] *E.g.*, Case No. 14-3220GC, MAC Preliminary Position Paper at 6 (Feb. 28, 2024) (citing 973 F. Supp. 2d, 1 (D.D.C. 2014). The case was ultimately affirmed in part, reversed in part, and remanded, though the general rationale of the District Court was affirmed. *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46 (D.C. Cir. 2015).
[30] MAC Preliminary Position Paper at 9.

IV. Decision of the Board

A. *Expedited Judicial Review*

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

i. Untimely Appeals

Pursuant to 42 C.F.R. § 405.1835(a)(3), unless a provider qualifies for a good cause extension, 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. The Board notes that, "[t]he date of receipt of a final determination is presumed to be five (5) days after the date of issuance," and "[t]he date of receipt of documents [by the Board] is presumed to be the date stamped "received" by the Board."[31] This effectively allows a Provider 185 days from the date of its final NPR to file an appeal with the Board.

In Case 15-0383GC, Mercy Hospital Northwest Arkansas (Prov. No. 04-0010, FYE 6/30/2012) is appealing from an NPR dated **October 20, 2014**. Any appeal was due to the Board no later than **Thursday, April 23, 2015**. This Provider, however, was not directly added to the appeal until **Friday, April 24, 2015**. This was 186 days after the NPR was issued, which is untimely and the Boardy hereby dismisses this Provider from its appeal.

In Case 15-0383GC, Mercy Hospital Ardmore, Inc. (Prov. No. 37-0047, FYE 6/30/2012) is appealing from an NPR dated **February 25, 2016**. Any appeal was due to the Board no later than **Monday, August 29, 2016**.[32] This Provider, however, was not directly added to the appeal until **Tuesday, August 30, 2016**. This was 187 days after the NPR was issued, which is untimely and the Boardy hereby dismisses this Provider from its appeal.

ii. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;

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[31] Board Rule 4.3 (2013). *See also* 42 C.F.R. § 405.1801(a)(1)(iii)(2008).
[32] The 185th day following the NPR was Sunday, August 28, 2016. Pursuant to 42 C.F.R. § 405.1801(d)(3) (2014), the due date was automatically extended to Monday, August 29, 2016.

- 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; [33]
- 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.[34]

Except as outlined above with regard to the two untimely appeals in Case 15-0383GC, the Providers' documentation shows that the appeals were timely, were taken from NPRs or the failure to issue a timely final determination, and the estimated amounts in controversy exceed $50,000, as required for a group appeal.[35]

a. Dissatisfaction - FYEs Prior to December 31, 2008 (Bethesda)

Case 13-3835GC has two Providers with Fiscal Years Ending ("FYEs") September 30, 2008.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[36] 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.[37]

The Board has determined that that the Outlier Threshold methodology at issue in these cases is governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, which are statutory and regulatory provisions that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. As such, since the Providers filed their cost reports in compliance with this regulation/policy, the Outlier Threshold issue is governed by the ruling in *Bethesda* and the Providers are not barred from claiming dissatisfaction with the amount of reimbursement allowed by the regulation/policy.

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[33] 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).
[34] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[35] *See* 42 C.F.R. § 405.1837.
[36] 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.).
[37] *Bethesda* at 1258-59.

b. Dissatisfaction - FYEs December 31, 2008 to December 31, 2016 (1727-R)

All twenty (20) cases have Providers with FYEs spanning from 2009 to 2013.

On August 21, 2008, new regulations governing the Board were effective.[38] 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*").[39] 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.[40]

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

The Board has determined that the Outlier Threshold methodology at issue in these cases is governed by CMS Ruling CMS-1727-R since the Providers are challenging the policy as set forth in 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84 and that Board review of the issues is not otherwise precluded by statute or regulation.

V. Board's Decision Regarding the EJR Request

The Board finds that:

1) In Case 15-0383GC, Mercy Hospital Northwest Arkansas (Prov. No. 04-0010, FYE 6/30/2012) and Mercy Hospital Ardmore, Inc. (Prov. No. 37-0047, FYE 6/30/2012) filed untimely appeals and are hereby ***dismissed*** from Case 15-0383GC;

[38] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[39] 201 F. Supp. 3d 131 (D.D.C. 2016).
[40] *Id.* at 142.

2) It has jurisdiction over the matter for the subject years and that the remaining participants in the twenty (20) cases listed in **Appendix A** are entitled to a hearing before the Board;

3) Based upon the participants' assertions regarding the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, there are no findings of fact for resolution by the Board;

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 Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of the Outlier Threshold issue as governed by 42 U.S.C. § 1395ww(d)(5) and 42 C.F.R. § 412.84 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in the twenty (20) cases listed in **Appendix A**, ***except for*** Mercy Hospital Northwest Arkansas (Prov. No. 04-0010, FYE 6/30/2012) and Mercy Hospital Ardmore, Inc. (Prov. No. 37-0047, FYE 6/30/2012) in Case 15-0353GC. 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 twenty (20) cases, the Board hereby closes the cases and removes them from its docket.

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

Board Members Participating:

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

FOR THE BOARD:

3/25/2026

X Kevin D. Smith, CPA

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

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Cecile Huggins, Palmetto GBA (J-J)
Scott Berends, FSS

Appendix A

16-0920GC	*QRS BMHCC 2013 Outlier Payments - Fixed Loss Threshold CIRP Group*
15-3375GC	*QRS Mercy Health 2013 Outlier Fixed Loss Threshold CIRP Group*
15-0383GC	*Mercy Health CYs 2009 & 2012 Outlier Fixed Loss Threshold CIRP Group*
13-3835GC	*VCH 2008 & 2012 Outlier Payments - Fixed Loss Threshold CIRP Group*
15-1023GC	*QRS WFHC 2012 Outlier Payments-Fixed Loss Threshold (Late Issuance of NPR) CIRP Group*
14-3774GC	*Ardent Health Services 2012 Outlier CIRP Group*
14-0530GC	*Memorial Hermann 2009 & 2013 Outlier Payments -Fixed Loss Threshold CIRP Group*
17-0329GC	*QRS Wellmont HS 2013 Outlier Payments-Fixed Loss Threshold CIRP Group*
16-0250GC	*QRS Wellmont HS 2012 Outlier Payments-Fixed Loss Threshold CIRP Group*
16-0080GC	*QRS BMHCC 2012 Outlier Payments - Fixed Loss Threshold CIRP Group*
17-1837G	*QRS 2013 Outlier Payments - Fixed Loss Threshold Group II*
15-2695GC	*Baycare CYs 2011 - 2012 Outlier Payments - Fixed Loss Threshold CIRP Group*
15-1541GC	*QRS Orlando Health 2012 Outlier Payments - Fixed Loss Threshold CIRP*
15-0589GC	*Orlando Health CYs 2011 & 2013 Outlier Payments - Fixed Loss Threshold CIRP Group*
14-3922GC	*QRS Memorial Healthcare System CYs 2011 & 2013 Outlier Payments - Fixed Loss Threshold CIRP Group*
14-3264GC	*Health First CYs 2009, 2011 & 2012 Outlier Payment-Fixed Loss Threshold CIRP Group*
16-2239GC	*QRS Novant 2013 Outlier Payments-Fixed Loss Threshold CIRP Group*
15-3028GC	*QRS Novant 2012 Outlier Payments-Fixed Loss Threshold CIRP Group*
17-1509GC	*QRS Carolinas HealthCare System 2013 Outlier Fixed Loss Threshold CIRP*
14-3220GC	*QRS Duke FFY 2012 Outlier - Fixed Loss Threshold Late Issuance of NPR CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
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RE: ***Expedited Judicial Review Determination***

Kaleida Health (Provider Number 33-0005)
Case Number: 25-5781
FYE: 12/31/2004

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed **February 25, 2026** in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

Kaleida Health ("Provider") filed an individual appeal request on **September 9, 2025**. The appeal is taken from a letter from the Medicare Contractor dated **March 18, 2025**. The letter states:

> The MAC is reviewing the above named remanded Part C Days appeal. In accordance with the Akin Gump Strauss Hauer & Feld, LLP (Akin Gump) Settlement Agreement dated June 25, 2016, the following provider accepted a settlement amount for its disproportionate share hospital (DSH) supplemental security income (SSI) and/or its DSH dual eligible days appeals under CMS Ruling 1498-R.
>
> 1. Kaleida Health, 33-0005, 12/31/2004
>
> In accordance with this settlement agreement, the payment calculation for the appealed cost reporting period became the final determination for the Medicare/SSI ratio and is not subject to any further reopening or revision. Accordingly, the MAC considers the appealed Part C issue for this provider and FYE closed and no further action will be taken.[1]

[1] Kaleida 2004 No Remand Letter at 1 (Mar. 18, 2025).

The Provider seeks to challenge the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[2] as it pertains to the Provider's December 31, 2004.[3]

The issue in this appeal is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Northeast Hospital* and *Allina II* litigation. The Provider contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[4] The Provider is seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[5]

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").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[8] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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[2] 88 Fed. Reg. 37772 (June 9, 2023).
[3] Appeal Request, Statement of Issue at 2 (Sept. 9, 2025).
[4] *Id.* at 1.
[5] *Id.* at 2-3.
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

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 . . . .[13]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[14]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[15]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[16]

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.

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).

In the September 4, 1990 Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[21] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[22] The Secretary did not finalize that policy in the FFY 2004

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[17] of Health and Human Services.
[18] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization 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.
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[22] *Id.*

IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[23]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[24] In the FFY 2005 IPPS final rule, the Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[25] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[26]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[28] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published

[23] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[24] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[25] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).
[26] *Id.* (emphasis added).
[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.

on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[29]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[34] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[35] A number of hospitals appealed this action.[36] In *Azar*

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[29] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

[31] 746 F. 3d 1102 (D.C. Cir. 2014).

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

[33] *Id.* at 2011.

[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

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

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

v. Allina Health Services ("*Allina II*"),[37] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[38] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[39] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[40]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[41] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

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

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[43] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY

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of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[37] 139 S.Ct. 1804 (2019).
[38] *Id.* at 1817.
[39] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[40] 139 S.Ct. at 1814.
[41] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[42] CMS Ruling 1739-R at 1-2.
[43] 88 Fed. Reg. 37772 (June 9, 2023).

> 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.[44]

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

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[45]

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**."[46]

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

[44] 88 Fed. Reg. at 37788 (emphasis in original).
[45] 88 Fed. Reg. at 37774-75 (emphasis added).
[46] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[47]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[48]

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

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.[49] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[50] and arbitrary and capricious.[51] The court ordered the parties to submit briefs on whether vacatur is the appropriate remedy for the situation, which have since been filed.[52]

C. Appealability of a Denial of Reopening

In addressing the issue of whether the Board has jurisdiction to review an Intermediary's refusal to reopen a reimbursement determination, the Supreme Court in *Your Home Visiting Nurse Services, Inc. v. Shalala*[53] addressed the interpretation of what qualifies as a "final determination . . . as to the amount of total program reimbursement due the provider" under 42 U.S.C. § 1395*oo*(a)(1)(A)(i).[54] The Court deferred to the Secretary of HHS' interpretation of that phrase, ultimately finding that an Intermediary's refusal to reopen a reimbursement determination is not a final determination for which the Board has jurisdiction to review.[55] Indeed, refusing to reopen is, more simply, "a refusal to make a new determination."[56]

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[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).
[49] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[50] *Id.* at *12-19.
[51] *Id.* at *19-22.
[52] *Id.* at *23.
[53] 525 U.S. 449, 119 S.Ct. 930 (1999).
[54] 525 U.S. at 449-50.
[55] *Id.*
[56] *Id.*

Provider's Position:

A. Provider's Appeal Request

The Provider's appeal request includes a "Statement of Jurisdiction" which argues that the Medicare Contractor's "final decision 'clos[ing]' the remand of [its] prior appeal" related to Part C days is an appealable "final determination" because "it reflects the MAC's final determination regarding the calculation of the Provider's [DSH] payment."[57] It argues:

> The MAC refuses to issue a revised NPR to the provider applying the June 2023 rule purportedly because the cost year at issue was included in a settlement agreement under which the parties agreed to the final calculation of the SSI fraction. But whether the parties entered into a settlement agreement finalizing the calculation of the SSI fraction (which notably has never included part C days for the periods at issue here) is irrelevant to the Provider's appeal to have part C days included in the DSH *Medicaid* fraction.
>
> Moreover, the MAC's closure of the remand of the Provider's earlier appeal is contrary to the final June 2023 DSH part C days rule, which states that Providers whose appeals were remanded will receive NPRs or revised NPRs from which they may appeal. In addition, it is contrary to the Administrator's order remanding the Provider's appeal to the CMS Office of Financial Management, which directs the MACs to issue revised NPRs applying the June 2023 final rule and states that those revised NPRs will be subject to appeal. The MAC's closure of the remand is also contrary to CMS Transmittal 12513 implementing the June 2023 part C rule and providing that "for cost reporting periods starting before 10/01/04, with DSH payment related appeals that have been or will be remanded by the CMS Administrator or PRRB, the MAC *shall issue* an RNPR within the later of 12 months from the date of this Change Request if the remand has already been issued by the date of this CR's issuance." The rule, Administrator's order, and transmittal obligate the MAC to issue a revised NPR for the cost year at issue here, and the MAC's letter refusing to do so and closing the remand of the Provider's appeal is just as much a final determination as an NPR applying the June 2023 part C days rule.[58]

The "Statement of Issue" included with the appeal request states that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Northeast Hospital* and *Allina II* litigation. The Provider contends that Part C days must be excluded in their entirety from the SSI fraction and those days must be included in the

[57] Appeal Request, Statement of Jurisdiction at 1 (Sept. 9, 2025).
[58] *Id.* (citations omitted).

numerator of the Medicaid fraction for patients eligible for Medicaid."[59]

The Provider characterized the relevant background facts as follows:

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

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."[60]

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 Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[61]

B. Provider's Petition for EJR

The Provider has requested EJR over the "post-*Allina* retroactive Part C policy issue" because it believes it has met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[62] It seeks a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[63] The request states that "[t]he Provider contends that the new, post-*Allina* retroactive part C days rule challenged 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

[59] Appeal Request, Statement of Issue at 1.
[60] *Id.* (citing to 139 S. Ct. at 1816).
[61] *Id.* at 2 (citing 4 U.S.C. § 706(2)).
[62] Provider's Petition for Expedited Judicial Review at 13 (Feb. 25, 2026).
[63] *Id.* at 16-17.

evidence."[64] Since the Board is bound by this regulation,[65] it lacks the authority to provide the relief requested, and thus the Provider believes EJR is appropriate. It argues that its appeal is appropriate because it "is dissatisfied with the final determination 'clos[ing]' the remand of an earlier appeal of the DSH part C days issue."[66]

The Provider also claims the Medicare Contractor's failure to issue an RNPR is appealable under 42 C.F.R. § 405.1877(g) "which provides that a determination issued in response to a court remand 'is subject to further proceedings before the Board . . .'"[67] They claim the letter being appealed is a response to the court remand order and thus "subject to further proceedings before the Board." Finally, they quote CMS' Motion to Dismiss in *Allina IV*, where they allege "the Secretary has specifically stated in federal court that 'any agency response after a court remand 'is subject to further proceedings before the Board.'"[68]

The Medicare Contractor's representative, Federal Specialized Services, filed a response on **March 3, 2026** in this case simply noting "the MAC will not file a jurisdictional challenge in this case, the MAC will not file a substantive claim challenge in the case."[69]

Decision of the Board:

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

A. Jurisdiction

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

- They are dissatisfied with a final determination 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 determination. 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; [70]
- The amount in controversy is $10,000 or more.[71]

[64] *Id.* at 1-2.
[65] 42 C.F.R. § 405.1867.
[66] Provider's Petition for EJR at 14.
[67] *Id.* at 15.
[68] *Id.*
[69] Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 3, 2026).
[70] 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).
[71] 42 U.S.C. § 1395oo(a)(2); 42 C.F.R. §§ 405.1835 – 1840.

While this is not a refusal to reopen the cost report, but rather a refusal to issue a new RNPR, the June 2023 Final Rule explained that DSH payments would be calculated for Providers "whose DSH payments for those periods are still open or have not yet been finally settled."[72] In this case, there was a settlement agreement for the FYE at issue. The June 2023 Final Rule also repeatedly referenced the appealability of NPRs or RNPRs that were issued pursuant to the Final Rule,[73] and no other "final determinations."

The record does not contain any evidence that the Provider was actually a part of the *Allina* litigation. It was a participant in Case 16-0314G, which was remanded to the **Medicare Contractor** pursuant to CMS Ruling 1739-R on **April 19, 2021**. Thus, the Board rejects the argument that the Medicare Contractor's failure to issue an RNPR is appealable under 42 C.F.R. § 405.1877(g) "which provides that a determination issued in response to a **court**[74] remand 'is subject to further proceedings before the Board . . .'"[75]

B. Board's Decision Regarding the EJR Request

The Board finds that it lacks jurisdiction over this appeal because the "No Remand Letter" from which Provider filed its appeal is not an appealable final determination. If the Medicare Contractor was, in fact, required to issue a Revised NPR, its refusal to do so is beyond the jurisdiction of the Board. The Board notes, however, that the cost report for this fiscal year appears to have been settled via a settlement agreement between the parties,[76] and Change Request 13294 explicitly states "[c]onsistent with §405.1885(c)(2), the final rule retroactively adopting the policy at §412.106(b)(2)(i) for fiscal years before FY 2014 is not a basis for reopening final settled cost reports."[77]

Since the Board lacks jurisdiction over this appeal, it is denying the Request for EJR. The Board is also dismissing the appeal and removing it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

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[72] 88 Fed. Reg. at 37774 (emphasis added).
[73] *See supra* n.45-48 and accompanying text.
[74] (Emphasis added).
[75] Provider's Petition for EJR at 15.
[76] Kaleida 2004 No Remand Letter; *see also*, Statement of Jurisdiction at 1 ("the cost year at issue was included in a settlement agreement under which the parties agreed to the final calculation of the SSI fraction . . ."
[77] CMS Transmittal 12513, Change Request 13294 at unnumbered page 4 (Feb. 21, 2024) (available at https://www.cms.gov/files/document/r12513otn.pdf).

FOR THE BOARD:

3/26/2026

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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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***
Southwest Consulting Medicare Part C Days Groups
Case Numbers: 25-1204GC *et al.* (83 Cases – *See* **Appendix A**)

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **March 5, 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 Common Issue Related Party ("CIRP") groups for these eighty-three (83) groups between **September, 2024** and **October, 2025**. All eighty-three (83) groups contain providers appealing from original and/or revised Notices of Program Reimbursement ("NPRs" and "RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYEs") spanning from 2005 to 2014.

The issue in this appeal is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contends 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. 25-1204GC, Statement of Group Issue at 1 (Dec. 28, 2024).
[3] *Id.* at 2-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

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

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

> included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

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

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

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

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

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

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

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

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[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

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

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

> notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] arbitrary and capricious.[49] The court ordered the parties to submit briefs on whether vacatur is the appropriate remedy in this situation, 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 Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

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

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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. 25-1204GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.,* Case No. 25-1204GC, 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 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.*, PRRB Case 25-1204GC, 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. 25-1204GC, Providers' Petition for Expedited Judicial Review at 13 (Mar. 5, 2026).
[57] *Id.* at 16-17.
[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 all eighty-three (83) cases. The responses simply advised that, in each case, that "the MAC will not file a jurisdictional 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 a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[62]

For these eighty-three (83) groups, the providers all appealed from original or revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers were directly added to the applicable groups within 180 days of the issuance of their NPRs and/or RNPRs and the amount in controversy exceeds $50,000 in each case.

The Board finds that the Providers in the eighty-three (83) cases listed in **Appendix A** have all filed timely appeals from their original and revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs and/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,

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[60] *E.g.*, Case No. 25-1204GC, Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 12, 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.

is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the eighty-three (83) Cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;

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

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

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

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes all eighty-three (83) cases and removes them from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/26/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L, J-H)
Cecile Huggins, Palmetto GBA (J-J)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Judith Cummings, CGS Administrators
Scott Berends, Federal Specialized Services

Appendix A

25-4991GC	*Baystate Health CY 2008 DSH Medicare Part C CIRP Group*
25-0576GC	*Baystate Health CY 2009 Medicare Part C CIRP Group*
25-0454GC	*SCL Health/Intermountain CY 2010 Medicare Part C Days CIRP Group*
24-2519GC	*Banner Health CYs 2011 & 2014 Medicare Part C CIRP Group*
25-0890GC	*UC Health CY 2010 Medicare Part C CIRP Group*
25-0780GC	*St. Elizabeth Healthcare CY 2012 Medicare Part C CIRP Group*
25-0665GC	*St. Elizabeth Healthcare CY 2010 Medicare Part C CIRP Group*
25-5531GC	*Memorial Hermann CY 2014 DSH Medicare Part C Days CIRP Group*
25-5522GC	*Lehigh Valley Health CY 2012 DSH Medicare Part C Days CIRP Group*
25-3818GC	*Intermountain Healthcare CY 2011 DSH Medicare Part C CIRP Group*
25-3479GC	*Memorial Hermann CY 2013 DSH Medicare Part C CIRP Group*
25-1205GC	*Memorial Hermann CY 2012 Medicare Part C CIRP Group*
25-1204GC	*Memorial Hermann CY 2011 Medicare Part C CIRP Group*
25-0554GC	*Catholic Hlth Initiatives CY 2009 Medicare Part C CIRP Group*
25-0550GC	*Catholic Hlth Initiatives CY 2010 Medicare Part C CIRP Group*
25-0950GC	*Memorial Hermann CY 2009 Medicare Part C CIRP Group*
25-4033GC	*Atrium Health CY 2007 DSH Medicare Part C CIRP Group*
25-4007GC	*RegionalCare Hosp Part CY 2013 DSH Medicare Part C CIRP Group*
25-1784GC	*Covenant Health (TN) CY 2011 Medicare Part C CIRP Group*
25-1270GC	*Covenant Health (TN) CY 2007 Medicare Part C CIRP Group*
25-0949GC	*Covenant Health (TN) CY 2013 Medicare Part C CIRP Group*
25-0948GC	*RegionalCare Hosp Part CY 2010 Medicare Part C CIRP Group*
25-0438GC	*Covenant Health (TN) CY 2014 Medicare Part C CIRP Group*
25-3789GC	*SUNY CY 2007 DSH Medicare Part C CIRP Group*
25-3787GC	*SUNY CY 2005 DSH Medicare Part C CIRP Group*
25-3786GC	*SUNY CY 2006 DSH Medicare Part C CIRP Group*
25-3561GC	*SUNY CY 2009 DSH Medicare Part C CIRP Group*
25-3475GC	*Lifespan CY 2006 DSH Medicare Part C CIRP Group*
25-3473GC	*Lifespan CY 2013 DSH Medicare Part C CIRP Group*
25-3472GC	*Lifespan CY 2011 DSH Medicare Part C CIRP Group*
25-3470GC	*Lifespan CY 2009 DSH Medicare Part C CIRP Group*
25-3469GC	*Lifespan CY 2008 DSH Medicare Part C CIRP Group*
25-3468GC	*Lifespan CY 2007 DSH Medicare Part C CIRP Group*
25-3467GC	*Lifespan CY 2012 DSH Medicare Part C CIRP Group*
25-3170GC	*Tufts Medicine CY 2007 DSH Medicare Part C CIRP Group*
25-3164GC	*CharterCARE CY 2006 & 2008 DSH Medicare Part C CIRP Group*
25-3471GC	*Lifespan CY 2010 DSH Medicare Part C CIRP Group*
25-1295GC	*Mass General Brigham CY 2007 Medicare Part C CIRP Group*
25-1162GC	*Beth Israel Lahey Health CY 2007 Medicare Part C CIRP Group*
25-0902GC	*UMass Memorial Health CY 2009 Medicare Part C CIRP Group*

25-0785GC	*UMass Memorial Health CY 2007 Medicare Part C CIRP Group*
25-0572GC	*UMass Memorial Health CY 2010 Medicare Part C CIRP Group*
26-0105GC	*St. Luke's University HN CY 2014 DSH Medicare Part C Days CIRP Group*
25-5881GC	*Lehigh Valley Health CY 2014 DSH Medicare Part C Days CIRP Group*
25-5773GC	*Conemaugh Health System CY 2011 DSH Medicare Part C Days CIRP Group*
25-5530GC	*St. Luke's University HN CY 2011 DSH Medicare Part C Days CIRP Group*
25-4041GC	*St. Luke's University HN CY 2010 DSH Medicare Part C CIRP Group*
25-4040GC	*St. Luke's University HN CY 2013 DSH Medicare Part C CIRP Group*
25-4038GC	*St. Luke's University HN CY 2008 DSH Medicare Part C CIRP Group*
25-4025GC	*Allegheny Health CY 2007 DSH Medicare Part C CIRP Group*
25-3997GC	*Lehigh Valley Health CY 2013 DSH Medicare Part C CIRP Group*
25-3993GC	*Lehigh Valley Health CY 2007 DSH Medicare Part C CIRP Group*
25-3982GC	*Jefferson Health CY 2011 DSH Medicare Part C CIRP Group*
25-3980GC	*Jefferson Health CY 2010 DSH Medicare Part C CIRP Group*
25-3976GC	*Jefferson Health CY 2008 DSH Medicare Part C CIRP Group*
25-3970GC	*Jefferson Health CY 2007 DSH Medicare Part C CIRP Group*
25-3859GC	*Excela Health CY 2013 DSH Medicare Part C CIRP Group*
25-3858GC	*Excela Health CY 2011 DSH Medicare Part C CIRP Group*
25-3829GC	*Excela Health CY 2014 DSH Medicare Part C CIRP Group*
25-3826GC	*Jefferson Health CY 2012 DSH Medicare Part C CIRP Group*
25-3820GC	*UPMC CY 2006 DSH Medicare Part C CIRP Group*
25-3819GC	*UPMC CY 2007 DSH Medicare Part C CIRP Group*
25-3817GC	*Excela Health CY 2012 DSH Medicare Part C CIRP Group*
25-3816GC	*Excela Health CY 2010 DSH Medicare Part C CIRP Group*
25-3813GC	*Catholic Health East CY 2008 DSH Medicare Part C CIRP Group*
25-3988GC	*Lehigh Valley Health CY 2008 DSH Medicare Part C CIRP Group*
25-3530GC	*UPMC CY 2008 DSH Medicare Part C CIRP Group*
25-3528GC	*UPMC CY 2009 DSH Medicare Part C CIRP Group*
25-3527GC	*UPMC CY 2011 DSH Medicare Part C CIRP Group*
25-4039GC	*St. Luke's University HN CY 2009 DSH Medicare Part C CIRP Group*
25-3168GC	*Trinity Health Catholic Health East CY 2006 DSH Medicare Part C CIRP Group*
25-4037GC	*St. Luke's University HN CY 2007 DSH Medicare Part C CIRP Group*
25-1421GC	*Catholic Health East CY 2007 Medicare Part C CIRP Group*
25-3978GC	*Jefferson Health CY 2009 DSH Medicare Part C CIRP Group*
25-0662GC	*Catholic Health East CY 2009 Medicare Part C CIRP Group*
25-3556GC	*Orlando Health CY 2008 DSH Medicare Part C CIRP Group*
25-3145GC	*Orlando Health CY 2013 DSH Medicare Part C CIRP Group*
25-1250GC	*BayCare Health CY 2007 Medicare Part C CIRP Group*
25-2929GC	*Carilion Clinic CY 2012 DSH Medicare Part C Days CIRP Group*
25-2924GC	*Carilion Clinic CY 2011 DSH Medicare Part C Day CIRP Group*

25-2866GC	*McLeod Health CY 2012 DSH Medicare Part C CIRP Group*
25-2217GC	*Carilion Clinic CY 2007 Medicare Part C CIRP Group*
25-0553GC	*Inova Health CY 2008 Medicare Part C CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Michael Newell
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RE: ***Expedited Judicial Review Determination***
Case Numbers: 25-1251GC *et al.* (83 cases – *see* **Appendix A**)

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **February 27, 2026** in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

Between **December 18, 2024 and December 1, 2025**, the Board received eighty-three (83) requests to establish Common Issue Related Party ("CIRP") groups. The Providers in nearly all 83 groups are appealing from revised Notices of Program Reimbursement ("RNPRs")[1] which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[2] as it pertains to the Providers' Fiscal Year Ends ("FYEs") spanning from 2005 to 2014.

The issue in this appeal is "the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") 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."[3] 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.[4]

[1] Note: A small number of Providers are appealing from initial Notices of Program of Reimbursement ("NPRs").
[2] 88 Fed. Reg. 37772 (June 9, 2023).
[3] *E.g.*, Case No. 25-1251GC, Statement of Group Issue at 1 (Jan. 1, 2025).
[4] *Id*. at 1-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[5] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[7] 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.[8]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[9] 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.[10] The DPP is defined as the sum of two fractions expressed as percentages.[11] 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 . . . .[12]

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.[13]

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[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(2)-(3).

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[14]

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.[15]

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[16] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[17]

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[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).
[16] of Health and Human Services.
[17] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[18]

With the creation of Medicare Part C in 1997,[19] 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.[20] 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."[21] 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.[22]

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.[23] 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."[24] In response to a comment regarding this change, the Secretary explained that:

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

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[18] *Id.*
[19] 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.
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[21] *Id.*
[22] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[23] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[24] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[25]

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.[26] 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).[27] 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."[28]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[29]

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[30] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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[25] *Id.* (emphasis added).
[26] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[27] *Id*. at 47411.
[28] 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).
[29] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[30] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[31] 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.[32] 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.[33] 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.[34] A number of hospitals appealed this action.[35] In *Azar v. Allina Health Services* ("*Allina II*"),[36] 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.[37] 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."[38] 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.[39]

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.[40] 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

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[31] *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.").
[32] *Id.* at 2011.
[33] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[34] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[35] 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)).
[36] 139 S.Ct. 1804 (2019).
[37] *Id.* at 1817.
[38] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[39] 139 S.Ct. at 1814.
[40] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> 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.[41]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[42] 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.[43]

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

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

[41] CMS Ruling 1739-R at 1-2.
[42] 88 Fed. Reg. 37772 (June 9, 2023).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

*fractions for **each** applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[44]

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**."[45]

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."[46]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[47]

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.[48] It ruled,

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[44] 88 Fed. Reg. at 37774-75 (emphasis added).
[45] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[46] *Id.* at 37788 (emphasis added).
[47] *Id.* (emphasis added).
[48] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

however, that the June 9, 2023 Final Rule is both impermissibly retroactive[49] and arbitrary and capricious.[50] The court ordered the parties to submit briefs on whether vacatur is appropriate remedy in this situation, which have since been filed.[51]

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[52]

In the Group Issue Statements, the Providers state 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."[53]

The Providers recount how, prior to 2004, CMS did not include Part C Days in the SSI Ratio, along with the subsequent rulemaking and litigation which can be outlined as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment 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.

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[49] *Id.* at *12-19.
[50] *Id.* at *19-22.
[51] *Id.* at *23.
[52] *E.g.,* Case No. 25-1251GC, Appeal Request, Statement of Jurisdiction (citations omitted).
[53] *E.g.,* Case No. 25-1251GC, Appeal Request, Statement of Group Issue at 1.
[54] *Id*. (citing to 139 S. Ct. at 1816).

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 outlined above. They argue that they filed their appeals within 180 days of the issuance of their NPRs and/or RNPRs; that the amount in controversy exceeds $50,000; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[56] They note that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy.[57]

The Medicare Contractor's representative, Federal Specialized Services ("FSS"), has filed timely responses to the Requests for EJR in each case simply advising that "the MAC will not file jurisdictional challenge and will not file a substantive claim challenge."[58]

Decision of the Board:

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

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [59]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and

[55] *Id.* (citing 4 U.S.C. § 706(2)).
[56] *E.g.*, Case No. 25-1251GC, Providers' Petition for Expedited Judicial Review at 13 (Feb. 27, 2026).
[57] *See id.* at 14-15.
[58] *E.g.*, Case No. 25-1251GC, Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 5, 2026).
[59] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).

- The amount in controversy is, in the aggregate, $50,000 or more.[60]

For these eighty-three (83) appeals listed in **Appendix A,** the Board finds that the Providers were directly added to the groups within 180 days of the issuance of their NPRs and/or RNPRs and the amount in controversy exceeds $50,000 in each case. ***Most*** of the providers 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. RNPRs in those cases are typically for $0 and specifically reference CR13294 or *Allina v. Sebelius* in the actual RNPR or in a cover letter accompanying the RNPR. Others have a Notice of Reopening included with the RNPR or a specific audit adjustment which makes a similar reference. The records for two of the following providers, however, do not have sufficient information in the record for the Board to be able to make a determination that that the RNPRs were issued to implement the new, retroactive Part C days rule.

1. Case No. 25-1911GC

In Case No. 25-1911GC, Memorial Hermann Hospital System (Provider No. 45-0184, FYE 6/30/2010) is appealing from an RNPR dated May 7, 2025. The RNPR resulted in a payment due to the Provider in the amount of $13,060. The audit adjustments reference properly stating the allowable DSH adjustment factor, but did not mention the SSI percentage, and including the last settlement on the reopened cost report. The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated May 7, 2025, was issued as a result of this remand.

Memorial Hermann Katy Hospital (Provider No. 45-0847, FYE 12/31/2010) is appealing from an RNPR dated June 26, 2025. The RNPR resulted in a payment due to the Provider in the amount of $0. The only adjustments on the audit adjustment report are, "To properly include the last settlement on the reopened cost report." The appeal did not include a reopening request or an actual reopening notice issued by the Medicare Contractor as required by Board Rule 7.1.2.1, but simply attached an Order of Administrator which remanded a number of court cases following the litigation in *Allina*. This Order, however, does not list specific providers or PRRB Cases, and there is nothing to indicate that this particular provider was part of this remand, or that the RNPR dated June 26, 2025, was issued as a result of this remand.

Therefore, for these two Providers, the Board is unable to determine whether the RNPRs were issued to implement the new, retroactive Part C days rule. As a result, the Board is dismissing Memorial Hermann Hospital System and Memorial Hermann Katy Hospital from Case No. 25-1911GC without prejudice. If the Providers have additional documentation that may establish that the two RNPRs were issued to implement the retroactive Part C final rule, then they have the ability to file reinstatement requests pursuant to PRRB Rule 47.

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[60] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

2. Case No. 25-1467GC

In Case No. 25-1467GC, Paris Regional Medical Center (Provider No. 45-0196, FYE 06/30/2012) is appealing from an RNPR dated September 3, 2024. Their assigned Medicare Contractor, Palmetto GBA, completed their review of the Schedule of Providers after the Group Representative sent notice that the Group was fully formed on January 6, 2026. The Medicare Contractor noted that Paris Regional Medical Center:

> [i]s noted to be included in CN: 25-0030GC LifePoint Health CY 2012 DSH Part C Days RNPR CIRP Group. The issue in 25-0030GC is substantively identical to the issue in this case, and therefore, this case should be considered a duplicate appeal for this provider.[61]

The issue statement in Case No. 25-0030GC is, indeed, substantively identical to the issue statement in Case No. 25-1467GC. After review, the Board finds that Paris Regional Medical Center is, indeed, appealing from the same RNPR in Case No. 25-0030GC. Paris Regional Medical Center in Case No. 25-0030GC was submitted via direct add on February 28, 2025, while in 25-1467GC the Provider was added via direct add on March 2, 2025. As the Provider was originally added to Case No. 25-0030GC, the Board finds that the issue is duplicative and, as duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, the Board dismisses this participant from the CIRP Group appeal.

For the remaining providers in these eighty-three (83) groups, the providers all appealed from NPRs 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 respective final determinations. Finally, the amount in controversy exceeds $50,000 in each case.

Except for Memorial Hermann Hospital System and Memorial Hermann Katy Hospital in Case No. 25-1911GC and Paris Regional Medical Center in Case No. 25-1467GC, the Board finds that the Providers in the eighty-three (83) cases listed in **Appendix A** have filed timely appeals from their final determinations concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

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[61] Case No. 25-1467GC, MAC Jurisdictional Review at 1 (Mar. 9, 2026).

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) Except for Memorial Hermann Hospital System and Memorial Hermann Katy Hospital in Case 25-1911GC and Paris Regional Medical Center in Case 25-1467GC (which are hereby dismissed from their respective cases), it has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the eighty-three (83) cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;

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

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

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

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years, except Memorial Hermann Hospital System in Case 25-1911GC and Paris Regional Medical Center in Case 25-1467GC.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes the eighty-three (83) 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:

3/26/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Danelle Decker, National Government Services, Inc. (J-K)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H, J-L)
Judith Cummings, CGS Administrators (J-15)
Cecile Huggins, Palmetto GBA (J-J)
Wilson C. Leong, Federal Specialized Services

Appendix A

25-1251GC	Banner Health CY 2008 Medicare Part C CIRP Group
25-1461GC	BayCare Health CY 2006 Medicare Part C CIRP Group
25-1294GC	BayCare Health CY 2008 Medicare Part C CIRP Group
25-1200GC	BayCare Health CY 2009 Medicare Part C CIRP Group
25-1271GC	BayCare Health CY 2010 Medicare Part C CIRP Group
25-1272GC	BayCare Health CY 2011 Medicare Part C CIRP Group
25-2877GC	BayCare Health CY 2012 DSH Medicare Part C CIRP Group
25-1201GC	BayCare Health CY 2013 Medicare Part C CIRP Group
25-1834GC	Beth Israel Lahey Health CY 2006 Medicare Part C CIRP Group
25-1206GC	Beth Israel Lahey Health CY 2008 Medicare Part C CIRP Group
25-1165GC	Beth Israel Lahey Health CY 2009 Medicare Part C CIRP Group
25-1166GC	Beth Israel Lahey Health CY 2010 Medicare Part C CIRP Group
25-1158GC	Beth Israel Lahey Health FFY 2011 Medicare Part C CIRP Group
25-1159GC	Beth Israel Lahey Health FFY 2012 Medicare Part C CIRP Group
25-1161GC	Beth Israel Lahey Health FFY 2013 Medicare Part C CIRP Group
25-3220GC	Care New England CY 2006 DSH Medicare Part C CIRP Group
25-3221GC	Care New England CY 2007 DSH Medicare Part C CIRP Group
25-3223GC	Care New England CY 2008 DSH Medicare Part C CIRP Group
25-3225GC	Care New England CY 2009 DSH Medicare Part C CIRP Group
25-3226GC	Care New England CY 2010 DSH Medicare Part C CIRP Group
25-3228GC	Care New England CY 2011 DSH Medicare Part C CIRP Group
25-3379GC	Care New England CY 2012 DSH Medicare Part C CIRP Group
25-3380GC	Care New England CY 2013 DSH Medicare Part C CIRP Group
25-2921GC	Carilion Clinic CY 2009 DSH Medicare Part C Days CIRP Group
25-2930GC	Carilion Clinic CY 2013 DSH Medicare Part C Days CIRP Group
25-1406GC	Catholic Health East CY 2011 Medicare Part C CIRP Group
25-1160GC	Catholic Hlth Initiatives CY 2007 Medicare Part C CIRP Group
25-1377GC	Centra Health CY 2013 Medicare Part C CIRP Group
25-1376GC	Centra Health CYs 2008 - 2010 Medicare Part C CIRP Group
25-3185GC	CharterCARE CY 2009 DSH Medicare Part C CIRP Group
25-3190GC	CharterCARE CY 2010 DSH Medicare Part C CIRP Group
25-3355GC	CharterCARE CY 2011 DSH Medicare Part C CIRP Group
25-3193GC	CharterCARE CY 2012 DSH Medicare Part C CIRP Group
25-3195GC	CharterCARE CY 2013 DSH Medicare Part C CIRP Group
25-1290GC	CHRISTUS Health CY 2009 Medicare Part C CIRP Group
25-3083GC	CHRISTUS Health CY 2010 DSH Medicare Part C CIRP Group
25-3030GC	CHRISTUS Health CY 2011 DSH Medicare Part C CIRP Group

26-0352GC	Conemaugh Health System CY 2014 DSH Medicare Part C Days CIRP Group
25-2275GC	Covenant Health (TN) CY 2008 Medicare Part C CIRP Group
25-1398GC	Covenant Health (TN) CY 2009 Medicare Part C CIRP Group
25-1292GC	Covenant Health (TN) CY 2010 Medicare Part C CIRP Group
25-1483GC	Covenant Health (TN) CY 2012 Medicare Part C CIRP Group
26-0294GC	Inova Health CY 2007 DSH Medicare Part C Days CIRP Group
25-1185GC	Inova Health CY 2009 Medicare Part C CIRP Group
25-1291GC	Inova Health CY 2010 Medicare Part C CIRP Group
25-3165GC	Intermountain Healthcare CY 2008 DSH Medicare Part C CIRP Group
25-1156GC	Intermountain Healthcare CY 2009 Medicare Part C CIRP Group
25-2876GC	Lehigh Valley Health CY 2010 DSH Medicare Part C CIRP Group
25-3393GC	Lehigh Valley Health CY 2011 DSH Medicare Part C CIRP Group
26-0557GC	Lifespan CY 2005 DSH Medicare Part C Days CIRP Group
25-1150GC	Mass General Brigham CY 2008 Medicare Part C CIRP Group
25-1151GC	Mass General Brigham CY 2009 Medicare Part C CIRP Group
25-1152GC	Mass General Brigham CY 2010 Medicare Part C CIRP Group
25-1153GC	Mass General Brigham CY 2011 Medicare Part C CIRP Group
25-1154GC	Mass General Brigham CY 2012 Medicare Part C CIRP Group
26-0026GC	McLeod Health CY 2013 DSH Medicare Part C Days CIRP Group
25-1911GC	Memorial Hermann CY 2010 Medicare Part C CIRP Group
25-3142GC	Orlando Health CY 2007 DSH Medicare Part C CIRP Group
25-2779GC	Orlando Health CY 2009 DSH Medicare Part C CIRP Group
25-2772GC	Orlando Health CY 2010 DSH Medicare Part C CIRP Group
25-2776GC	Orlando Health CY 2011 DSH Medicare Part C CIRP Group
25-2852GC	Orlando Health CY 2012 DSH Medicare Part C CIRP Group
25-1467GC	RegionalCare Hosp Part CY 2012 Medicare Part C CIRP Group
25-1484GC	St. Elizabeth Healthcare CY 2008 Medicare Part C CIRP Group
25-1728GC	St. Elizabeth Healthcare CY 2009 Medicare Part C CIRP Group
25-1474GC	St. Elizabeth Healthcare CY 2013 Medicare Part C CIRP Group
25-2209GC	St. Luke's University HN CY 2012 Medicare Part C CIRP Group
25-1308GC	Steward Health Care CY 2006 Medicare Part C CIRP Group
25-2250GC	Steward Health Care CY 2007 Medicare Part C CIRP Group
25-1309GC	Steward Health Care CY 2008 Medicare Part C CIRP Group
25-1310GC	Steward Health Care CY 2009 Medicare Part C CIRP Group
25-1186GC	Steward Health Care CY 2010 Medicare Part C CIRP Group
25-1208GC	Steward Health Care CY 2011 Medicare Part C CIRP Group
25-1209GC	Steward Health Care CY 2012 Medicare Part C CIRP Group
25-1218GC	Steward Health Care CY 2013 Medicare Part C CIRP Group

25-1181GC	Tufts Medicine CY 2010 Medicare Part C CIRP Group
25-1181GC	Tufts Medicine CY 2010 Medicare Part C CIRP Group
25-1182GC	Tufts Medicine CY 2011 Medicare Part C CIRP Group
25-1183GC	Tufts Medicine CY 2012 Medicare Part C CIRP Group
25-1245GC	UC Health CY 2013 Medicare Part C CIRP Group
25-2213GC	UMass Memorial Health CY 2006 Medicare Part C CIRP Group
25-1207GC	Vidant Health CY 2009 Medicare Part C CIRP Group
25-1105GC	Vidant Health CYs 2007 - 2008 Medicare Part C CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Avenue NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
Case Number: 25-3494GC Northwell Health CY 2007 Post-Allina II DSH Part C Days CIRP Grp.
Case Number: 25-5227GC Northwell Health CY 2005 Post-Allina II DSH Part C Days CIRP Grp.
Case Number: 25-5027GC Northwell Health CY 2006 Post-Allina II DSH Part C Days CIRP Grp.
Case Number: 26-1954 Shands Jacksonville (Provider Number 10-0001), FYE 06/30/2006
Case Number: 26-1953 Unity Hospital (Provider Number 24-0132), FYE 12/31/2004

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed **March 3 and 4, 2026** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Providers in these Common Issue Related Party ("CIRP") groups and individual appeals are all appealing from original and/or revised Notices of Program Reimbursement ("NPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYEs") in calendar years spanning 2004 to 2007.

The issue in these appeals is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.,* Case No. 25-3494GC, Statement of Group Issue at 1 (Mar. 3, 2025).
[3] *Id*. at 2-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

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]

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

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 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]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

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

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

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

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

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[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).

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

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

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

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

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

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

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

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

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[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board,* ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

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

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

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

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

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

[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

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

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions **contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

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

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[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

however, that the June 9, 2023 Final Rule is both impermissibly retroactive[48] and arbitrary and capricious.[49] The court ordered the parties to file supplemental briefs addressing whether vacatur is the appropriate remedy for the situation, 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 revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

The "Statement of Group Issue" included with the group appeal requests state that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[52] The Providers contend that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

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[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.,* Case No. 25-3494GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.*, Case No. 25-3494GC, Appeal Request Statement of Group Issue at 1. The Statement of Issue included with each individual appeal is materially identical to the Statement of Group Issue included with each group appeal.
[53] *Id.*
[54] *Id.* (citing to 139 S. Ct. at 1816).

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[55]

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

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[57] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[58] The request states that "[t]he Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[59] Since the Board is bound by this regulation,[60] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

The Medicare Contractor's representative, Federal Specialized Services, filed timely responses to all five (5) Requests for EJR in these cases. Each response simply noted "that the MAC will not file a jurisdictional challenge and will not file a substantive claim challenge."[61]

Decision of the Board:

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

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[55] *Id.*
[56] *Id.* (citing 4 U.S.C. § 706(2)).
[57] *E.g.*, Case No. 25-3494GC, Providers' Petition for Expedited Judicial Review at 13 (Mar. 3, 2026).
[58] *Id.* at 16-17.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.
[61] *E.g.*, Case No. 25-3494GC, Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 9, 2026).

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [62]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[63]

For these five (5) appeals, the providers all appealed from original and revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the Providers in the individual appeals filed their appeals within 180 days of the issuance of their RNPRs and the amount in controversy exceeds $10,000. Likewise, all the providers in the group appeals were directly added to the groups within 180 days of the issuance of their NPRs and RNPRs (or filed separate appeals within the same time period and were subsequently transferred to their current group cases) and the amount in controversy exceeds $50,000 in each case.

The Board finds that the Providers in Cases 25-3494GC, 25-5227GC, 25-5027GC, 26-1954, and 26-1953 have all filed timely appeals from their original and revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs and RNPRs. The Board also finds that the amount in controversy in each individual appeal exceeds $10,000 as required by 42 C.F.R. § 405.1835(a)(2), and in each CIRP group appeal exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Cases 25-3494GC, 25-5227GC, 25-5027GC, 26-1954, and 26-1953, and that the Providers in each appeal are entitled to a hearing before the Board;

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[62] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[63] 42 U.S.C. § 1395oo(a) and (b); 42 C.F.R. §§ 405.1835 – 1840.

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 Case Nos. 25-3494GC, 25-5227GC, 25-5027GC, 26-1954, and 26-1953, the Board hereby closes these five (5) cases and removes them from its docket.

Board Members Participating:

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

FOR THE BOARD:

3/26/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements & Denial of Extension***

Case Number: 26-2004GC - St. Francis Health System CY 2014 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group

Case Number: 26-2005GC - St. Francis Health System CY 2014 Improper Rule-making - DSH SSI Fraction Dual Eligible Days CIRP Group

Case Number: 26-2006GC - St. Francis Health System CY 2014 Improper Recalculation of SSI CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced group appeals. After review of the facts outlined below, the Board has determined that the appeal requests are fatally flawed as they were not filed in accordance with the regulations and Board Rules. The Pertinent Facts and the Board's determination are set forth below.

Pertinent Facts:

On **March 9 and 10, 2026**, Quality Reimbursement Services, Inc. ("QRS") filed the three referenced common issue related party ("CIRP") groups on behalf of St. Francis Health System for calendar year ("CY") 2014. The groups were all formed with a single provider: St. Francis Hospital, Inc. ("St. Francis"/Provider Number 37-0091) for the Fiscal Year Ended ("FYE") 6/30/2014. St. Francis was directly added to the group from a revised Notice of Program Reimbursement ("RNPR") made for the purpose of SSI realignment dated September 9, 2025. The Appointment of Designated Representative letter filed by QRS for St. Francis was dated April 24, 2025, and referenced fiscal years 1988 through 2013.

On **March 10, 2026**, the Board issued Acknowledgement and Critical Due Dates Notices ("ACDD") in all 3 cases, in which it set a briefing schedule for the Parties to file preliminary position papers and requested an updated Representation letter which includes the correct fiscal

year under appeal (2014) pursuant to Board Rule 5.4. The deadline for the corrected copy of the Representation Letter was set for **March 20, 2026**.[1]

On **March 20, 2026**, (*the due date for submission of the updated Representation letters*) QRS filed a Request for Extension referencing all three groups. QRS indicated that "due to turn over at the Medical Center, it has taken longer than expected to receive the new authorization letter. Accordingly, QRS respectfully requests an additional 30 days in which to submit the updated Notice of Authorization."[2]

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. § 405.1883 addresses the authority of a representative & states, in pertinent part: "[a] representative appointed by a provider . . . may accept or give on behalf of the provider or other party any request or notice relative to any proceeding before a hearing officer or the Board. A representative shall be entitled to present evidence and allegations as to facts and law in any proceeding affecting the party."

Based on its authority under 42 C.F.R. § 405.1868(a), the Board issued rules to implement § 405.1883. Specifically, Board Rule 5.1 stipulates that "[t]he Board will not accept an appeal or other correspondence from any external organization that is not the case representative's organization."

Additionally, Board Rule 12.10 discusses Certifications for Group Appeals: This rule requires that the Representative certify that:

- . . . the group issue filed in this appeal is not pending in any other appeal for same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal.
- . . . there are no other providers to which these participating providers are related by common ownership or control that have a pending request for a Board hearing on the same issue for a cost reporting period that ends in the same calendar year covered in this request.
- . . . [they] have read and [are] familiar with Board statutes, regulations, and rules and, to the best of [their] knowledge, the appeal is filed in full compliance wityh such statutes, regulations, and rules. [AND]

[1] In Case Nos. 26-2005GC and 26-2006GC, the ACDD also included a request for calculation support for St. Francis. In both groups, the calculation support was timely submitted on March 20, 2026.
[2] Request for Extension to Submit Representation Letter at 1 (Mar. 20, 2026).

- ***[that it is] authorized to submit an appeal on behalf of the listed providers***.[3]

Finally, Board Rule 41.2 permits the Board to "dismiss a case or an issue on its own motion . . . upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868)."

Board Determination:

The Board finds that the subject group appeal requests are fatally flawed as they were not filed in accordance with the regulations at 42 C.FR. § 405.1883.

When filing an appeal or directly adding a provider to a group, the representative must certify that it is authorized to make the filing on behalf of the provider and include a copy of the representation letter evidencing that authorization.[4] Requiring a representation letter to be properly executed for the fiscal year at issue protects providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

The Representation Letter filed by QRS for the initiating provider in Case Nos. 26-2004GC through 24-2006GC covers different fiscal years than those associated with the CIRP groups it filed and is nearly a year old. As indicated in Board Rule 14, "[T]he **acknowledgement (or future correspondence) may also set various deadlines and due dates** including, but not limited to, position paper deadlines, full formation of the group, discovery and **other documentation requirements. Failure by a party to comply with such deadlines may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868."**[5]

Here, QRS was granted an opportunity to remedy the identified deficiency; however, it failed to do so within the prescribed deadline, instead submitting a request for extension on the day the deadline expired. Given QRS's familiarity with Board procedures, it should be well aware that any request for an extension must be submitted prior to the applicable due date in order to afford the Board adequate time to review and act upon it.[6]

In addition, the Board notes that the Direct Add requests for St. Francis were filed on the 182nd day after issuance of the Provider's Realignment RNPR. Therefore, it is clear that when QRS filed the CIRP groups, it had no authorization to act on behalf of St. Francis for CY 2014 and falsely certified that it was authorized to do so.[7]

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[3] Board Rule 12.10 (2023) (Bold and italics emphasis added).
[4] *See* Board Rules 5, 12.8, 12.10, Model Form B, Model Form E.
[5] (Bold emphasis added.)
[6] See Rule 23.5, which although specific to Preliminary position papers, emphasizes the need to file in advance of a deadline and indicates that if the Board has not notified the moving party[ies] before the due date that an extension was granted . . . and the document [*position paper*] has not been filed, the appeal will be dismissed.
[7] The Board notes that there are no appeals in OH CDMS for St. Francis for any of the other years listed on the Representation Letter that have QRS listed as the designated representative.

Accordingly, the Board hereby dismisses Case Nos. 26-2004GC, 26-2005GC and 26-2006GC since the appeal requests for the initiating provider in each group are fatally flawed and do not meet the *minimum* filing requirements as outlined above AND based on QRS' failure to respond to the Board's request for updated Representation letters by the deadline.

Based on the above, the Board closes these cases and removes them from its docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 105.1877.

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

For the Board:

3/27/2026

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Woodland Heights Medical Center (Prov. No. 45-0484), FYE 12/31/2018
Case No. 22-1441

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1441. Set forth below is the decision of the Board to dismiss two (2) of the remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Pymt SSI % (Provider Specific) and DSH Pymt - Medicaid Eligible Days issues.

Background:

A. ***Procedural History for Case No. 22-1441***

On **March 28, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **September 22, 2022**, Community Health Systems, Inc. ("CHS") filed the Provider's appeal request. The request included seven (7) issues:

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

[1] On April 26, 2023, this issue was transferred to Case No. 21-1206GC.
[2] On April 26, 2023, this issue was transferred to Case No. 21-0066GC.
[3] On April 26, 2023, this issue was transferred to Case No. 20-2149GC.
[4] On April 26, 2023, this issue was transferred to Case No. 20-2149GC.
[5] On April 26, 2023, this issue was transferred to Case No. 21-0066GC.

On **September 15, 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* "PPPs"). 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 5, 2023**, CHS timely filed the Provider's PPP in which it briefed the two remaining issues SSI Provider Specific and Medicaid Eligible Days.

On **July 21, 2023**, the Medicare Contractor ("MAC") filed a jurisdictional challenge over the DSH SSI Provider Specific & Medicaid eligible days issues in the case. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge.

On **July 24, 2023**, CHS requested, and the Board granted, a change of representation to Quality Reimbursement Services, Inc. ("QRS").

On **August 21, 2023**, the MAC timely filed its PPP. The MAC indicated that it had still not received a list of additional Medicaid eligible days even though the Provider indicated one would be sent under separate cover at the time it filed its PPP.

On **November 13, 2023**, QRS filed the "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission." The 6-page listing, showing roughly 1,069 eligible days, included a *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[7]

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 21-1206GC

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

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

[6] (Emphasis added.)
[7] (Italic Emphasis added.)

> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator'. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[8]

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue 2 (the SSI Percentage), reads in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to

[8] Issue Statement at 1 (Sept. 15, 2022).

> settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[9]

On May 5, 2023, the Board received the Provider's PPP in Case No. 22-1441. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a full and complete set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. See 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[10]

[9] Group Issue Statement, Case No. 21-1206GC.
[10] Provider's PPP at 10 (May 5, 2023).

The amount in controversy listed on the calculation support for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $35,789.

C. Description of Issue 3 in the Individual Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation 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.[11]
>
> Audit Adjustment Number(s): 5, 16, 18, S-D
>
> Estimated Reimbursement Amount: $59,001

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[12] 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.[13]

[11] Issue Statement at 3 (Sept. 15, 2022).
[12] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[13] Provider's PPP at 9 (May 5, 2023).

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

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider's appeal request, this issue has three components: 1) SSI data accuracy; 2) SSI realignment and 3) Individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the two components related to SSI data accuracy should be dismissed because they are duplicative of the DSH SSI Percentage issue transferred to Case No. 21-1206GC. Additionally, the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. In addition, the MAC argues that the issue should be dismissed because the Provider failed to file a complete position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[14]

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

The MAC also argued that the Provider failed to include a list of additional Medicaid eligible days it expected to be included, even though the Provider's PPP indicated a listing would be sent under separate cover. In addition, in its PPP, the MAC indicates it requested the Provider submit a listing of days to which the Provider did not respond.[15] Again, the MAC contends that the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.3. Therefore, since the issue was not properly developed, the Provider did not provide a list of additional Medicaid days, nor did it explain why it could not produce the documentation, the MAC contends the "burden of proof, which was upon the provider, has not been met.[16]

Provider's Jurisdictional Response: Issue 1 and 3- SSI Percentage (Provider Specific) & Medicaid Eligible Days

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

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[17]

The Provider did not file a response to the Jurisdictional Challenge over the SSI Provider Specific and Medicaid Eligible Days issues and the time for doing so has elapsed.

[14] MAC's Jurisdictional Challenge at 2 (July 21, 2023).
[15] MAC's PPP at 13. (Aug 21, 2023).
[16] MAC's Jurisdictional Challenge at 14 (July 21, 2023).
[17] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

Board Analysis and Decision:

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

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

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 21-1206GC.

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

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case No. 21-1206GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Percentage (Provider Specific) issue in Case No. 22-1441 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 21-1206GC. Because the issue is duplicative, and

[18] Issue Statement at 1.
[19] *Id.*
[20] *Id.*

duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[21], the Board dismisses this aspect of the SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[22] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and* *explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[23]

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

---

[21] PRRB Rules v. 3.1 (Nov. 2021).
[22] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[23] (Italics and underline emphasis added.)

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

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[24]

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case No. 21-1206GC are the same issue.[25] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover,

[24] Last modified March 17, 2026.
[25] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

without this written request, the MAC cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. Medicaid Eligible Days

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

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the*

> *relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[26]

Similarly, with regard to position papers,[27] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[28] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

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

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

This appeal was initiated on September 15, 2022 (over 3 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[29]

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[26] (Emphasis added).
[27] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[28] (Emphasis added).
[29] Provider's PPP at 9 (May 5, 2023).

On July 21, 2023, the MAC filed a Jurisdictional Challenge, requesting dismissal of the two remaining issues, one of which was the Medicaid eligible days issue. Specifically, the MAC argued that: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) in its appeal request; and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its PPP in violation of Board Rules 25.2.1 and 25.2.2. Therefore, the MAC maintained 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 regulations and the Board Rules.[30]

Pursuant to Board Rule 44.4.3, the Provider had 30 days to respond to the challenge to jurisdiction. However, the Provider failed timely respond by the August 20, 2023 filing deadline (i.e., 30 days after July 21, 2023). Almost three months after the deadline, on November 13, 2023, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 6 pages with roughly 1,069 Medicaid eligible days. QRS' filing did not explain why the listing, which included substantially more than the 100 days noted in the initial appeal, was being submitted at this late date or why it was not final despite having been submitted almost five after the fiscal year at issue had closed. Regardless, this filing was more than 2.5 months past the deadline for responding to the jurisdictional challenge and, more importantly, was almost six months past the deadline for including it with its PPP since that deadline was May 15, 2023.

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

The fact that the Listing was filed almost 4 months after the Provider requested the change of its designated representative to QRS does not excuse the Provider for its failure to include the information with its PPP or its failure to timely respond to the jurisdictional challenge. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the

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

Provider's attempt to label the November 13, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed almost 6 months after the deadline for that exhibit to be included with its PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's jurisdictional challenge and the alleged "Supplement" was filed almost 3 months after the deadline for filing a response to the challenge.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.,* upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 1,069 days was not previously available, in whole or in part (*i.e.,* it is not clear why the Provider failed to identify a single day at issue until more than a year after this appeal was filed and almost five 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 September 15, 2022 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the "Supplement" filing 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 position paper 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 PPP nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP (indeed the *tentative* 1,069 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[31]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[32] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provided the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under

[31] See, e.g., Board Rule 27.3 (Nov. 2021) which indicates that, except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence.
[32] (Emphasis added).

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)- (3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[33]

****

Given these facts, the Board is dismissing the DSH Pymt - SSI % (Provider Specific) – (Issue #1) and the DSH Pymt - Medicaid Eligible Days (Issue #3) issues from the appeal. As there are no remaining issues in the appeal, Case No. 22-1441 is hereby closed 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 Participating:

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

For the Board:

3/30/2026

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Hillcrest Baptist Medical Center, Prov. No. 45-0101, FYE 08/31/2018
PRRB Case No. 22-0113

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0113. 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/Section 1115 Waiver days issue.

Background

On **May 17, 2021**, the Medicare Contractor ("MAC") issued a Notice of Program Reimbursement ("NPR") for Hillcrest Baptist Medical Center ("Hillcrest BMC"/Prov. No. 45-0101) for its fiscal year end ("FYE") August 31, 2018.

On **September 17, 2020**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of Hillcrest BMC which included eight (8) issues:

1. DSH SSI Percentage (Provider Specific)[1]
2. DSH SSI Percentage[2]
3. Medicaid Eligible Days
4. DSH Medicare Managed Care Part C Days (SSI & Mcaid Fractions)[3]
5. DSH Dual Eligible Days (Exh Part A SSI fraction)[4]
6. Standardized Payment Amount[5]
7. ATRA IPPS Payment Reduction[6]
8. DSH Dual Eligible Days (Exh Part A Medicaid Fraction)[7]

The provider is under common ownership of Baylor Scott & White Health ("BSW") and is therefore subject to the CIRP Rules at 42 C.F.R. § 405.1837.

[1] On January 9, 2026, Issue 1 was withdrawn.
[2] On June 8, 2022, Issue 2 was transferred to a CIRP group, Case No. 20-1747GC.
[3] On June 8, 2022, Issue 4 was transferred to a CIRP group, Case No. 20-1748GC.
[4] On June 8, 2022, Issue 5 was transferred to a CIRP group, Case No. 20-1749GC.
[5] On June 8, 2022, Issue 6 was transferred to a CIRP group, Case No. 20-1752GC.
[6] On June 8, 2022, Issue 7 was withdrawn.
[7] On June 8, 2022, Issue 8 was transferred to a CIRP group, Case No. 20-1751GC.

On **November 9, 2021**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

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

On **July 5, 2022, QRS** filed the Provider's PPP.

On **October 14, 2022**, the MAC filed its PPP.

On **September 23, 2025**, the Board issued a Notice of Hearing scheduling the case for a hearing on **April 10, 2026**.

On **January 9, 2026**, QRS filed the Provider's final PP which included an exhibit that indicated a listing of the additional Medicaid Eligible days being claimed will be submitted directly to the MAC and that a redacted listing would be uploaded to the portal.

On **January 18, 2026**, the MAC filed its final PP.

On **February 10, 2026**, the MAC filed a jurisdiction challenge over the last remaining issue: Medicaid eligible days issue.

On **March 17, 2026**, QRS submitted a responsive brief to the jurisdictional challenge and uploaded a "Redacted Additional ME days & 1115 Waiver Days listing" in OH CDMS.

On **March 26, 2026**, QRS requested a postponement to give the Board time to decide the jurisdictional challenge.

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

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

[8] (Emphasis added.)

Section 1115 Waiver Days

Finally, the MAC argues that the Provider is attempting to untimely and improperly add the Section 1115 Waiver days issue as a sub-issue via its final position paper filed on January 9, 2026. The Provider originally characterized the Medicaid eligible days issue in its initial appeal request using the following language:

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

Neither the appeal request, nor the PPP, identified or mentioned the Section 1115 Waiver days issue. It was not until the final position paper submission that the Provider raised the issue – (*which was more than 6.5 years after the regulatory deadline to add a new issue to the case*.) Therefore, the MAC contends that the Section 1115 Waiver days, which is a separate issue from the Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider failed to file a response by the deadline (**which was Thursday, March 12, 2026** – *30 days after February 10, 2026*) and the time for doing so elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Although QRS responded to the jurisdictional challenge on Tuesday, March 17, 2026, the response was 5 days overdue. Therefore, QRS' arguments will not be considered.

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.

[9] Board Rule v. 3.1 (Nov. 1, 2021).

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.[10]

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

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

[10] (Bold emphasis added.)

Rule 25 - Preliminary Position Papers[11]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

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

> 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 November 9, 2021 Acknowledgement and Critical Due Dates notice issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[12]

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

[12] (Emphasis added.)

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

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

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

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

On July 5, 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.[13] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $50,865 based on an estimated 100 days). The Provider's complete briefing of this issue in its PPP is as follows:

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

[13] Provider's PPP at 8 (July 5, 2022).

> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its February 10, 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.[14]
(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 its final PP submission.

On March 17, 2026, QRS uploaded a "Redacted Additional ME Days Listing" in the Office of Hearings Case and Document Management System ("OH CDMS"). The 26-page listing did not include the sum, but when extracted and totaled, it shows 4,826 "Additional ME Days & 1115 Waiver Days." The Listing does not explain why the number of days included was over the initial 100 days the Provider claimed in its appeal, nor did it explain why it was being submitted at this late date. Regardless, the filing ***was 3.5 years past the deadline for including it with the Provider's PPP*** for which the deadline was July 6, 2022.

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

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 March 17, 2026 (*purportedly, as a supplement to its final position paper*) because:

1. The upload was filed ***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 4,826 days were not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until almost 4.5 years after this appeal was filed and more than 7.5 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the November 9, 2021 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload that they do).

4. Given that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the appeal request, nor the PPP, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP (indeed the *tentative* 4,826 days listed in the late exhibit is, without explanation, *significantly* larger than the original estimated 100 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 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

[15] *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."
[16] (Emphasis added.)

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 November of 2021 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…[17]

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

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
> - the 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 (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:

[17] 42 C.F.R. § 405.1835(b).

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

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

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

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

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

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

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

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

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

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

1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final PP is perfunctory in that it only makes cursory conclusions.[21] Again, the Provider failed to so develop its PP, notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Nov. 2021) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final PP met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[22] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[23] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[24] The Court found that this 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 No. 3). As no issues remain, the Board hereby closes Case No. 22-0113 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:

3/30/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway, Suite 620
Plano, TX 75093-8724

RE: ***Expedited Judicial Review Determination***
Southwest Consulting Medicare Part C Days Groups
Case Numbers: 25-4325GC *et al.* (31 Cases – *See* **Appendix A**)

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **March 6, 2026** in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish Common Issue Related Party ("CIRP") groups for these thirty-one (31) groups between **September, 2024** and **December, 2025**. All thirty-one (31) 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 Year Ends ("FYEs") spanning from 2005 to 2014.

The issue in this appeal is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contends 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. 25-4325GC, Statement of Group Issue at 1 (Apr. 21, 2025).
[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]

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]

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

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 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]

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[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).

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

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

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

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

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[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).

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

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

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

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

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).
[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern

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[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

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

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

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court 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

[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).
[43] 88 Fed. Reg. at 37774-75 (emphasis added).

on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissible retroactive[48] arbitrary and capricious.[49] The court ordered the parties to submit briefs on whether vacatur is the appropriate remedy in this situation, which have since been filed.[50]

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[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their original and/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 Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

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

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

[51] *E.g.*, Case No. 25-4325GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.*, Case No. 25-4325GC, Appeal Request, Statement of Issue at 1.
[53] *Id.*
[54] *Id.* (citing to 139 S. Ct. at 1816).

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 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.

The Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all thirty-one (31) cases. It simply advised that, in each case, that "the MAC will not file a jurisdictional challenge. The MAC 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

[55] *Id.* (citing 4 U.S.C. § 706(2)).
[56] *E.g.*, Case No. 25-4325GC, Providers' Petition for Expedited Judicial Review at 12-13 (Mar. 6, 2026).
[57] *Id.* at 16.
[58] *Id.* at 1-2.
[59] 42 C.F.R. § 405.1867.
[60] *E.g.*, Case No. 25-4325GC, Response to Provider's Request for Expedited Judicial Review at 1 (Mar. 13, 2026).

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 thirty-one (31) 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 the groups within 180 days of the issuance of their NPRs and/or RNPRs and the amount in controversy exceeds $50,000 in each case.

The Board finds that the Providers in the thirty-one (31) cases listed in **Appendix A** have all filed timely appeals from their original and/or revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs and/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.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the thirty-one (31) Cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;

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

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

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

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

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[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.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes all thirty-one (31) cases and removes them from its docket.

Board Members Participating:

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

For the Board:

3/31/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L, J-H)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Judith Cummings, CGS Administrators (J-15)
Scott Berends, Federal Specialized Services

Appendix A

24-2525GC	*Catholic Hlth Initiatives CY 2012 Medicare Part C CIRP Group*
24-2760GC	*Catholic Hlth Initiatives CY 2013 Medicare Part C CIRP Group*
25-0556GC	*Catholic Health East CY 2012 Medicare Part C CIRP Group*
25-0782GC	*Catholic Hlth Initiatives CY 2008 Medicare Part C CIRP Group*
25-3814GC	*Excela Health CYs 2007 & 2008 DSH Medicare Part C CIRP Group*
25-3821GC	*UPMC CY 2013 DSH Medicare Part C CIRP Group*
25-3822GC	*UPMC CY 2012 DSH Medicare Part C CIRP Group*
25-3854GC	*UPMC CY 2010 DSH Medicare Part C CIRP Group*
25-4018GC	*Univ. of PA Health System CY 2010 DSH Medicare Part C CIRP Group*
25-4019GC	*Univ. of PA Health System CY 2011 DSH Medicare Part C CIRP Group*
25-4035GC	*Jefferson Health CYs 2013 & 2014 DSH Medicare Part C CIRP Group*
25-4064GC	*Catholic Health East CY 2010 DSH Medicare Part C CIRP Group*
25-4321GC	*Baystate Health CY 2006 DSH Medicare Part C CIRP Group*
25-4325GC	*UC Health CYs 2011 & 2012 DSH Medicare Part C CIRP Group*
25-4656GC	*Catholic Hlth Initiatives CY 2005 DSH Medicare Part C CIRP Group*
25-4988GC	*CHRISTUS Health CY 2012 DSH Medicare Part C CIRP Group*
25-4992GC	*Catholic Health East CY 2005 DSH Medicare Part C CIRP Group*
25-5496GC	*Banner Health CY 2007 DSH Medicare Part C CIRP Group*
25-5529GC	*Catholic Hlth Initiatives CY 2006 DSH Medicare Part C Days CIRP Group*
25-5708GC	*UMass Memorial Health CY 2005 DSH Medicare Part C Days CIRP Group*
25-5871GC	*Univ. of PA Health System CY 2009 DSH Medicare Part C Days CIRP Group*
25-5873GC	*Univ. of PA Health System CY 2012 DSH Medicare Part C Days CIRP Group*
26-0142GC	*Univ. of PA Health System CY 2013 DSH Medicare Part C Days CIRP Group*
26-0143GC	*BayCare Health CY 2005 DSH Medicare Part C Days CIRP Group*
26-0146GC	*Steward Health Care CY 2005 DSH Medicare Part C Days CIRP Group*
26-0148GC	*CHRISTUS Health CY 2008 DSH Medicare Part C Days CIRP Group*
26-0209GC	*Conemaugh Health System CY 2013 DSH Medicare Part C Days CIRP Group*
26-0227GC	*Memorial Hermann CY 2007 DSH Medicare Part C Days CIRP Group*
26-0238GC	*CHRISTUS Health CY 2007 DSH Medicare Part C Days CIRP Group*
26-0558GC	*Tufts Medicine CY 2005 DSH Medicare Part C Days CIRP Group*
26-0609GC	*Beth Israel Lahey Health CY 2005 DSH Medicare Part C Days CIRP Group*