DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Hearthstone Health & Rehab
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Rosewood Rehabilitation
2045 Silverada Boulevard
Reno, NV 89512

Re: "Ensign Group FFY 2026 Non-compliance that may result in a 2% reduction in FY 2026 CIRP Group," PRRB Case No. 26-2351GC

"Ensign Group FFY 2026 Non-Compliance that May Result in a 2% Reduction CIRP Group," PRRB Case No. 26-2333GC

Dear Mr. Stenvold and Ms. Willis:

The Provider Reimbursement Review Board ("Board") is in the above-referenced common issue related party ("CIRP") groups. The Board notes there is a deficiency related to one of the filings and the two groups appear to be duplicative. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

Case No. 26-2333GC

On **April 21, 2026**, Rosewood Rehabilitation ("Rosewood"/Prov. No. 29-5020) filed the "*Ensign Group FFY 2026 Non-Compliance that May Result in a 2% Reduction CIRP Group*" under Case No. 26-2333GC. The group was filed in the Office of Hearings Case & Document Management System ("OH CDMS") with a single participant, Rosewood.[1]

Rosewood filed from a "Notice of Quality Reporting Program Noncompliance Decision Upheld" ("QRP Reconsideration Determination") dated November 17, 2025 and identified the issue under appeal as "Non-Compliance that May Result in a 2% Reduction."

Although the 2% Reduction issue is not normally suitable for the group format (due to factual distinctions between providers), and although Case No. 26-2333GC included only one provider when it was filed, based on Rosewood's Representation Letter, it appeared that a second provider would be included in the group: "Truckee Meadows Healthcare, Inc. dba Hearthstone Health & Rehabilitation (Hearthstone"/Prov. No. 29-5044)." Therefore, the Board allowed the appeal to proceed in the group format and, on April 22, 2026, issued a Case Acknowledgement and Critical Due Dates Notice ("ACDD").

[1] According to the Representation Letter filed with the initiating participant, Rosewood, the Provider is commonly owned by The Ensign Group.

Case No. 26-2351GC

On **April 21, 2026,** Hearthstone filed a second group titled the "*Ensign Group FFY 2026 Non-compliance that may result in a 2% reduction in FY 2026 CIRP Group*" under Case No. 26-2351GC. This CIRP group was also formed in OH CDMS with a single participant, Hearthstone.[2]

Like Rosewood, Hearthstone also identified the date of its final determination in OH CDMS as November 17, 2025. However, instead of including a copy of the November 17, 2025 determination as the required support, Hearthstone uploaded a copy of a July 28, 2025 determination which was titled "Non-compliance that May Result in a 2% Reduction to Your FY 2026 Annual Payment Update for CCN 295044." ("Non-compliance determination.") The July 28, 2025 determination included the following language:

> If you believe you have been identified for this payment reduction in error, you have the right to request a reconsideration of this decision. Reconsideration requests will only be accepted via email no later than 11:59:59 pm local time zone, August 26, 2025, at the following email address: SNFQRPReconsiderations@cms.hhs.gov.

The July 28, 2025 determination submitted with the appeal was the *initial determination* from which the Provider was required to request a reconsideration as the first step in its appeals process. The initial determination is not directly appealable to the Board. Only the reconsideration determination constitutes a final CMS decision that may be appealed to the Board

Analysis and Board Determination:

As noted, there are several problems with these groups which are discussed in further detail below.

Appeal Format

First, 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.[3] Consistent with this regulation, Board Rule 12.6 provides the *minimum* number of providers in a group (CIRP and optional) and specifies that mandatory and optional group appeals must have a *minimum of **two** different providers*.

[2] Hearthstone filed a similar Representation Letter, indicating the Provider is commonly owned by The Ensign Group and identifying a second group participant, "Group appeal with Wildcreek Healthcare, Inc. dba Rosewood Rehabilitation Center . . . (Provider number 29-5020)."
[3] Bold emphasis added.

Although neither group has been marked as fully formed yet, both Case Nos. 26-2333GC and 26-2351GC include only a single participant (and based on the Representation Letters filed in both groups to date- there appear to be only two potential Ensign Group providers to be included).

Final Determination for Participant in Case No. 26-2351GC

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

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

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

As discussed *supra*, a party must exhaust each appeal level before proceeding to the next. Here, Hearthstone's initial July 28, 2025 determination triggered the Provider's right to seek reconsideration from CMS. The Reconsideration Determination (CMS's final decision on that reconsideration) is what constitutes the reviewable action for purposes of a Board appeal.

Based on the final determination date Hearthstone identified in OH CDMS *(i.e.*, November 17, 2025), the Provider is still within its appeal period. Therefore, Hearthstone may elect to refile an appeal with the Board provided it meets certain requirements, one of which is supplying the correct final determination under appeal.

Duplicative Groups

Relatedly, the Board has established rules governing individual and group appeal filings to facilitate control of its docket. In that regard, Board Rule 4.6 indicates there must be no duplicate filings.[4] In this instance, there appear to be identical CIRP groups filed on behalf of The Ensign Group which are appealing the same issue for the same Federal fiscal year ("FFY"). The first group, Case No. 26-2333GC, is not due to become fully formed for almost a year.

From a review of the documentation supplied in both groups, it appears that rather than having filed a second CIRP group for The Ensign Group (Case No. 26-2351GC), it may have been appropriate for Hearthstone to have been directly added to the already pending CIRP group under Case No. 26-2333GC. Further information is required before the Board can make that determination.

[4] Board Rule 4.6 was written specific to individual appeals but applies in this group scenario as well.

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.

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

Finally, 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.

In **Case No. 26-2351GC**, the Board finds that:

1) Hearthstone failed to submit the correct copy of the final determination under appeal ***(i.e.,*** November 17, 2025 QRP Reconsideration Determination) in Case No. 26-2351GC;
2) Hearthstone does not meet the minimum regulatory requirements for filing an appeal before the Board and must be dismissed;
3) Because Hearthstone was the sole participant in Case No. 26-2351GC, there are no remaining providers in the group. Case No. 26-2351GC 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.

As noted herein, based on the final determination date Hearthstone identified in OH CDMS, the Provider is still within its appeal period. (*The provider has 180 days from receipt of the final determination. Based on the alleged date of November 17, 2025, the appeal period would expire on Thursday, May 21, 2026*).

Therefore, if Hearthstone elects to, it may refile an appeal with the Board by either:

1) requesting to be directly added as a participant to Case No. 26-2333GC;[5] OR

[5] See External User Manual at https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/oh-cdms-prrb-external-user-manual-v-10.pdf. Specifically, 3.3.3.2 discusses adding a participant to a group.

2) if the basis of its denial includes any factual distinctions from that of Rosewood's, Hearthstone may elect to file an individual appeal in OH CDMS.[6]

Note: *Should Hearthstone determine that factual distinctions exist and elect to file an individual appeal, Rosewood is hereby on notice that its appeal may also be unsuitable for the group appeal format — particularly as it does not satisfy either the minimum aggregate amount in controversy threshold, nor the minimum participant requirement for a group appeal, absent the inclusion of additional related providers.*

Group Representatives

As has been noted, both "The Ensign Group" CIRPs involve different representatives: Case No. 26-2333GC was filed by Rosewood and Case No. 26-2351GC was filed by Hearthstone.

Board Rule 5.1 advises that there may be only one (1) case representative per appeal. In this situation where there are potentially duplicate groups and each group listed a different representative, the Parties are advised that if Hearthstone is directly added to the original CIRP group, Case No. 26-2333GC, the Representative of record for the group will remain Ms. Willis.[7]

If "The Ensign Group" subsequently wishes to change the representative of record in Case No. 26-2333GC, it must enter a formal request with the Board via OH CDMS (using a "Change Representative" case action) with an updated Representation Letter identifying the contact for both participants. The Board will not communicate with different representatives for different providers within the same appeal. (See Board Rules 5, 5.4.)

Alternatively, if Hearthstone instead finds it appropriate to file an individual appeal, the two cases may have different representatives. Therefore, Mr. Stenvold may remain the representative for Hearthstone if so authorized by The Ensign Group.

Request for Information in Case No. 26-2333GC

Within 15 days of the date of this notice, the Board is requiring comments from Rosewood regarding whether there are factual distinctions between The Ensign Group providers that would preclude the pursuit of the 2 Percent Quality Reporting issue for FFY 2026 in the group appeal format. The comments must be filed in OH CDMS using "Other" case correspondence and must include a statement indicating whether there are any other potential providers in The Ensign Group pursuing the issue for FFY 2026.

Based on Rosewood's response, the Board may find it appropriate to create an individual appeal for the sole participant and close Case No. 26-2333GC. Failure of Rosewood to timely respond to this request may result in dismissal of the group in its entirety.

[6] Please see 42 CFR § 405.1835 and Board Rule 6, which both discuss individual appeal rights, and requirements.
[7] Hearthstone would be required to file a Representation Letter authorizing Ms. Willis to handle the 2 Percent Quality Reporting issue in the group.

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

For the Board:

5/1/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, FSS
Dean Wolfe, Noridian Healthcare Solutions (J-F) (MAC for 26-2333GC)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Admin (J-E) (MAC for 26-2351GC)

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Via Electronic Delivery

Isaac Blumberg
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11400 West Olympic Boulevard, Suite 700
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RE: ***Expedited Judicial Review Determination***
Case Number: 24-2575GC - UnityPoint Health CY 2012 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group
Case Number: 24-2578GC - UnityPoint Health CY 2011 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group
Case Number: 25-5569G - Blumberg Ribner CY 2014 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction Group
Case Number: 26-2287GC - Medisys Health CY 2007 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group
Case Number: 26-0370GC - Medisys Health CY 2006 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **April 7 and 16, 2026** in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

Between **September, 2024 and April, 2026**, the Board received five (5) requests to establish Common Issue Related Party ("CIRP") and optional groups. The Providers in all five (5) 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 years ended ("FYEs") between 2006 and 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"). 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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.*, Case No. 24-2575GC, Statement of Issue at 1-2 (Sept. 19, 2024).

retroactively for periods prior to October 1, 2013.[3]

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[6] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[11]

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[3] *Id.* at 2-5.
[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 ordered the parties to submit 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 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 to 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. 24-2575GC, Statement of Issue at 1.
[52] *Id.* at ¶ 3.
[53] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).

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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, has filed timely responses to the Requests for EJR in each case simply advising that "the MAC will not file a jurisdictional challenge. The MAC will not file a substantive claim challenge."[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. 24-2575GC, Providers' Petition for Expedited Judicial Review at 1-4 (Apr. 7, 2026).
[56] *Id.* at 11.
[57] *E.g.*, Case No. 24-2575GC, Response to Provider's Request for Expedited Judicial Review at 1 (Apr. 10, 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]

For these five (5) groups, the providers all appealed from revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers were directly added to their respective groups within 180 days of the issuance of their RNPRs, and the amount in controversy exceeds $50,000 in each case.

The Board finds that the Providers in Cases 24-2578GC, 24-2575GC, 25-5569G, 26-2287GC, and 26-0370GC have filed timely appeals from their revised NPRs concerning the issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Case Nos. 24-2578GC, 24-2575GC, 25-5569G, 26-2287GC, and 26-0370GC 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.

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[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.

§ 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes Case Nos. 24-2578GC, 24-2575GC, 25-5569G, 26-2287GC, and 26-0370GC 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:

5/6/2026

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)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Lisa Ellis
Toyon Associates, Inc.
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Concord, CA 94520

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

Case Number: 25-0515GC - Scripps Health CYs 2019 - 2020 Disallowance of Capital DSH Payment CIRP Group
Case Number: 24-2707G - Toyon Associates CY 2021 Disallowance of Capital DSH Payment Group
Case Number: 24-2017G - Toyon Associates CY 2020 Disallowance of Capital DSH Payment Group
Case Number: 23-1348G - Toyon Associates CYs 2018 - 2019 Disallowance of Capital DSH Payment Group
Case Number: 23-1290GC - Dignity Health CY 2018 Disallowance of Capital DSH Payment CIRP Group
Case Number: 23-1166GC - Providence St. Joseph CY 2018 Disallowance of Capital DSH Payment CIRP Group

Dear Ms. Ellis:

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

Issue under Dispute:

In these group cases, the Providers are challenging:

> [T]he regulation at 42 C.F.R. § 412.320(a)(1)(iii), in effect for periods prior to October 1, 2023, which says that an urban hospital that has reclassified as rural pursuant to 42 C.F.R. § 412.103 is categorically ineligible to receive capital DSH payments.

[1] Consolidated Petition for Expedited Judicial Review (Apr. 8, 2026) ("Request for EJR").
[2] The Request for EJR encompasses eleven (11) group cases. Pursuant to Board Rule 44.6 (2023), the Medicare Contractor and/or its representative made filings which indicated they would be submitting Substantive Claim Challenges in Cases 24-1300GC, 24-1301GC, 25-3526GC, 25-4819GC, and 26-0087G which will be addressed by the Board under separate cover.

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> The Providers maintain that the version of 42 C.F.R. § 412.320(a)(1)(iii) in effect during the pre-October 1, 2023 periods encompassed by Toyon's group appeals is unlawful and they seek relief in the form of the capital DSH adjustment that was wrongfully withheld from them.[3]

Background:

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

1. Geographic Reclassification

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

2. Operating DSH Adjustment Under Operating IPPS

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

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

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

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

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

3. Capital DSH Adjustment Under Capital IPPS

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

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

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

> (ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

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

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

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

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

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Jan. 6, 2026).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).

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

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

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

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

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the

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

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

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

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

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

> 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l){ii) of the regulations.[20]

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

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

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

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

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

> income patients but whose patient percentage is below the artificial level we would set.[22]

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

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

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

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

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

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and

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

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

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

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

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

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

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

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

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.
>
> ****
>
> Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).
>
> This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is*

significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

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

****

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.

****

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

> underlying the description of the House bill in the Conference Report.[28]

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

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http:// www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

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

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[28] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).
[29] *Id*. at 47026, 47048.
[30] 56 Fed. Reg. at 43452.

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

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

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

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

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

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

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

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—
>
> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
>
> (C) The term *rural area* means any area outside an urban area.
>
> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

[35] 69 Fed. Reg. 48916 (Aug. 11, 2004).

> (2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.
>
> (3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[36]

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

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

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments if either of the following conditions is met:

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

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

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

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

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment

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

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

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

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

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

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

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

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[43]

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

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

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

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

> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[45]**

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

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

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

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[48] The Court also noted how Congress enacted legislation in 1999[49] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[50] The Court also noted the

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

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

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

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

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

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

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

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

    - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the

[51] *Id.* at *19-20.
[52] *Id.* at *21.
[53] *Id.* at *22.
[54] *Id.* at *23-25.
[55] *Id.* at *29.
[56] *Id.*
[57] *Id.*

> Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[58]
>
> - "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. 103 S. Ct. 2856. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[59]

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

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

Providers' Request for EJR

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

The Providers insist that, consistent with the D.C. District Court's holding in *Toledo*, 42 C.F.R. § 412.320(a)(1)(iii) (for periods prior to October 1, 2023) is arbitrary, unreasonable, and unenforceable. The Providers believe they are entitled to a DSH adjustment on their capital PPSH payments because they are "located in an urban area" as defined in 42 C.F.R. § 412.64 and have more than 100 beds.[67] They also point out that the court in *Toledo* found the decision to categorically disqualify reclassified rural hospitals from capital DSH payments to be arbitrary

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

and capricious because CMS "did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did [it] take costs into account at all" as required by 42 U.S.C. § 1395ww(g)(1)(A).[68] The Providers argue that CMS did eventually take costs into account in the IPPS Final Rule for 2023, and abandoned the policy of excluding reclassified rural hospitals, which serves as a tacit concession "that the relative capital costs of reclassified rural hospitals cannot justify categorically disqualifying reclassified rural hospitals from receiving the capital DSH adjustment."[69]

Finally, the Providers urge the Board to grant EJR since it is bound by the regulation being challenged,[70] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), and thus, it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[71]

Medicare Contractor's Response:

Following receipt of the Request for EJR on **April 8, 2026**, the Medicare Contractor's representative, Federal Specialized Services ("FSS") filed notices indicating it had previously filed Substantive Claim Challenges in Cases 23-1166GC, 23-1290GC, 23-1348G, 24-2017G, 24-2707G, and 25-0515GC. The Providers for which FSS has filed a Substantive Claim Challenge in these six (6) cases will be referred to collectively as "the Challenged Providers."

1. Case 23-1166GC

FSS filed a Substantive Claim Challenge in this case on **July 16, 2024** asserting that all five (5) providers in the group failed to include an appropriate claim on their cost reports.[72] It claims that each provider either did not cite an audit adjustment for the Capital DSH issue or that that cited audit adjustments are unrelated to the issue. Additionally, while the Providers did identify protested amounts on their cost reports, the summary or listing of protested items submitted alongside the cost report did not establish a self-disallowed item for the Capital DSH issue. It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[73] Finally, the Medicare Contractor believes the Group Issue Statement appears to concede that at least some Providers did not make an appropriate claim on their cost reports, stating "CMS's self disallowance requirement should not be treated as a bar on payment because it itself is invalid…."[74]

The Providers filed a Response to MAC's Substantive Claim Challenge on **August 9, 2024**. They do not refute the Medicare Contractor's assertions that they did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argue that the

[68] *Id.* (quoting *Toledo* at 29).
[69] *Id.* at 9.
[70] *See* 42 C.F.R. § 405.1867.
[71] Request for EJR at 9-12.
[72] Case No. 23-1166GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (July 16, 2024).
[73] *Id.* at 4-8.
[74] *Id.* at 8 (quoting Group Issue Statement, copy at Ex. C-1).

requirements are unlawful.[75] They cite *Bethesda Hosp. Ass'n v. Bowen*[76] and *Banner Heart Hospital v. Burwell*[77] in support of their position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[78]

2. Case 23-1290GC

FSS filed a Substantive Claim Challenge in this case on **July 29, 2024** asserting that the following Provider failed to make an appropriate claim on its cost report:

- Yavapai Regional Medical Center (Prov. No. 03-0012, FYE 12/31/2018)[79]

The only cited audit adjustments for this issue are either standard adjustments or generic revisions to the DSH percentage and SSI ratio, which are unrelated to the Capital DSH payment issue.[80] While this Provider did identify a Part A Protested amount in its cost report, the Summary of Protested Amounts did not identify the Capital DSH issue.[81] It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[82] Finally, the Medicare Contractor believes the Group Issue Statement appears to concede that this Provider did not make an appropriate claim on its cost report, stating "CMS's self disallowance requirement should not be treated as a bar on payment because it itself is invalid…."[83]

The Providers filed a Response to MAC's Substantive Claim Challenge on **August 27, 2024**. They do not refute the Medicare Contractor's assertions that they did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argue that the requirements are unlawful.[84] They cite *Bethesda Hosp. Ass'n v. Bowen*[85] and *Banner Heart Hospital v. Burwell*[86] in support of their position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[87]

3. Case 23-1348G

FSS filed a Substantive Claim Challenge in this case on **August 16, 2024** asserting that all six (6) providers in the group failed to include an appropriate claim on their cost reports.[88] It claims that each provider either did not cite an audit adjustment for the Capital DSH issue or that that cited audit adjustments are unrelated to the issue. Additionally, while the Providers did identify

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[75] Case No. 23-1166GC, Response to MAC's Substantive Claim Challenge at 1 (Aug. 9, 2024).
[76] 485 U.S. 399 (1988).
[77] 201 F.Supp.3d 131 (D.D.C. 2016)
[78] Case No. 23-1166GC, Response to MAC's Substantive Claim Challenge at 4-5.
[79] Case No. 23-1290GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (July 29, 2024).
[80] *Id.* at 4-5.
[81] *Id.* at 5.
[82] *Id.*
[83] *Id.* (quoting Group Issue Statement (copy at Exhibit C-1)).
[84] Case No. 23-1290GC, Response to MAC's Substantive Claim Challenge at 1 (Aug. 27, 2024).
[85] 485 U.S. 399 (1988).
[86] 201 F.Supp.3d 131 (D.D.C. 2016)
[87] Case No. 23-1290GC, Response to MAC's Substantive Claim Challenge at 4-5.
[88] Case No. 23-1348G, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Aug. 16, 2024).

protested amounts on their cost reports, the summary or listing of protested items submitted alongside the cost report did not establish a self-disallowed item for the Capital DSH issue. It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[89] Finally, the Medicare Contractor believes the Group Issue Statement appears to concede that at least some Providers did not make an appropriate claim on their cost reports, stating "CMS's self disallowance requirement should not be treated as a bar on payment because it itself is invalid…."[90]

The Providers filed a Response to MAC's Substantive Claim Challenge on **September 11, 2024**. They do not refute the Medicare Contractor's assertions that they did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argue that the requirements are unlawful.[91] They cite *Bethesda Hosp. Ass'n v. Bowen*[92] and *Banner Heart Hospital v. Burwell*[93] in support of their position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[94]

4. Case 24-2017G

FSS filed a Substantive Claim Challenge in this case on **October 13, 2025** asserting that all seven (7) providers in the group failed to include an appropriate claim on their cost reports.[95] It claims that each provider either did not cite an audit adjustment for the Capital DSH issue or that that cited audit adjustments are unrelated to the issue. Additionally, while the Providers did identify protested amounts on their cost reports, the summary or listing of protested items submitted alongside the cost report did not establish a self-disallowed item for the Capital DSH issue. It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[96] Finally, the Medicare Contractor claims the Providers' Representative specifically conceded that these Providers did not make an appropriate claim on their cost reports, stating "Capital DSH was not protested" for the Providers in question.[97]

The Providers filed a Response to MAC's Substantive Claim Challenge on **November 10, 2025**. They do not refute the Medicare Contractor's assertions that they did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argue that the requirements are unlawful.[98] They cite *Bethesda Hosp. Ass'n v. Bowen*[99] and *Banner Heart Hospital v. Burwell*[100] in support of their position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[101]

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[89] *Id.* at 4-10.
[90] *Id.* (quoting Group Issue Statement, copy at Exhibit C-1).
[91] Case No. 23-1348G, Response to MAC's Substantive Claim Challenge at 1 (Sept. 11, 2024).
[92] 485 U.S. 399 (1988).
[93] 201 F.Supp.3d 131 (D.D.C. 2016)
[94] Case No. 23-1348G, Response to MAC's Substantive Claim Challenge at 4-5.
[95] Case No. 24-2017G, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Oct. 13, 2025).
[96] *Id.* at 4-7.
[97] *Id.* at 7 (quoting Correspondence with Provider Representative, Ex. C-3).
[98] Case No. 24-2017G, Response to MAC's Substantive Claim Challenge at 1 (Nov. 10, 2025).
[99] 485 U.S. 399 (1988).
[100] 201 F.Supp.3d 131 (D.D.C. 2016)
[101] Case No. 24-2017G, Response to MAC's Substantive Claim Challenge at 4-5.

5. Case 24-2707G

FSS filed a Substantive Claim Challenge in this case on **January 14, 2026** asserting that the following two (2) of the (3) providers in the group failed to include an appropriate claim on their cost reports:

- Parkview Medical Center Inc. (Prov. No. 06-0020)
- Salinas Valley Memorial Hospital (Prov. No. 05-0334)[102]

It claims that neither Provider cited an audit adjustment for the Capital DSH issue. Parkview Medical Center did not protest any items on its cost report, and Salinas Valley Memorial Hospital did not include Capital DSH payments on its Listing of Issues Filed Under Protest.[103] Both Providers indicated that they believed trying to claim Capital DSH payments would have been futile,[104] and that the Providers' Representative specifically conceded that these Providers did not protest this item on their cost reports.[105] Finally, FSS argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[106]

The Providers filed a Response to MAC's Substantive Claim Challenge on **February 12, 2026** (incorrectly dated January 11, 2026). They do not refute the Medicare Contractor's assertions that they did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argue that the requirements are unlawful.[107] They cite *Bethesda Hosp. Ass'n v. Bowen*[108] and *Banner Heart Hospital v. Burwell*[109] in support of their position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[110]

6. Case 25-0515GC

FSS filed a Substantive Claim Challenge in this case on **February 11, 2026** asserting that both providers in the group failed to include an appropriate claim on their cost reports.[111] It claims that neither provider cited an audit adjustment for the Capital DSH issue. Additionally, while the Providers did identify protested amounts on their cost reports, the summary or listing of protested items submitted alongside the cost report did not establish a self-disallowed item for the Capital DSH issue. It argues that none of the exceptions at 42 C.F.R. § 413.24(j)(3)(i) through (iii) apply.[112] Finally, the Medicare Contractor claims the Providers' Representative specifically conceded that Scripps Mercy Hospital did not protest this issue on its cost report.[113]

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[102] Case No. 24-2707G, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Jan. 14, 2026).
[103] *Id.* at 4-5.
[104] *Id.* (quoting Ex. C-4 at 2 and Ex. C-5 at 2, "audit adjustment" narratives in OH CDMS).
[105] *Id.* (citing Ex. C-3, correspondence with Providers' Representative)
[106] *Id.*
[107] Case No. 24-2707G, Response to MAC's Substantive Claim Challenge at 1 (Feb. 12, 2026).
[108] 485 U.S. 399 (1988).
[109] 201 F.Supp.3d 131 (D.D.C. 2016)
[110] Case No. 24-2707G, Response to MAC's Substantive Claim Challenge at 4-5.
[111] Case No. 25-0515GC, Medicare Administrative Contractor's Substantive Claim Challenge at 1 (Feb. 11, 2026).
[112] *Id.* at 4-5.
[113] *Id.* at 5 (quoting Correspondence with Provider Representative, Ex. C-3).

The Providers filed a Response to MAC's Substantive Claim Challenge on **March 12, 2026**. They do not refute the Medicare Contractor's assertions that they did not comply with the regulatory requirements set forth in 42 C.F.R. §§ 413.24 and 405.1873 but instead argue that the requirements are unlawful.[114] They cite *Bethesda Hosp. Ass'n v. Bowen*[115] and *Banner Heart Hospital v. Burwell*[116] in support of their position that these regulations are unlawful and in conflict with 42 U.S.C.§ 1395oo.[117]

Board Decision

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

1. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [118]

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[114] Case No. 25-0515GC, Response to MAC's Substantive Claim Challenge at 1 (Mar. 12, 2026).
[115] 485 U.S. 399 (1988).
[116] 201 F.Supp.3d 131 (D.D.C. 2016)
[117] Case No. 25-0515GC, Response to MAC's Substantive Claim Challenge at 4-5.
[118] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986). Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

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

- 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.[119]

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

The Board lacks the authority to decide the legal question presented here because it is a challenge to the validity of a regulation, namely 42 C.F.R. § 412.320(a)(1)(iii).[120] All of the providers in these two (6) groups, however, are subject to the substantive claim regulations at 42 C.F.R. §§ 413.24 and 405.1873.

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[121] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[122] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in these five (5) cases have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement for the Board's ***jurisdiction*** is not applicable.

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[119] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.
[120] 42 C.F.R. § 405.1842(f)(1)(ii).
[121] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[122] *Id.* at 70555.

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

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

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

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

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

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[123] 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. [124]

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

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

For the remaining participants in these group cases who are not one of the Challenged Providers (collectively "the Non-Challenged Providers"), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[125] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for the Non-Challenged Providers. Accordingly, the Board

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[123] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[124] *See* 42 C.F.R. § 405.1873(a).
[125] 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."

need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the Non-Challenged Participants.

4. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in the six (6) Cases listed in **Appendix A** are entitled to a hearing before the Board;

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

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in the six (6) Cases listed in **Appendix A**. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

5/6/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

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

Appendix A

PRRB Case Number	PRRB Case Name
25-0515GC	*Scripps Health CYs 2019 - 2020 Disallowance of Capital DSH Payment CIRP Group*
24-2707G	*Toyon Associates CY 2021 Disallowance of Capital DSH Payment Group*
24-2017G	*Toyon Associates CY 2020 Disallowance of Capital DSH Payment Group*
23-1348G	*Toyon Associates CYs 2018 - 2019 Disallowance of Capital DSH Payment Group*
23-1290GC	*Dignity Health CY 2018 Disallowance of Capital DSH Payment CIRP Group*
23-1166GC	*Providence St. Joseph CY 2018 Disallowance of Capital DSH Payment CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Michael Newell
Southwest Consulting Associates
28505 North Dallas Parkway, Suite 620
Plano, TX 75093-8724

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

Case Number 25-3463GC: RegionalCare Hosp Part CY 2009 DSH Medicare Part C CIRP Group
Case Number 25-1248GC: RegionalCare Hosp Part CYs 2007-2008 Medicare Part C CIRP Group

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 two Common Issue Related Party ("CIRP") groups on **January 1 and March 1, 2025**. Both groups contain providers appealing from revised Notices of Program Reimbursement ("RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' fiscal years ended ("FYEs") in 2007 through 2009.

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. 25-1248GC, Statement of Group Issue at 1 (Jan. 1, 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]

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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 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 revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

The "Statement of Group Issue" included with the appeal requests state that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[52] The Providers contend that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

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

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[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.*, Case No. 25-1248GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.*, case No. 25-1248GC, 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 again states that "[t]he Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [RNPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[58] Since the Board is bound by this regulation,[59] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

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[54] *E.g.*, Case No. 25-1248GC, 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. 25-1248GC, Providers' Petition for Expedited Judicial Review at 13 (Mar. 5, 2026).
[57] *Id.* at 16.
[58] *Id.* at 1-2.
[59] 42 C.F.R. § 405.1867.

The Medicare Contractors' designated representative, Federal Specialized Services ("FSS"), submitted timely[60] certifications that it would be filing Jurisdictional Challenges in these two (2) cases. FSS filed a Jurisdictional Challenges in both cases on **March 24, 2026**. Each challenge alleged that certain providers were pursuing the same issue, from the same final determination, in more than one appeal.[61] On **March 31, 2026**, the Board issued a Scheduling Order to limit the time in which Providers could file a response to those challenges. The Providers filed timely responses on **April 10 and 14, 2026** explaining that the challenged Providers had been withdrawn from the additional cases to which they were a part of, and now simply remained in Cases 25-3463GC and 25-1248GC.[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.

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; [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

[60] Board Rule 44.6 (2023) governs the timing of Jurisdictional and Substantive Claim Challenges in cases where a Request for EJR is filed less than sixty (60) days from the filing of a Final Schedule of Providers (or Board Rule 20 Certification filed in lieu of a Final SOP which certifies that the group is complete and fully populated in OH CDMS). In such instances, Board Rule 44.6 requires any party questioning the Board's jurisdiction or whether an appropriate cost report claim was made to file the challenge, or a certification that a challenge is forthcoming, within five (5) business days of the date the EJR Request was filed. The Requests for EJR in these cases were filed on **March 5, 2026**, so any challenges (or certification that a challenge was forthcoming) were due no later than close of business **March 12, 2026**. Certifications were filed by the Medicare Contractor or FSS in these cases between **March 11 and 12, 2026**.

[61] *E.g.*, Case No. 25-3463GC, Medicare Administrative Contractor's Jurisdictional Challenge at 1. (Mar. 24, 2026).

[62] *E.g.*, Case No. 25-3463GC, Response to Jurisdictional Challenge and Board Inquiry for Information at 1 (Apr. 14, 2026).

[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).

- The amount in controversy is, in the aggregate, $50,000 or more.[64]

For these two (2) 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 (or filed timely individual appeals and later transferred the Part C issue to their respective group cases). Finally, the amount in controversy exceeds $50,000 in both cases. While FSS challenged whether the Board had jurisdiction over some Providers who were pursuing the same issue in more than one appeal, they were withdrawn from the duplicative appeals and FSS' challenges are now moot.

The Board finds that the Providers in Cases 25-3463GC and 25-1248GC have all filed timely appeals from their revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy in each case exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

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 25-3463GC and 25-1248GC and that the Providers in both group appeals are entitled to a hearing before the Board;

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

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

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

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

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[64] 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 Case Nos. 25-3463GC and 25-1248GC 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:

5/6/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Cecile Huggins, Palmetto GBA (J-J)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephen Price, Sr.
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RE: ***Expedited Judicial Review Determination***

Case Number 25-5344GC:	ARH (KY) FFY 2009 DSH Medicare Part C Days CIRP Group
Case Number 25-5775GC:	ARH (KY) FFY 2012 DSH Medicare Part C Days CIRP Group
Case Number 25-5779GC:	ARH (KY) FFY 2010 DSH Medicare Part C Days CIRP Group
Case Number 26-0277:	Beckley ARH Hospital (Prov. No. 51-0062), FYE 06/30/2008
Case Number 26-0280:	Beckley ARH Hospital (Prov. No. 51-0062), FYE 06/30/2007

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed **April 7 and 14, 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 three (3) Common Issue Related Party ("CIRP") groups and two (2) individual appeals are all 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 years ended ("FYEs") between 2008 and 2012.

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. 25-5344GC, Statement of the Group Issue at 1 (Aug. 8, 2025).
[3] *Id.*

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 submit briefs on whether vacatur is the appropriate remedy for the situation, which have since been filed.[50]

Providers' Position:

A. Providers' Appeal Requests

The "Statement of the Group Issue" included with the group appeals requests state that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina II* litigation.[51] 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.[52]

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 2015 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 policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking.

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

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[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.*, Case No. 25-5344GC, Statement of the Group Issue at 1. (Aug. 8, 2025). The Board notes that the Statement of the Issue included with each individual appeal is materially identical to the Statement of the Group Issue included with each common issue related party group appeal.
[52] *Id.*

> procedurally invalid and must be set aside because it was taken without observance of procedure required by law, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.[53]

Finally, the Providers claim that "vacatur of the 2004 rule in *Allina I* effectively restored the pre-2004 DSH Part C standard embodied in the 1986 regulation" and that the retroactive, new Part C regulation is unlawful.[54]

B. Providers' Petitions for EJR

The substance of the Providers' Requests for EJR is materially identical to the Statement of the Group Issue. 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.[55] They argue that the 2023 Final Rule "is substantively and procedurally invalid," and that enactment of this rule "is arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law," and impermissibly retroactive.[56]

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. The MAC will not file a substantive claim challenge."[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

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

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[53] *Id.* at 1-2.
[54] *Id.* at 2-3.
[55] *E.g.*, Case No. 25-5344GC, CIRP Group's Motion for Expedited Judicial Review at 3-4 (Apr. 7, 2026).
[56] *Id.* at 3.
[57] *E.g.,* Case No. 25-5344GC, Response to Provider's Request for Expedited Judicial Review at 1 (Apr. 14, 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, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[59]

For these five (5) appeals, 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 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 RNPRs and the amount in controversy exceeds $50,000 in each case.

The Board finds that the Providers in Cases 25-5344GC, 25-5779GC, 25-5775GC, 26-0280, and 26-0277 have all filed timely appeals from their revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy in each 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 25-5344GC, 25-5779GC, 25-5775GC, 26-0280, and 26-0277, and that the Providers in each appeal are entitled to a hearing before the Board;

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

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

[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.

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. 25-5344GC, 25-5779GC, 25-5775GC, 26-0280, and 26-0277, the Board hereby closes these five (5) 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:

5/6/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

Case Number 25-5497G: Southwest Consulting CY 2005 DSH Medicare Part C Group
Case Number 25-4212G: Southwest Consulting CY 2014 DSH Medicare Part C Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **April 9, 2026** in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish two optional groups on **April 2 and August 21, 2025**. Both groups contain providers appealing from revised Notices of Program Reimbursement ("RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' fiscal years ended ("FYEs") in 2005 and 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. 25-4212G, Statement of Group Issue at 1 (Apr. 2, 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]

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[14]

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

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

In the September 4, 1990 Federal Register, the Secretary[15] stated that:

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

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

> included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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[16] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[17] *Id.*
[18] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[20] *Id.*
[21] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[22] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

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

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

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

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

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

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

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

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[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).
[42] 88 Fed. Reg. at 37788 (emphasis in original).

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[44]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

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

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

> notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissible retroactive[48] arbitrary and capricious.[49] The court ordered the parties to submit briefs on 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 revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

The "Statement of Group Issue" included with the appeal requests state that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[52] The Providers contend that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

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

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[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.*, Case No. 25-4212G, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E.g.*, Case No. 25-4212G, 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.*, Case No. 25-4212G, 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. 25-4212G, Providers' Petition for Expedited Judicial Review at 13 (Apr. 9, 2026).
[57] *Id.* at 16.
[58] *Id.* at 1-2.
[59] 42 C.F.R. § 405.1867.

The Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in both cases simply advising that "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 their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [61]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[62]

For these two (2) groups, the providers all appealed from revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All of the providers were directly added to their respective groups within 180 days of the issuance of their RNPRs (or filed timely individual appeals and later transferred the Part C issue to their respective group cases). Finally, the amount in controversy exceeds $50,000 in both cases.

The Board finds that the Providers in Cases 25-5497G and 25-4212G have all filed timely appeals from their revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy in each case exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

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[60] *E.g.*, Case No. 25-4212G, Response to Provider's Request for Expedited Judicial Review at 1 (Apr. 15, 2026).
[61] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[62] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Cases 25-5497G and 25-4212G and that the Providers in both group appeals are entitled to a hearing before the Board;

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

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

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

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes Case Nos. 25-5497G and 25-4212G 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:

5/6/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Flowers Hospital (Prov. No. 01-0055), FYE 09/30/2021, Case No. 25-4607

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-4607. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background:

A. ***Procedural History for Case No. 25-4607***

On **December 19, 2024**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2021.

On **June 4, 2025**, the Board received the Provider's individual appeal request. The Appeal Request was filed by the parent organization, Community Health Systems, Inc. (hereinafter "CHS") and included five (5) issues:

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

On **June 5, 2025**, the Board issued the Acknowledgement and Critical Due Dates ("ACDD") notice, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter*, "PPP"). This Notice also gave the following instructions to the Provider regarding the content of its PPP:

[1] On January 29, 2026, this issue was withdrawn.
[2] On December 8, 2025, this issue was transferred to Case No. 24-1384GC.
[3] On December 8, 2025, this issue was transferred to Case No. 24-1835GC.
[4] On December 8, 2025, this issue was transferred to Case No. 24-1836GC.

> 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 **December 8, 2025,** CHS transferred Issues 3, 4 and 5, respectively, to CHS CIRP groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there were two (2) remaining issues in this appeal: Issue 1: DSH Pymt/SSI % (Provider Specific) and Issue 3: DSH Pymt - Medicaid Eligible Days.

On **January 29. 2026**, CHS withdrew the SSI Provider Specific issue and filed its PPP.

On **February 4, 2026,** the MAC filed a copy of a request to the Provider for an Auditable Medicaid Eligible Days Listing.

On **March 23, 2026**, the MAC filed a Motion to Dismiss the Medicaid Eligible Days issue.

On April 6, 2026, CHS requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS"). The Board effectuated the change to QRS on the same day.

B. ***Description of Issue 2 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.

[5] (Emphasis added.)

> 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): 1, 8, 9, S-D
>
> Estimated Reimbursement Amount: $92,600

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

MAC's Contentions: Issue 2 – DSH Payment – Medicaid Eligible Days

In its Motion to Dismiss, the MAC argues the Board lacks jurisdiction over the Medicaid Eligible Days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their PPP (even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.)[8] In addition, the Provider has not responded to the MAC's request for an auditable listing of Medicaid Eligible Days after one was requested on February 4, 2026. Finally, the MAC argues the Provider has abandoned this issue because it failed to sufficiently develop and set forth the relevant facts and arguments in its PPP and because it neglected to include all supporting documentation (per Board Rules 25.2.1, 25.2.2, 25.3 and 27.2).[9]

Provider's Response to the Motion to Dismiss

The Board Rules require that Provider Responses to the MAC's Motion to Dismiss must be filed within thirty (30) days from the date the motion was sent to the Board and the opposing party.[10] The Provider did not file a response to the Motion to Dismiss and the time for doing so has elapsed (on April 22, 2026). A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

---

[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's PPP at 7 (Jan. 9, 2026).
[8] MAC's Motion to Dismiss at 2 (March 23, 2026).
[9] *Id.* at 4-5.
[10] Board Rule 44.3, v. 3.2 (Dec. 2023).

Board Analysis and Decision

The Board finds it appropriate to dismiss the DSH Payment – Medicaid Eligible Days issue.

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 2 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*.[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 instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> **25.2.2 Unavailable and Omitted Documents[14]**
>
> 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.[15]

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.

---

[11] (Emphasis added).
[12] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[13] (Emphasis added).
[14] PRRB Rules v. 3.2 (Dec. 2023)
[15] (Italics and underline emphasis added.)

This appeal was initiated on June 4, 2025 (almost 11 months 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.[16] ***To date, there is no evidence that the auditable listing has been provided***.

Although the Provider submitted **a redacted** listing of eligible days as an exhibit to its PPP, the listing included a notation that "Listing pending finalization upon receipt of State eligibility data." Based on the evidence in the record, the Provider has not yet provided a **complete, unredacted, auditable listing**, nor has it explained why such documentation is unavailable as required in Board Rules 7 and 25.2.2.

In summary, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. Accordingly, the Board finds that the Provider 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]

****

Based on the foregoing, the Board is dismissing the last remaining issue in this case: "DSH - Medicaid Eligible Days" - Issue 2. As no issues remain, the Board hereby closes Case No. 25-4607 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:

5/8/2026

X Nicole E. Musgrave

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

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson C. Leong, Esq., Federal Specialized Services

[16] Provider's PPP at 8.

[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.

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***
Cox Medical Centers (Prov. No. 26-0040), FYE 09/30/2017
Case No. 22-0760

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0760. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") - Medicaid Eligible Days issue.

Background:

A. *Procedural History for Case No. 22-0760*

On **August 31, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end 9/30/2017.

On **February 10, 2022**, the Board received the Provider's individual appeal request. The Individual Appeal Request, which was filed by Quality Reimbursement Services, Inc. ("QRS") included two issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH Medicaid Eligible Days

On **February 11, 2022**, the Board issued the Acknowledgement and Critical Due Dates ("ACDD") notice, providing among other things, the filing deadlines for the parties' preliminary position papers (hereinafter "PPP"). This notice also gave the following instructions to the Provider regarding the content of its PPP:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *include* ***any exhibits*** *the Provider will use to support its position* and a statement indicating

> how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. See Board Rule 25.[1]

On **October 8, 2022**, the Provider timely filed its PPP.

On **January 23, 2023**, the Medicare Contractor ("MAC") timely filed its PPP.

On **March 6, 2023**, FSS filed a Motion to Dismiss the SSI Provider Specific and Medicaid Eligible Days Issues.

On **April 5, 2023**, the Provider filed a responsive jurisdictional brief.

On **September 25, 2025**, the Board issued a Notice of Hearing scheduling the case for May 11, 2026.

On **February 10, 2026**, QRS withdrew the SSI Provider Specific issue from the case and filed its final PP.

On **March 9, 2026**, the MAC filed its final PP.

B. ***Description of Issue 2 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 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 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.

[1] (Emphasis added.)

Audit Adjustment Number(s): 8, 9, 103, S-D

Estimated Reimbursement Amount: $617,870

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[2] 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.[3] The estimated reimbursement impact in the PPP is $772,424, but this amount was not supported by an updated calculation.

MAC's Contentions: Issue 2 – DSH Medicaid Eligible Days

In its Jurisdictional Challenge, the MAC argues the Board lacks jurisdiction over the Medicaid Eligible days issue. The MAC contends that the Provider failed to include a list of additional Medicaid eligible days they expect to be included with their appeal or their PPP (even though the Provider advised that it would send a listing of additional Medicaid eligible days under separate cover.)[4] As of March 2026, when the MAC filed its Jurisdictional Challenge, it had not received a listing of additional Medicaid eligible days, even though the Provider indicated one would be sent at the time it filed its PPP.

Although in its final PP the MAC acknowledges the Provider submitted **a redacted** listing of eligible days with its final PP, it still has not a **complete, unredacted, auditable listing**, nor has the Provider explained why such documentation is unavailable as required in Board Rules 7 and 25.2.2. Finally, the MAC argues the Provider has abandoned this issue because it failed to sufficiently develop and set forth the relevant facts and arguments in its PPs and because it neglected to include all supporting documentation.[5]

Provider's Response to the Jurisdictional Challenge

QRS timely filed a response to the MAC's jurisdictional challenge in which it argues that, based on the Rules in effect at the time PPPs were filed *in 2019* (Note: **The Provider's PPP was filed in Oct. 2022 which was 3 years after the referenced rule**), the listing of Eligible Days would not be due until the Final PP date. QRS also alleges that, due to COVID, its operations were disrupted and therefore, the Board should find that it has not abandoned the appeal.

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

[2] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[3] Provider's PPP at 7 (Oct. 8, 2022).
[4] MAC's Juris. Challenge at 2 (March 6, 2023).
[5] *Id.* at 5-6.

$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.

DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider's issue statement for Issue 2 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*.[6]

Similarly, with regard to position papers,[7] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[8] 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.

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

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

Relative to a Medicaid Eligible Days determination, it is well-established that adequate data to prove eligibility for each Medicaid patient day claimed is a complete and accurate (i.e., auditable) Medicaid eligible days listing, which upon timely submission by a provider, a MAC can examine to make applicable adjustments. This appeal was initiated on February 10, 2022 (more than 4 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.[9] 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 $617,870 based on an estimated 1,620 days). The Provider's complete briefing of this issue in its PPP is as follows:

> **Calculation of Medicaid Eligible Days**

[6] (Emphasis added).
[7] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[8] (Emphasis added).
[9] Provider's PPP at 8.

> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its March 6, 2023 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because the Provider failed to file a complete Position Paper. Therefore, the Provider is in violation of Board Rules 25.3 and 42 C.F.R. § 405.1853 because it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim. The Provider also neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. The MAC asserts that the Provider has essentially abandoned the issue by

failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[10]

As noted, QRS did include a redacted "Eligibility Listing" as an exhibit to its final position paper. The 162-page listing showed 41,845 "Additional Medicaid Eligible Days."[11] The Listing does not, however, explain why the number of days included was over the initial 1,620 days the Provider claimed in its appeal, nor did it explain why it was being submitted at such a late date as the filing ***was more than 3 years past the deadline for including it with the Provider's PPP*** for which the deadline was October 8, 2022.

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

The Board rejects the Provider's attempts to include the eligible days listing included *as an exhibit with its final position paper* because:

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

2. The uploaded exhibit fails to explain 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 41,845 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 more than 4 years after this appeal was filed and more than 8 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the February 11, 2022 ACDD notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege the Final PP exhibit was a being filed as a supplement).

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 the Final PP Exhibit as a

[10] *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.
[11] Provider Final PP Exhibit P-1 (Feb. 10. 2026)

"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 listing submitted cannot be considered a refinement of the PPP paper since no specific days or listing were included with the PPP (indeed the *tentative* 41,845 days listed in the late exhibit is, without explanation, *significantly* larger than the original estimated 1620 days included with the appeal request).[12]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[13] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[14] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

****

Based on the foregoing, the Board is dismissing the last remaining issue in this case: DSH Medicaid Eligible Days - Issue 2. As no issues remain, the Board hereby closes Case No. 22-0760 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.

[12] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[13] (Emphasis added.)
[14] *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.

Board Members Participating:

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

For the Board:

5/8/2026

X Nicole E. Musgrave

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Greg Justice, CEO
Medical Behavioral Hospital of Indianapolis
1167 Wilson Drive
Greenwood, IN 46143

Re: "MBH of Indianapolis FFY 2024 notice of Participation Group"
PRRB Case No. 26-2429G

Dear Mr. Justice:

The Provider Reimbursement Review Board ("Board") is in receipt of the above-referenced *group* appeal request to which it assigned Case No. 26-2429G. The pertinent facts and background regarding the case and the Board's determination are set forth below.

Pertinent Facts:

On **May 1, 2026**, Medical Behavioral Hospital of Indianapolis ("MBH of Indianapolis"/Prov. No.15-4068) filed an optional group appeal with the Board. The group as filed in the Office of Hearings Case & Document Management System ("OH CDMS") includes a single participant, MBH of Indianapolis.[1]

A review of the support uploaded as the group's "Issue Statement Document," further reinforces that the appeal was filed on behalf of a ***single*** Provider requesting a reconsideration of the determination which denied the reconsideration of the decision to reduce the fiscal year ("FY") 2026 Annual Payment Update ("APU") buy 2 percentage points.[2] In addition to the Issue Statement, the only other support uploaded by MBH of Indianapolis was a copy of the final determination (i.e., the January 12, 2026 Notice of Quality Reporting Program Noncompliance Decision Upheld ("QRP Determination").

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."[3] 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."

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

[1] Because all necessary information was not completed, this provider is listed as a "draft" participant in OH CDMS.
[2] The uploaded support is described as an "Issue Statement Document" but is titled PRRB Representation Letter 2026.docx"
[3] Board Rules Version 3.2 (Dec. 15, 2023)

As noted, the Issue Statement includes a copy of a March 27, 2026 letter which consists of four sentences. Based on date of the letter and the address, this appears to be the Provider's request to the Centers for Medicare & Medicaid Services ("CMS") for a reconsideration of the 2% reduction to its inpatient Psychiatric Facility Quality Reporting Program ("IPFQR") hospice payment.

The contents of a request for Board hearing, specifically the **Issue Statement**, are discussed in 42 C.F.R. 405.1835(b)(2) which indicates:

> For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.[4]

In addition, there is no other information related to the issue for the sole participant (specifically, an estimated amount in controversy with calculation support. As discussed in Board Rule 16.2, a provider that is directly added to a group ". . . must include the same information required for a provider filing an individual appeal . . . including the determination and issue-specific information addressed in Rule 7, plus a copy of the representative letter associated with the group." 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 participant.

Finally, 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." The letter must include the contact information for the representative which includes the name, organization, address, telephone number and email address. Here, the **issue statement** was titled as the "PRRB Representation Letter 2026.docx." Although the issue statement includes sufficient information to be considered as the Representation letter, it was not uploaded as part of the required support for MBH of Indianapolis.

[4] 42 C.F.R. § 405.1837(b)(2)

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 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 Provider failed to file any issue related support and thus failed to establish that the amount in controversy threshold has been met (**i.e.**, $50K for a group or $10K for an individual appeal); and
3) The Provider failed to submit a document that meets the requirements of an Issue Statement;

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. 26-2429G 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 MBH of Indianapolis, the Provider is still within its appeal period.[5] 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.

[5] The Provider has 180 days from receipt of the final determination to appeal to the Board. Based on the January 12, 2026 QRP determination, the appeal period for the Provider would expire on Thursday, July 16, 2026.

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

For the Board:

5/11/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-8)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
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RE: ***Expedited Judicial Review Determination***

Case Numbers:

25-5487GC	Northwell Health CY 2002 Post-Allina II DSH Part C Days CIRP Group
25-5488GC	Northwell Health CY 2003 Post-Allina II DSH Part C Days CIRP Group
25-5782GC	Northwell Health CY 2004 Post-Allina II DSH Part C Days CIRP Group
25-5485GC	Northwell Health CY 2000 Post-Allina II DSH Part C Days CIRP Group
25-5486GC	Northwell Health CY 2001 Post-Allina II DSH Part C Days CIRP Group

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed **March 3, 2026** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

Several of the Providers in these Common Issue Related Party ("CIRP") group appeals are appealing from original 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 Years Ended ("FYEs") in calendar years spanning 2000-2004. As outlined *infra*, however, many are taken from letters from the Medicare Contractor which explain:

> 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 [date], 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. [Provider]

[1] 88 Fed. Reg. 37772 (June 9, 2023).

> 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.[2]

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

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."

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[2] *E.g.*, Case No. 25-5782GC, Forest Hills Hospital, Letter re: Remand of Medicare Part C Days Under CMS Ruling CMS-1739-R (Mar. 18, 2025).
[3] *E.g.,* Case No. 25-0396GC, Statement of Group Issue at 1 (Oct. 23, 2024).
[4] *Id.* at 2-3.
[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).

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]

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

[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(2)-(3).
[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).

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]

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

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[16] of Health and Human Services.
[17] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[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.*

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 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

[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).
[25] *Id.* (emphasis added).
[26] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[27] *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."[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 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.*

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[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).

[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

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 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

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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)).
[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).
[41] CMS Ruling 1739-R at 1-2.
[42] 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.[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 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

[43] 88 Fed. Reg. at 37788 (emphasis in original).
[44] 88 Fed. Reg. at 37774-75 (emphasis added).
[45] *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."[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, 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 addressing whether vacatur is the appropriate remedy for the situation, which have since been filed.[51]

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*[52] 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. § 1395oo(a)(1)(A)(i).[53] 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.[54] Indeed, refusing to reopen is, more simply, "a refusal to make a new determination."[55]

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[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).
[49] *Id.* at *12-19.
[50] *Id.* at *19-22.
[51] *Id.* at *23.
[52] 525 U.S. 449, 119 S.Ct. 930 (1999).
[53] 525 U.S. at 449-50.
[54] *Id.*
[55] *Id.*

Providers' Position:

A. Providers' Appeal Requests

For the Providers appealing from the denial of the Medicare Contractor to issue a revised NPR, the appeal requests include a "Statement of Jurisdiction" which argues that the Medicare Contractor's final decision "closing" 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."[56] 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.[57]

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."[58] The Providers contend that the Part C days must be

[56] *E.g.*, Case No. 25-5782GC, Forest Hills Hospital, Statement of Jurisdiction.
[57] *Id.* (citations omitted).
[58] *E.g.*, Case No. 25-5487GC, Appeal Request, Statement of Group Issue at 1 (Aug. 20, 2025).

included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[59]

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."[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.[61]

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."[62]

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.[63] 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.[64] The request states, again, that "[t]he Providers contend 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

[59] *Id.*
[60] *Id.* (citing to 139 S. Ct. at 1816).
[61] *Id.*
[62] *Id.* (citing 4 U.S.C. § 706(2)).
[63] *E.g.*, Case No. 25-5487GC, Provider's Petition for Expedited Judicial Review at 13 (Mar. 3, 2026).
[64] *Id.* at 16-17.

is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[65] Since the Board is bound by this regulation,[66] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate. For the Providers appealing the refusal to issue a RNPR, they argue that their appeals are appropriate because they are dissatisfied with the final determination "'clos[ing]' the remand of an earlier appeal of the DSH part C days issue."[67]

The Providers also claim 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 . . .'"[68] They claim the letters being appealed are 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.'"[69]

The Medicare Contractor's representative, Federal Specialized Services, filed timely responses to all five (5) Requests for EJR in these cases. It argues that the letters declining to issue an RNPR are not valid, appealable "final determinations" as the term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. §1835(a).[70] It asks the Board to dismiss the following Providers from the following cases on that basis ("the Challenged Providers"):

- Case 25-5782GC:
  - NS/LIJ Southside Hospital (Provider No. 33-0043)
  - Long Island Jewish Medical Center (Provider No. 33-0195)
  - Forest Hills Hospital (Provider No. 33-0353)

- Case 25-5488GC:
  - Forest Hills Hospital (Provider No. 33-0353)
  - Long Island Jewish Medical Center (Provider No. 33-0195)

- Case 25-5487GC:
  - Forest Hills Hospital (Provider No. 33-0353)

- Case 25-5486GC:
  - Forest Hills Hospital (Provider No. 33-0353)
  - Long Island Jewish Medical Center (Provider No. 33-0195)

- Case 25-5485GC:
  - Forest Hills Hospital (Provider No. 33-0353)

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[65] *Id.* at 1-2.
[66] 42 C.F.R. § 405.1867.
[67] *E.g.*, Case No. 25-5487GC, Provider's Petition for Expedited Judicial Review at 11.
[68] *Id.* at 15.
[69] *Id.*
[70] *See*, *e.g.*, Case No. 25-5487GC, Medicare Administrative Contractor's Jurisdictional Challenge at 1-2 (Mar. 23, 2026).

- Long Island Jewish Medical Center (Provider No. 33-0195)

The Providers filed identical responses to each Jurisdictional Challenge on **April 13, 2026**. They argue that the closure of the remands at issue is plainly a Medicare Contractor action that following the remand by a court that is reviewable.[71]

The Providers explain that they originally appealed the 2004 final DSH Part C Days Rule from earlier NPRs in group appeals.[72] The Providers in Case No. 25-5782GC were initially remanded pursuant to CMS Ruling 1739-R,[73] while others requested EJR, which was granted by the Board.[74] The Providers filed a complaint in district court which was eventually consolidated and later remanded for further action in light of the Supreme Court ruling in *Allina II*. The CMS Administrator then remanded those appeals to have the final Part C Final Rule applied.[75] Letters were later issued by the Medicare Contractor "closing" the remands, from which the Providers later appealed.[76]

The Providers claim the Medicare Contractor had a mandatory duty to implement the Administrator's remand order by issuing a revised NPR, but that the letter declining to do so "constitutes a final determination as to the amount of total program reimbursement due to the Providers, regardless of how the MAC labeled it."[77] They urge the Board to, at a minimum, assert that it has jurisdiction to decide whether the Medicare Contractor should be required to issue revised NPRs that *would* be appealable.[78]

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

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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[71] *See*, *e.g.*, Case No. 25-5487GC, Providers' Response to MAC's Jurisdictional Challenge at 1-2 (Apr. 13, 2026).
[72] *Id.* at 12.
[73] Case No. 25-5782GC, Providers' Response to MAC's Jurisdictional Challenge at 12.
[74] *See*, *e.g.*, Case No. 25-5487GC, Providers' Response to MAC's Jurisdictional Challenge at 12.
[75] *Id.*
[76] *Id.* at 13.
[77] *Id.* at 13-14.
[78] *Id.* at 15.

- 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; [79]
- 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.[80]

For the Challenged Providers, while the letters issued are not refusals to reopen the cost reports, but rather refusals to issue new RNPRs, 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.[81] For those Providers, there was a settlement agreement for the FYEs at issue. The June 2023 Final Rule also repeatedly referenced the appealability of NPRs or RNPRs that were issued pursuant to the Final Rule,[82] and no other "final determinations."

The Board notes, however, that since only one provider remains in Case Nos. 25-5487GC, 25-5488GC, 25-5782GC, and 25-5486GC, they no longer meet the requirements for a group appeal. Nevertheless, the remaining Providers' listed amounts in controversy exceed $10,000 as required for an individual appeal and they meet the remaining requirements for a hearing before the Board. 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 it lacks jurisdiction over the Challenged Providers outlined above because the "Refusal to Issue New RNPR" letters from which they filed their appeals are not appealable final determinations. If the Medicare Contractor was, in fact, required to issue Revised NPRs, its refusal to do so is beyond the jurisdiction of the Board. The Board notes, however, that the cost reports for these fiscal years appear to have been settled via a settlement agreement between the parties,[83] 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."[84]

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[79] 42 U.S.C. § 1395oo(a) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[80] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.
[81] 88 Fed. Reg. at 37774-75 (emphasis added).
[82] *See supra* n.44-46 and accompanying text.
[83] *See*, *e.g.*, Case No. 25-5487GC, Statement of Jurisdiction for Forest Hills Hospital 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."). The Statement of Jurisdiction for all of the Challenged Providers contains a similar statement.
[84] CMS Transmittal 12513, Change Request 13294 at unnumbered page 4 (Feb. 21, 2024) (available at https://www.cms.gov/files/document/r12513otn.pdf).

The Board finds that:

1) The Board lacks jurisdiction over the Challenged Providers and therefore denies the Request for EJR as it relates to those Providers and dismisses them from their respective appeals;

2) Since both Providers in Case No. 25-5485GC were Challenged Providers, the Board denies the request for EJR for that case in its entirety and will close the case;

3) The Board finds that, except for the Challenged Providers, it has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Case Nos. 25-5487GC, 25-5488GC, 25-5782GC, and 25-5486GC, and that the remaining Providers in each appeal are entitled to a hearing before the Board;

4) 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;

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

6) It is without the authority to decide the legal question of whether the 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 for*** the Challenged Providers.

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. 25-5487GC, 25-5488GC, 25-5782GC, 25-5485GC, and 25-5486GC, the Board hereby closes the 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:

5/11/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
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RE: ***Expedited Judicial Review Determination***

Case Number 25-5958: Geisinger-Bloomsburg Hospital (39-0003), FYE 06/30/2008
Case Number 25-5927: Geisinger-Bloomsburg Hospital (39-0003), FYE 06/30/2009
Case Number 25-5926: Geisinger-Bloomsburg Hospital (39-0003), FYE 06/30/2011
Case Number 25-5959: Geisinger-Bloomsburg Hospital (39-0003), FYE 06/30/2012
Case Number 25-5957: Geisinger-Bloomsburg Hospital (39-0003), FYE 06/30/2013
Case Number 26-0746: El Centro Regional Medical Center (05-0045), FYE 06/30/2011

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed **April 18, 2026** in the six (6) above-referenced individual appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

In **September and December of 2025**, the Board received six (6) individual appeal requests, each appealing from a revised Notice of Program Reimbursement ("RNPR") concerning fiscal years ended ("FYEs") between 2008 and 2013. The Providers' RNPRs implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule").[1]

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. 25-5958, Statement of Issue (CMS 1739R Challenge issue) at 1 (Sept. 19, 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]

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 submit briefs on 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 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 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]

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[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.*, Case No. 25-5958, Statement of Issue (CMS 1739F Challenge issue) at 1.
[52] *Id.* at ¶ 3.
[53] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).
[54] *Id.* at ¶¶ 6-18.

B. Providers' Petitions for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that each appeal was filed appeal within 180 days of the issuance of the RNPRs; that the amount in controversy exceeds $10,000 in each case; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[55] They note that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[56]

On **April 24, 2026**, the Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed a response to each Request for EJR simply advising that:

> [T]he MAC will not file a jurisdictional challenge. The MAC's decision not to file a jurisdictional challenge is based on its review of the provider's request for EJR which, the MAC notes, does not mention or address the unreasonable delay issue. If provider is seeking EJR as to the unreasonable delay issue, then the MAC opposes EJR for that issue. The MAC will not file a substantive claim challenge.[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

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

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[58] and
- The amount in controversy is $10,000 or more.[59]

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[55] *E.g.*, Case No. 25-5958, Provider's Petition for Expedited Judicial Review at 1-4 (Apr. 18, 2026).
[56] *Id.* at 11.
[57] *E.g.*, Case No. 25-5958, Response to Provider's Request for Expedited Judicial Review at 1 (Apr. 24, 2026).
[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(a)(2); 42 C.F.R. §§ 405.1835 – 1840.

These Providers appealed from revised NPRs which implemented the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Providers' appeals were filed within 180 days of the issuance of the RNPRs and the amount in controversy exceeds $10,000 in each case.

Each appeal contains two separate "issues" – one a specific challenge over whether Part C Days should be in the Medicaid or Medicare Fraction, and a second which seeks attorneys' fees and interest for the years of delay in tendering the Provider's DSH reimbursement. The second, separate "unreasonable delay" issue specifically states:

> **The issue in this Appeal is UNREASONABLE DELAY: whether DSH reimbursement for Providers' year in this appeal has been unreasonably delayed, should be made without further delay under the long-standing rulings of the *Northeast Decision, Allina I* and *Allina II*, and should include payment of attorney fees and interest for all the years of delay, as provided in 42 U.S.C. § 1395oo(f)(2).[60]**

The Part C Days issue statement has an entire section dedicated to the same arguments, with a heading which reads:

> **Unreasonable Delay: Administration of these claims, as required by *Allina I, Northeast Hospital, and Allina II*, has been long and unreasonably delayed since 2010[61]**

This issue also seeks Providers' DSH payment and "payment of attorney fees and interest for all the years of delay, as provided in 42 U.S.C. § 1395oo(f)(2)."[62]

Since this argument for attorney's fees and interest is encompassed within the Part C Days issue, and the Board is granting EJR over that issue in its entirety, the "separate" Unreasonable Delay issue is hereby be ***dismissed*** from these six (6) cases as duplicative.

Similarly, though it is not specifically identified as such within the appeal requests or listed issues, the Board notes that the Part C Days issue also encompasses a *third*, multi-faceted issue: "SSI Data Problems Abound in the Calculation of the Medicare Fraction (SSI Ratio).[63] In reality, the arguments made on this topic encompass several distinct issues. Indeed, arguments are made about the interpretation of "entitled to SSI benefits," an issue which was finally settled by *Advocate Christ* (which specifically rejected the Providers' arguments),[64] and the use of only three SSI status codes in determining SSI entitlement. There are also arguments made that CMS

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[60] *E.g.*, Case No. 25-5958, Statement of Issue (Unreasonable Delay) at 1.
[61] *E.g.*, Case No. 25-5958, Statement of Issue (CMS 1739R Challenge issue) at ¶¶ 19-24.
[62] *Id.* at ¶ 19.
[63] *Id.* at ¶¶ 25-35.
[64] *Advocate Christ Med. Ctr. v. Kennedy*, 145 S.Ct 1262, 1274 (2025).

is in violation of MMA § 951,[65] which mandates that CMS must give hospitals the information necessary to compute the number of patient days used in computing their DPPs. These arguments were raised within the issue statement for the Part C Days challenge but are distinct and unrelated to that issue. They concern completely different legal authorities and their potential impact on a Provider's DSH payment is distinct and unrelated to the treatment of Part C Days.

Board Rule 8 requires that multiple components of issues be "described as narrowly as possible." To the extent that the Provider wished to include legal challenges related to *Advocate Christ*, MMA § 951, or any other SSI DSH issue in the appeal, they should have been raised, briefed, and argued as separate issues. Additionally, the Board notes that the Revised NPRs being appealed made no change to the Providers' SSI percentages and was issued solely to implement the retroactive Part C Days rule. Since no adjustment was made related to the SSI percentages that would implicate any issues related to SSI Data Matching, *Advocate Christ*, or MMA § 951, the Board lacks jurisdiction over these portions of the Part C Days issue statement[66] and hereby ***dismisses*** them from the appeals.

The Board finds that the Providers in Cases 25-5958, 25-5927, 25-5926, 25-5959, 25-5957, and 26-0746 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 this RNPR. The Board also finds that the amount in controversy in each case exceeds $10,000 as required by 42 C.F.R. § 405.1839(a)(1). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Case Nos. 25-5958, 25-5927, 25-5926, 25-5959, 25-5957, and 26-0746 and that the Providers are entitled to a hearing before the Board;

2) The "Unreasonable Delay" issue in these six (6) appeals is duplicative of the arguments raised in the Part C Days issue and the second, separate issue in each appeal is hereby dismissed from each case;

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[65] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).
[66] 42 C.F.R. § 405.1889(b).

3) The SSI Data Problems arguments raised in the Part C Days Appeal[67] are beyond the scope of the Board's jurisdiction from the RNPRs being appealed and are hereby dismissed from the appeal;

4) 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;

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

6) It is without the authority to decide the legal question of whether the 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 the Board is dismissing the second Unreasonable Delay issue in each appeal and no other issues will remain in the cases, the Board hereby closes Case Nos. 25-5958, 25-5927, 25-5926, 25-5959, 25-5957, and 26-0746 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:

5/12/2026

X Kevin D. Smith, CPA

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

cc: Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Scott Berends, Federal Specialized Services

[67] *E.g.*, Case No. 25-5958, Statement of Issue (CMS 1739R Challenge issue) at ¶¶ 25-35.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Christian Hospital Northeast (Provider Number 26-0180)
FYE: 12/31/2018
Case Number: 23-0185

Dear Mr. Kramer:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0185. Set forth below is the decision of the Board regarding the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH")/SSI Percentage (Provider Specific).

Background

A. *Procedural History for Case No. 23-0185*

On **June 2, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018. The Provider is commonly owned by BJC Health ("BJC") and represented by Quality Reimbursement Services, Inc. ("QRS").

On **November 8, 2022**, QRS filed the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payment – Medicaid Eligible Days[1]

After the withdrawal of Issue 2, there is one (1) remaining issue in this appeal: Issue 1 (the DSH – SSI Percentage (Provider Specific)).

On **November 9, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

[1] This issue was withdrawn on August 24, 2023.

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

On **July 3, 2023**, the Provider timely filed its preliminary position paper.

On **September 27, 2023**, the Medicare Contractor filed its preliminary position paper.

On **October 2, 2023**, the Medicare Contractor timely filed a Jurisdictional Challenge[3] with the Board over Issue 1 requesting that the Board dismiss this issue. The Provider filed a timely response on **November 1, 2023**.

B. Description of Issue 1 in the Individual Appeal Request and the Issue in Case No. 21-1724GC – BJC Healthcare CY 2018 DSH SSI Percentage CIRP Group for the Commonly-Owned Entities

In its Individual Appeal Request, in Case No. 23-0185, the Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

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

---

[2] (Emphasis added.)

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

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term 'entitled' as it 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.[4]

Case No. 21-1724GC is a Common Issue Related Party ("CIRP") DSH/SSI Percentage (Systemic Errors) case involving multiple providers commonly owned by BJC. BJC is also the owner of Christian Hospital Northeast. The Group Issue Statement in Case No. 21-1724GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

[4] Case No. 23-0185, Issue Statement at 1 (Nov. 8, 2022).

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[5]

On July 3, 2023, the Board received the Provider's preliminary position paper in Case No. 23-0185. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Issue #1: Provider Specific

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 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).[6]

MAC's Contentions

[5] Group Appeal Issue Statement in Case No. 21-1724GC.
[6] Provider's Preliminary Position Paper at 7-8 (Jul. 3, 2023).

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Case No. 23-0186GC, in which the Provider is a participant.[7]

The Medicare Contractor also argues that the SSI realignment issue was not briefed in the preliminary position paper, is therefore abandoned, and should be withdrawn.[8] Alternatively, the MAC argues the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[9]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[10] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[11]

Provider's Jurisdictional Response

The Provider argues that the issues are not duplicative because "each of the appealed SSI issues are separate and distinct, and that the Board should find jurisdiction over PRRB Case Number 23-0185."[12]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2018, resulting from its understated SSI percentage due to errors of omission and commission."[13]

Decision of the Board

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

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[7] Medicare Contractor's Jurisdictional Challenge at 4-6 (Oct. 2, 2023).
[8] *Id*. at 6-7.
[9] *Id*. at 7.
[10] *Id*. at 8.
[11] *Id*. at 9.
[12] Provider's Jurisdictional Response at 1 (Nov. 1, 2023).
[13] *Id*. at 2.

1. *First Aspect of Issue 1*

Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that the Provider's commonly owned entities appealed in Case No. 21-1724GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns the argument that "its' [sic] SSI percentage published by [CMS] was incorrectly computed . . ."[14] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The commonly owned entities' DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1724GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). The Board finds the DSH/SSI Percentage (Provider Specific) issue in this appeal is common to the DSH/SSI Percentage (Systemic Errors) issue being appealed by commonly owned entities in Case No. 21-1724GC. Because the issue is common amongst providers under common ownership, and common issues being appealed for fiscal years that end in the same calendar year must being appealed under a group appeal,[17] the Board requires the Provider to transfer the issue to Case No. 21-1724GC within ten (10) days of the date of this letter or the issue will be dismissed.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers, but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Case No. 21-1724GC, and why those alleged "provider specific"

[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*
[17] Board Rule 12.3.1 (v. 3.1, Nov. 2021).
[18] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1724GC.[19]

2. *Second Aspect of Issue 1*

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

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

3. *Third Aspect of Issue 1*

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

The Board notes that this issue is being pursued by the Provider in CIRP Group Case No. 23-0186GC, based upon the same final determination, the NPR dated June 22, 2022. Board Rule 4.6.1 clearly states "[a] provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group)."[20] As the provider is pursing this issue as part of the Unduly Narrow CIRP group, it is being dismissed from the individual appeal.

* * * * *

In summary, the Board has dismissed aspects 2 and 3 of the DSH Payment/SSI Percentage (Provider Specific) issue.

As the Provider is not currently participating in Case No. 21-1724GC and the DSH/SSI Percentage issue is common to the commonly owned entities and being appealed in CIRP Group No. 21-1724GC, the Board is requiring the Provider to transfer the issue to Case No. 21-1724GC within

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[19] It is also not clear whether this is a systemic issue for BJC providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

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

ten (10) days of the date of this letter. If the Provider fails to do so, the issue will be dismissed, and the case will be closed.

Upon final disposition of this appeal, 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:

5/12/2026

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – DSH Medicaid Eligible Days Issue**
United Hospital Center (Provider No. 51-0006)
FYE 12/31/2017
Case No. 24-1704

Dear Mr. Ravindran and Ms. Johnson,

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. 24-1704*

On **September 27, 2023**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

On **March 18, 2024**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

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

[1] Issue was withdrawn May 1, 2026.
[2] On October 15, 2024, this issue was transferred to PRRB Case No. 22-1450GC.
[3] On October 15, 2024, this issue was transferred to PRRB Case No. 22-1452GC.
[4] On October 9, 2024, this issue was bifurcated and Issue No. 7 was created for the Medicaid Fraction Dual Eligible Days issue. Issue No. 7 was subsequently transferred to PRRB Case No. 22-1453GC on October 15, 2024.
[5] On October 15, 2024, this issue was transferred to PRRB Case No. 22-1454GC.
[6] On October 15, 2024, this issue was transferred to PRRB Case No. 22-1451GC.

The Provider is commonly owned/controlled by West Virginia University Health System (hereinafter "WVU Medicine") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **October 15, 2024**, the Provider transferred Issues 2, 4, 5, 6 and 7 to WVU Medicine groups. As a result, there are two (2) remaining issues in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)) and Issue 3 (DSH Payment – Medicaid Eligible Days).

On **March 20, 2024**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **November 11, 2024**, the Provider timely filed its preliminary position paper.

On **January 23, 2025**, the Medicare Contractor timely filed its preliminary position paper.

On **February 26, 2025**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **May1, 2026**, the Provider withdrew issue 1, leaving issue 3 as the sole remaining issue in the appeal.

B. Description of Issue 3 in the Appeal Request

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

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

[7] (Emphasis added).

> 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): 1,16,17,18,19,20,23,30,31,S-D
>
> Estimated Reimbursement Amount: $102,202[8]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that pursuant to the *Jewish Hospital* case[9] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[10] 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).[11]

MAC's Contentions

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

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

The MAC argues the Provider has not submitted a complete, unredacted Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

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

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 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:

> **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

[12] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

> 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.[13]

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

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the*

[13] Individual Appeal Request, Issue 3.

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

Similarly, with regard to position papers,[15] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[16] 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.[17]

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.

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

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 March 18, 2024 (over 1 year 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.[18] ***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.[19] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

B. 1115 Waiver Days

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

The appeal was filed with the Board in March of 2024 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…

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

> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[20]

Board Rule 7.2.1 (2023) elaborated on this regulatory requirement, instructing providers:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the 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:
>
> . . .
>
> ***Section 1115 waiver days (program/waiver specific). . .***[21]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[22]

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

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[20] 42 C.F.R. § 405.1835(b).
[21] (Bold and italic emphasis added).
[22] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

In practice, this means that new issues had to be added to this case no later than 240 days after receipt of the contractor's determination. However, there is no evidence in the record to indicate the Provider 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.[23] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 Waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program and not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

> **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)(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.[24] 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 (Dec. 2023).

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*.[25] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[26] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[27] The

---

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

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

[26] *Id*. at *11.

[27] *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.[28] 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. 24-1704 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:

5/12/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

[28] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Springs Memorial Hospital (Prov. No. 42-0036), FYE 11/30/2016
Case No. 19-2780

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 19-2780. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") - Medicaid Eligible Days issue.

Background:

A. *Procedural History for Case No. 19-2780*

On **March 5, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end 11/30/2016.

On **August 28, 2019**, the Board received the Provider's individual appeal request. The Individual Appeal Request, which was filed by Community Health Systems ("CHS") included five issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage
3. DSH Payment -Medicaid Eligible Days
4. Uncompensated Care ("UCC") Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction

Because the Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") it is subject to the mandatory common issue related party "CIRP" group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 20, 2020**, the Provider transferred issues 2 and 5 to CHS CIRP Groups.

On **September 27, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary

position papers (*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.[1]

On **April 22, 2020**, the Provider timely filed its PPP.

On **June 17, 2020**, the MAC filed a jurisdiction challenge over the SSI Provider Specific issue and Uncompensated Care ("UCC") Distribution Pool issues which were both subsequently withdrawn.

On **August 13, 2020**, the Medicare Contractor ("MAC") filed its PPP.

On **November 14, 2022**, the MAC filed a consolidated jurisdiction challenge over the Medicaid Eligible Days issue for 45 cases (which included Case No. 19-2780).

On **December 14, 2022**, CHS Responded to the Jurisdictional Challenge.

On **December 15, 2022**, CHS requested a change of Representative from CHS to Quality Reimbursement Services, Inc. ("QRS") which was acknowledged the following day.

On **December 28, 2022**, the MAC filed a Request for Dismissal reiterating its request that the Medicaid Eligible Days issue be dismissed.

On **August 22, 2025**, the Board issued a Notice of Hearing scheduling the case for a hearing on **June 8, 2026** and requiring final position papers be filed by the Parties.

On **February 24, 2026**, QRS withdrew the Uncompensated Care ("UCC") Distribution Pool issue (#4) and **on March 3, 2026**, it withdrew the SSI Percentage (Provider Specific) issue (#1).

On **March 6, 2026**, QRS filed the Provider's final PP.

On **April 6, 2026**, the MAC timely filed a final position paper. The MAC indicated that it had not yet received a complete, auditable listing of additional Medicaid eligible days.[2]

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[1] (Emphasis added.)
[2] MAC Final PP at 5 (April 6, 2026).

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

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 7, 12, 13, S-D
>
> Estimated Reimbursement Amount: $53,000

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[3] 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.[4]

MAC's Jurisdictional Challenge – Issue 3 – Medicaid Eligible Days

On November 14, 2022, the MAC filed a jurisdictional challenge over various PRRB Cases including this case. The MAC contends the Medicaid Eligible days issue was abandoned when the Provider failed to provide a listing of additional Medicaid eligible days or any other support explaining why those documents could not be produced. In addition, the MAC contends that the Provider failed to file a complete PPP in accordance with 42 CFR § 405.1853(b)(2) and Board Rule 25.

[3] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[4] Provider's PPP at 8 (April 22, 2020).

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

On December 14, 2022, CHS filed a responsive jurisdictional brief in which argued that:

- It is unclear which version of the Board Rules the MAC relied on when asserting its challenge. The Provider contends that Version 2.0 of the Rules, which was in effect when the PPP was filed, required a final PP to be filed. Therefore, it was reasonable for the Provider to assume "that the outside date for submission of the listing of additional Medicaid eligible days was the Final Position Paper deadline;"[5]
- Operations of the Provider were disrupted by the COVID pandemic;
- The MAC failed to recognize the "practical impediments" that hindered its ability to obtain the Medicaid eligible days support.[6]
- The impediments preventing it from obtaining the necessary support are related to ". . . the State eligibility matching being unavailable . . . due to a change in the State's matching vendor changes."
- A listing of additional Medicaid eligible days for providers not impacted by the practical impediment was simultaneously forwarded to the MAC (with a redacted version posted to OH CDMS).[7]

The Provider concluded that because the sole defect in the MAC's Motion to Dismiss has been cured, the MAC was able to now generate a sample for which the Providers would submit support so the issue could be administratively resolved.

MAC's Motion to Dismiss

On December 28, 2022, in response to the Provider's jurisdictional responsive brief, the MAC filed a follow-up "Motion to Dismiss" for the previously challenged cases (*including Case No. 19-2780*).

The MAC's Motion responded to each element of the Provider's arguments regarding:

Board Rules in effect

- the MAC states the Rules are clear that providers must file complete PPPs, including exhibits. Final PPs became optional for appeals filed on or after August 29, 2018 (the effective date of Version 2.0.) Thus, the Providers' understanding and expectation that PPPs could be filed without fully

[5] Jurisdictional Response at 1 (Dec. 14, 2022)
[6] *The Provider cited Norwalk Hospital (Norwalk, Conn.) v. Blue Cross Blue Shield Association / National Government Services, PRRB Dec. No. 2012-D14 (March 9, 2012) (Medicare and Medicaid Guide (CCH) ¶82,791), rev'd CMS Administrator Decision May 21, 2012 (Medicare and Medicaid Guide (CCH) ¶ 82,809; and Danbury Hospital v. Blue Cross Blue Shield Association / National Government Services, PRRB Dec. No. 2014-D3 (February 11, 2014) (Medicare and Medicaid Guide (CCH) ¶ 82,898); CMS Alert 10 (May 23, 2014).*
[7] There is no listing uploaded in OH CDMS, other than the Exhibit to the Provider's final PP.

developed positions and exhibits is erroneous and without merit. The Providers failed to submit PPPs with fully developed positions, as required under both Versions 2.0 and 3.1 of the PRRB Rules. [8]

Disruption due to COVID

- the MAC notes there is nothing in the record to suggest the Providers were relying on Alert 19 (which was issued suspending Board deadlines from 3/13/2020 forward due to the pandemic) or otherwise prevented the Provider from responding due to COVID.

Practical Impediment Argument

- the MAC indicates that argument applies only in the context of whether there was a circumstance or barrier that prevented the Provider from identifying and/or verifying eligible days with the State, prior to filing its cost report.

Assertion regarding Cured Defect

- the MAC contends there is no regulatory or Board rule allowing for "curing a defect" to justify the Provider's failure to follow the Board's rules regarding PPP submissions or suggesting that the case can be resolved (because a listing has been provided to the MAC).

In summary, the MAC argued that it is not requesting the Board to deny jurisdiction but rather to dismiss the issue due to the Provider's failure to file PPPs in accordance with Board rules.[9]

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.

DSH Payment – Medicaid Eligible Days

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

[8] MAC's Request for Dismissal at 2 (Dec. 28, 2022).
[9] *Id.* at 3 (Dec. 28, 2022).

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*.[10]

Similarly, with regard to position papers,[11] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[12] 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 August 28, 2019 (more than 6.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[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 $53,262 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.

[10] (Emphasis added).
[11] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[12] (Emphasis added).
[13] Provider's PPP at 8 (April 22, 2020).

> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 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 both the November 14, 2022 Jurisdictional Challenge and the December 28, 2022 Motion to Dismiss, the MAC requested dismissal of the Medicaid eligible days issue because:

- the Medicaid Eligible days issue was abandoned when the Provider failed to provide a listing of additional Medicaid eligible days or any other support explaining why those documents could not be produced; and[14]
- the Provider was in violation of Board Rules 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim. The Provider also 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.

[14] The MAC notes that a list of additional Medicaid eligible days was not submitted with the PPP or under separate cover, despite the MAC having requested it twice (on 10/31/2019 & 9/8/2022). (MAC Juris Challenge Exhibit C-1)

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 documents, as required by the Board Rules.[15]

As noted, QRS included a redacted "Eligibility Listing" as an exhibit to its final position paper. The 25-page listing showed 3,081 "Additional ME Days."[16] The Listing does not, however, 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 such a late date as the filing ***was almost 6 years past the deadline for including it with the Provider's PPP*** for which the deadline was April 24, 2020.

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 provide any supporting documentation for those days).

The Board rejects the Provider's attempts to include the eligible days listing included *as an exhibit with its final position paper* because:

1. The upload was filed almost 6 ***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 3,081 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 more than 6.5 years after this appeal was filed and more than 9 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the September 27, 2019 ACDD notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege the final PP exhibit was a being filed as a supplement).

---

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

[16] Provider Final PP Exhibit P-1 (March 6, 2026)

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 the Final PP Exhibit as 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 listing submitted cannot be considered a refinement of the PPP paper since no specific days or listing were included with the PPP (indeed the *tentative* 3,081 days listed in the late exhibit is, without explanation, *significantly* larger than the original estimated 100 days included with the appeal request).[17]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[18] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the PPP filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

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.[19] 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.

****

Based on the foregoing, the Board is dismissing the last remaining issue in this case: "DSH Payment - Medicaid Eligible Days" - Issue 3. As no issues remain, the Board hereby closes Case No. 19-2780 and removes it from the Board's docket.

[17] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[18] (Emphasis added.)
[19] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

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:

5/13/2026

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Ronald Connelly
Powers, Pyles, Sutter & Verville, PC
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RE: ***Notice of Dismissal***

University of Michigan Hospitals & Health Centers (Provider Number 23-0046)
FYE: 6/30/2012
Case Number: 23-1320

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the record in this case and the Jurisdictional Challenge filed on **June 12, 2023**. The decision of the Board to ***dismiss*** the appeal is set forth below.

Procedural History:

University of Michigan Hospitals & Health Centers ("Provider") filed an individual appeal request with the Board on **April 17, 2023** from a Revised Notice of Program Reimbursement ("RNPR") dated **October 17, 2022**. The sole issue appealed is related to Incorrect DGME Managed Care Reduction. Specifically, the Provider is appealing:

> Whether the Medicare Administrative Contractor ("MAC") improperly reduced the Provider's direct graduate medical education ("DGME") managed care payment by using an inaccurate and overstated reduction percentage.[1]

The Provider claims its NPR was reopened to recalculate its DGME as required by the court's decision in *Milton S. Hershey Med. Ctr. v. Becerra* ("*Hershey v. Becerra*").[2] That case held that HHS' "application of the regulation to compute Plaintiffs' full-time equivalent residents was contrary to law because the regulation effectively changed the weighting factors statutorily assigned to residents and fellows."[3] The "Notice of Reopening"[4] submitted with the RNPR appeal is simply an e-mail from WPS Government Health Administrators, the Provider's

[1] Issue Statement: DGME Managed Care Payments.
[2] 2021 WL 1966572 (D.D.C.).
[3] *Id.* at *1.
[4] Board Rule 7.1.2.1 (2023) requires the reopening notice issued by the Medicare Contractor be included with a request for hearing when taken from an RNPR.

designated Medicare Contractor, dated September 28, 2022 which sent the Provider a set of proposed audit adjustments and a revised cost report. The RNPR itself does not indicate the reason for the reopening. The audit adjustments, however, indicate Part A and Part B adjustments described as follows:

> Other adjustment made based on the recalculation of the provider's graduate medical education (GME) full-time equivalent (FTE) cap when a provider's weighted FTE count is greater than its FTE cap. 42 C.F.R. § 413.79(c)(2)(iii).[5]

Even though Audit Adjustment documentation was submitted, the appeal request also includes a "1727 Statement" which argues:

> No audit adjustment or protest item is required because the Provider in this appeal challenges a Centers for Medicare & Medicaid Services ("CMS") payment policy that bound the Medicare Administrative Contractor ("MAC") and left it with no authority or discretion to make payment in the manner sought by the provider. CMS has issued Ruling 1727, which requires the Board to take jurisdiction over appeals challenging Medicare regulations, even if the Provider did not protest the issue on their cost reports.[6]

On **June 12, 2023**, the Medicare Contractor filed a Jurisdictional Challenge arguing that the appealed issue was not specifically adjusted in the RNPR and asking the Board to dismiss the appeal.[7]

Relevant Law:

A. DMGE Part C Payments

Payments for Direct Graduate Medical Education Costs are permitted by Section 1886(h) of the Social Security Act (codified at 42 U.S.C. § 1395ww(h)). While there are other potential factors, the payments are generally calculated by multiplying the "aggregate approved amount" by "the hospital's' Medicare patient load."[8] The "aggregate approved amount" is based on the approved full-time equivalent ("FTE") amount and the "per resident amount" ("PRA").[9] The PRA is calculated by dividing a hospital's allowable costs of GME for a base period by its number of residents in the base period.[10] The total FTE count has a weighting factor applied to each

[5] Appeal Request, Audit Adjustment 5.
[6] Appeal Request, 1727 Statement.
[7] Medicare Administrative Contractor Jurisdictional Challenge at 6 (Jun. 12, 2023).
[8] 42 U.S.C. § 1395ww(h)(3)(A)(i)-(ii); 42 C.F.R. § 413.76(b).
[9] 42 U.S.C. § 1395ww(h)(3)(B); 42 C.F.R. § 413.76(a).
[10] 42 C.F.R. § 413.77.

resident for the purposes of DGME calculation.[11] The "Medicare patient load" is "the fraction of the total number of inpatient-bed-days . . . which are attributable to patients with respect to whom payment may be made under part A."[12]

Hospitals receive an additional DGME payment for services furnished to certain patients enrolled in Part C plans ("DGME Part C Payment").[13] These payments are, however, reduced based on the total, nationwide additional payments made to hospitals for nursing and allied health education ("NAHE").[14] The Part C (Managed Care) NAHE payments are capped at $60 million in the aggregate for all hospitals nationwide for any given year.[15] The DGME Part C Payments are "reduced by a percentage equal to the ratio of the [Part C] nursing and allied health payment 'pool' for the current calendar year as described at § 413.87(f) [capped at $60 million], to the projected total [Part C] direct GME payments made to all hospitals for the current calendar year."[16] A hospital's DGME Part C Payment is reduced even if it does not actually receive an additional NAHE Payment.[17] This payment reduction amount is the item contested by the Provider in this case.

The Provider notes that at the inception of the NAHE payment and corresponding DGME reduction in 2000, CMS implemented a 10.5% reduction to the DGME Part C Payments.[18] The Secretary also indicated that a reduction percentage would be calculated each year and published in the final rule for the annual update to the hospital inpatient prospective payment system rates.[19] For 2001, the DGME Part C Payment reduction was announced in a CMS Transmittal and set at 14.13%.[20] No new DGME Part C Payment reductions were published until 2020 when reduction rates were published for CYs 2002 through 2018.[21] The DGME Part C Payment Reductions for CYs 2011 and 2012 (which encompass Provider's FYE 6/30/2012) were set at

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[11] 42 C.F.R. § 413.79.
[12] 42 U.S.C. § 1395ww(h)(3)(C).
[13] 42 U.S.C. § 1395ww(h)(3)(D).
[14] 42 U.S.C. § 1395ww(h)(3)(D)(iii); 42 C.F.R. § 413.76(d). The NAHE payments are governed by 42 U.S.C. § 1395ww(l) and 42 C.F.R. § 413.87.
[15] 42 U.S.C. § 1395ww(l)(2)(B)(i); 42 C.F.R. § 413.87(f)(3).
[16] 42 C.F.R. § 413.76(d).
[17] *See* CMS Transmittal A-03-043, Change Request 2692, 4-5 (May 23, 2003), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03043.pdf ("Transmittal A-03-043") ("[A]ll hospitals that receive Medicare+Choice direct GME payments (including those that do not receive additional nursing and allied health payments under the BIPA provision) will have these payments reduced by **14.13 percent**." (emphasis in original))
[18] Issue Statement: DGME Managed Care Payments (citing 65 Fed. Reg. 47026, 47039 (Aug. 1, 2000)).
[19] 65 Fed. Reg. at 47038.
[20] Transmittal A-03-043 at 4-5.
[21] CMS Transmittal 10520, Change Request 11642 (Dec. 14, 2020), *available at* https://www.cms.gov/files/document/r10520otn.pdf ("CMS last provided instructions to the Medicare Administrative Contractors (MACs) on May 23, 2003, in the form of Transmittal A-03-043, CR 2692, for the purpose of making the Calendar Year (CY) 2001 nursing and allied health Medicare+Choice payments. This CR provides MACs with instructions on how to compute and/or reconcile these payments for CYs 2002 through 2018, as applicable.").

7.85% and 7.16% , respectively.[22] Medicare Contractors were instructed to reopen settled cost reports within the 3-year reopening period and implement the updated percentages.[23]

B. Hershey v. Becerra and FTE Weighting Factors ("DGME Fellows Penalty Issue")

Two statutory provisions govern how FTEs are counted for DGME purposes: 42 U.S.C. § 1395ww(h)(4)(C) (which assigns different weighting factors to fellows and residents in their initial residency period ("IRP") and 42 U.S.C. § 1395ww(h)(4)(F) (which places a cap on the number of unweighted FTEs that a hospital can count in a given year). Hospitals have argued that, in effecting these provisions, CMS created a flawed formula (found at 42 C.F.R. § 413.79(c)(2)(iii)) which penalizes hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement.

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. § 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency program---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.00 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[24] ("IRP residents") are weighted at 100 percent or 1.00, while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "fellows") are weighted at 50 percent or 0.50. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[25] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For

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[22] *Id.* at unnumbered page 15.
[23] *Id.* at unnumbered page 13.
[24] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[25] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, §42 U.S.C. 1395ww(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[26]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three-year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[27] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> To address situations in which a hospital increases the number of FTE residents ***over*** the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • Determine the ratio of the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, to the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.

[26] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[27] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> ·Multiply the ratio determined above by the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[28]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[29] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> Step 1. Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). ***If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap,*** the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced ***in the***

[28] 62 Fed. Reg. at 46005 (emphasis added).
[29] 66 Fed. Reg. 39828 (Aug. 1, 2001).

> ***same proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[30]

To codify this change, the Secretary added clause (iii) to 42 § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[31] This regulation stated the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[32]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

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[30] *Id.* at 39894 (emphasis added).
[31] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that was in the prior version of the regulation and replacing it them with reference to "the limit described in this section."
[32] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility in that year.[33]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count based upon the present, prior and penultimate years' counts. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[34]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

In *Hershey v. Becerra*, however, the District Court for the District of Columbia held this formula for counting DGME FTEs violates the Medicare statute.[35] In 2022, CMS published the FY 2023 Final Rule which changed the method for calculating DGME payments following the court's ruling in *Hershey*.[36] The new method would be applied prospectively, as well as retroactively to certain providers, including those remanded in *Hershey v. Becerra*, including the Provider in this case.

C. RNPR Appeals

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2023), which provides in relevant part:

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

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[33] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[34] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[35] *Milton S. Hershey Med. Ctr. v. Becerra*, 2021 WL 1966572, *3 (D.D.C. 2021).
[36] 87 Fed. Reg. 48780, 49066-72 (Aug. 10, 2022).

Additionally, 42 C.F.R. § 405.1889 (2023)[37] explains the effect of a cost report revision:

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

These limitations are applicable to revised contractor determinations issued following a court remand order.[38]

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[39]

Positions of the Parties:

The Medicare Contactor's Jurisdictional Challenge can be summarized as follows:

> [T]he Provider is not challenging an adjustment related to the weighted FTE value, but rather is appealing the DGME Reduction percentage utilized by the MAC. As reflected in the Audit Adjustment Report for the October 17, 2022 RNPR, the MAC did not adjust the DGME Reduction percentage. Thus, that specific item was not adjusted within the final determination from which the Provider takes its appeal. Accordingly, the MAC contends that the Board lacks jurisdiction over the sole issue on appeal.[40]

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[37] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).
[38] 42 C.F.R. § 405.1877(g)(2)(iii)(A) ("If the contractor issues a revised contractor determination after remand, the provider may request a Board hearing on the revised determination (as described in §§ 405.1803(d) and 405.1889 of this subpart)").
[39] 42 C.F.R. § 405.1889(b)(1).
[40] Medicare Administrative Contractor's Jurisdictional Challenge at 5 (June 12, 2023).

The Jurisdictional Challenge also notes that the Medicare Contractor "did not issue a Notice of Reopening (NOR) because the 3-year reopening period had expired, and it was not necessary to implement the Court Order."[41]

The Provider filed a Response to the Jurisdictional Challenge on **July 12, 2023**. The Provider's original NPR was issued on **March 10, 2017**.[42] It filed an appeal from that NPR and later added the DGME Fellows Penalty Issue. The Provider joined Group Appeal Case No. 18-1241G which requested Expedited Judicial Review ("EJR"). The Board granted EJR in that case, which was ultimately decided in *Hershey v. Becerra*.[43] The court there opted to "remand to the agency so that it may recalculate Plaintiffs' reimbursement payments consistent with this Opinion."[44] The accompanying Order stated:

> The case is hereby REMANDED to Defendant, who shall, as promptly as practicable in a manner consistent with the Court's Opinion, recalculate Plaintiffs' DGME payments.[45]

The Provider argues that the Board should find that the Medicare Contractor "adjusted all aspects of the DGME payment, including the DGME MA payment and the DGME MA reduction."[46] It explains:

> A provider is entitled to DGME payments attributable to MA patient days, which are included on Worksheet E-4, line 26. The Provider's patient days, including MA patient days are then used to determine the Total Direct Program Amount on line 25. Provider Reimbursement Manual ("PRM"), ch. 40, § 4034. Prior to the RNPR, line 25 was $65,726,973. Exhibit P-2. The MAC's RNPR revised this amount to $76,449,240. Exhibit P-4. The MAC therefore revised the DGME MA payment. Furthermore, the MAC revised the DGME MA payment reduction, which is stated on Worksheet E-4, line 30. Prior to the RNPR, the Provider's line 30 was $580,470. Exhibit P-2. When issuing the RNPR, the MAC revised the MA reduction on line 30 to $675,164.[47]

Though the DGME payments were revised, the Medicare Contractor used the 14.13% DGME Part C Payment Reduction percentage, instead of those published in CMS Transmittal 10520.[48]

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[41] *Id.* at 4, n.5.
[42] *See* Provider's Opposition/Response to MAC's Jurisdictional Challenge at 8 (July 12, 2023).
[43] Provider's Opposition/Response to MAC's Jurisdictional Challenge at 8-9.
[44] *Hershey v. Becerra* at *1.
[45] Provider's Opposition/Response to MAC's Jurisdictional Challenge, Ex. P-1.
[46] *Id.* at 11-12.
[47] *Id.* at 12.
[48] Change Request 11642 (Dec. 14, 2020).

Decision of the Board:

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[49] The court in *Hershey v. Becerra* remanded the Provider's appeal to, "in a manner consistent with the Court's Opinion, recalculate Plaintiffs' DGME payments."[50] The court's opinion was related to the DGME Fellows Penalty Issue, and the audit adjustment reflects that the revision made was specific to this issue.[51] It was not related to the DGME Part C Payment Reduction issue.

Though the cost report was reopened and there were, in fact, updated DGME Part C Payment Reduction factors available, those were implemented via CMS Transmittal 10520. That Transmittal **only** applied to open cost reports and those which had been settled less than 3 three years (i.e., were within 3 years of settlement).[52] Indeed, the Transmittal states clearly "MACs shall not make recalculations or reconciliations for N&AH MA or DGME MA payments for cost report that are already beyond the 3-year reopening period as of the issuance date of this Transmittal." In this case, the Provider's original NPR was issued on **March 10, 2017**, so the cost report was not open when the Transmittal was implemented on **December 21, 2020**. When the Transmittal was implemented, it was past the three-year reopening window for the original NPR, which would have ended **March 9, 2020**.

The Provider's reliance on CMS Ruling 1727-R (which was argued within the original appeal request but not addressed in the jurisdictional response) is also misplaced. The Ruling deals with appeals from **original** NPRs[53] and the self-disallowance policy in filing a cost report.[54] It does not mention revised NPRs, which are governed by specific, limiting regulations at 42 C.F.R. § 405.1889 and are issued long after the cost report is filed.

Conclusion:

The court order remanding Provider's case specifically required a recalculation based on the DGME Fellows Penalty Issue. The RNPR in this case was issued to implement a revision specific to that issue. The audit adjustment accompanying the RNPR shows the adjustment was related to that issue. The sole issue in this appeal, however, relates to a different DGME Part C Payment Reduction issue. It may be true that the DGME Part C Payment Reduction *amount*

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[49] 42 C.F.R. § 405.1889(b)(1).
[50] Provider's Opposition/Response to MAC's Jurisdictional Challenge, Ex. P-1.
[51] Audit Adjustment 5.
[52] CMS Transmittal 10520 at F (unnumbered page 8 of 14).
[53] CMS Ruling 1727-R at 2 (unnumbered page 3 of 10) (Apr. 23, 2018) ("Upon receipt of a provider's cost report, the contractor reviews or audits the cost report, makes any necessary adjustments to the provider's Medicare reimbursement for the cost reporting period, and issues a notice of program reimbursement (NPR) stating the contractor's final determination of the total amount of payment due the provider. The NPR can be appealed, and the contractor determination is final and binding unless it is revised on appeal or reopening.") (*available at* https://www.cms.gov/regulations-and-guidance/guidance/rulings/downloads/cms-1727-r.pdf.)
[54] *Id.* at 3 (unnumbered pages 3-4).

changed following the DGME Fellows Penalty Issue revisions, this was incidental and did not change or specifically adjust the actual DGME Part C Payment Reduction *percentage* (which is the basis for the appeal). Since appeals from RNPRs are limited in scope to those issues specifically adjusted, the Board finds it is appropriate to ***dismiss*** the DGME Part C Payment Reduction issue. Since this is the only issue in the appeal, the Board hereby closes the case and removes it from its docket.

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

Board Members:

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

For the Board:

5/13/2026

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-8)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Mr. James Ravindran
President
Quality Reimbursement Services
150 N. Santa Anita Avenue
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Arcadia, CA 91006

RE: **Determination re: Filing Requirements**
Putnam Hospital Center (33-0273)
Appealed Period: FYE 09/30/2022
PRRB Case No.: 26-2466

Dear Mr. Ravindran:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On May 8, 2026, Quality Reimbursement Services filed, on behalf of the above-captioned Provider, the above referenced appeal request based on a Notice of Program Reimbursement ("NPR") dated 11/19/2025. The appeal request identified seven (7) issues in dispute:

Improper Rulemaking-Medicaid Fraction Dual Eligible Days
Improper Rulemaking-SSI Medicare Fraction Dual Eligible Days
Medicaid Eligible Days
SSI MCD PT C
SSI-Provider Specific
Standardized Payment Amount
Unduly Narrow Definition of SSI Entitlement

The Board notes that the final determination date entered into OH CDMS was stated as 11/19/2025. However, the support document uploaded for the final determination is another copy of the Appointment of Designated Representative letter and not a copy of the NPR.

After review, a copy of the final determination dated 11/19/2025 could not be located in the case record to which the Provider indicates the appeal is based.

RULES/REGULATIONS:

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

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

Board Rule 4.1 General Requirements

See 42 C.F.R. §§ 405.1835 - 405.1840.

> **The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements.** A jurisdictional challenge (see Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements.

Board Rule 6.1 Initial Filing

> 6.1.1 **Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. **The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.**

Board Rule 7.1 Final Determination

> 7.1.1. **General Requirements**

Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination.

> Example: Provider has a 6/30 FYE and is appealing a Federal Register notice applicable to 9/30/18. The impacted cost reporting periods would be FYE 6/30/18 (based on the portion of the FFY from 10/1/17 through 6/30/18) and FYE 6/30/19 (based on the remainder of the FFY from 7/1/18 through 9/30/18).

> **Include a copy of the final determination, such as the NPR, revised NPR**, exception determination letter, Federal Register notice, or quality reporting payment reduction

decision. Note that preliminary determinations are not appealable. (See Rule 7.5 for appeals based on the lack of a timely issued determination.)

Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.

BOARD DETERMINATION:

The above captioned appeal, as filed, is jurisdictionally deficient and does not meet the regulatory requirements for filing since the Provider failed to submit the ***correct final determination,*** dated November 19, 2025, on which the appeal is based. The Board requires the final determination on which the appeal is based in order to determine whether the appeal is jurisdictionally valid.

The Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. §§ 405.1835 - 405.1840 and the Board Rules cited above. As a result, the Board hereby dismisses case number 26-2466, in its entirety, and removes it from its docket.

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

Board Members:

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

FOR THE BOARD:

5/15/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

Cc: Wilson C. Leong, Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Expedited Judicial Review Determination***
Case Numbers: 24-2001G *et al.* (8 Cases - *see* **Appendix A**)
Toyon Associates Rural Floor Wage Index Groups

Dear Ms. Ellis:

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

Issue:

The Board received requests to establish these eight (8) Common Issue Related Party ("CIRP") and optional groups from Toyon Associates, Inc. between **June 24, 2024** and **June 11, 2025**. The participants in these groups are all appealing from the original Notices of Program Reimbursement ("NPRs") with regard to the calculation of the rural floor for their fiscal years ending ("FYEs") in calendar years ("CYs") 2019 through 2021. Specifically, the Providers argue that, for the FYEs at issue, CMS unlawfully excluded reclassified rural hospitals from the data used to calculate the rural wage index and the rural floor.[1] On **April 27, 2026**, the Providers filed a Consolidated[2] Petition for Expedited Judicial Review over this issue.

Statutory and Regulatory Background:

1. Wage Index; Rural and Urban Classification

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

[1] Consolidated Petition for Expedited Judicial Review at 2-3 (Apr. 27, 2026).
[2] The Consolidated Request for EJR included nine (9) additional cases which will be addressed under separate cover.
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

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]

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

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

[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).

[6] of the Department of Health and Human Services.

[7] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/wage-index (last visited May 19, 2026).

[8] *Id.*

[9] *Robert Wood Johnson University Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).

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

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

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

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

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and 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]

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

2. Rural Floor Adjustment

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

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

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

3. Changes to the Wage Index Calculation

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

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

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

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

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

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

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

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

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

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

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

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

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

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[27] *Id*.
[28] *Id*.
[29] *Id*.
[30] *Id.*
[31] *Id*.
[32] *Id*.
[33] *Id.*
[34] 85 Fed. Reg. 58432, 58766 (Sept. 18, 2020).
[35] 86 Fed. Reg. 44774, 45175 (Aug. 13, 2021).
[36] 84 Fed. Reg. 61142, 61187-61188 (Nov. 12, 2019) (stating "as proposed, we are using the FY 2020 hospital IPPS post-reclassified wage index for urban and rural areas as the wage index under the OPPS to determine the wage adjustments for both the OPPS payment rate and the copayment standardized amount for CY 2020.").
[37] 85 Fed. Reg. 85866, 85916-17 (Dec. 29, 2020) (stating "We also are continuing to apply for the CY 2021 OPPS wage index any other adjustments for the FY 2021 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").
[38] 86 Fed. Reg. 63458, 63511 (Nov. 16, 2021) (stating "We are continuing to apply for the CY 2022 OPPS wage index any adjustments for the FY 2022 IPPS post-reclassified wage index, including, but not limited to, the rural floor adjustment . . . .").

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

Positions of the Parties:

1. Providers' Appeal Requests

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

> The Providers in this group appeal challenge the calculation of their wage index values for the reporting periods under appeal. CMS ignored a clear congressional directive that if followed have resulted in higher wage index adjustments for the Providers. The agency's error had the effect of diluting the payments the Providers received under the inpatient and outpatient prospective payment systems ("IPPS" and "OPPS") and the capital prospective payment system ("capital PPS") during the cost reporting periods under appeal.
>
> The Medicare statute says that if a hospital located in an urban area elects to reclassify as rural, CMS 'shall treat the hospital as being located in the rural area…of the State in which the hospital is located' for all purposes of the IPPS and OPPS. 42 U.S.C. §§ 1395ww(8)(d)(E); 1395*l*(t)(16)(A). This includes the annual wage index calculation required by 42 U.S.C. § 1395ww(d)(3)(E).
>
> CMS ignored this clear instruction in calculating the wage index values in the federal fiscal years for the reporting periods overlapping with this appeal. First, CMS failed to treat reclassified rural hospitals the same as geographically rural hospitals (i.e., hospitals actually located in rural areas) in calculating the rural wage index [by excluding reclassified rural hospitals.]
>
> * * *
>
> Second, CMS again failed to treat reclassified rural hospitals the same as geographically rural hospitals when it excluded the wage data of reclassified rural hospitals from the calculation of the rural floor under section 4410 of the Balanced Budget Act of 1997 and the 'the wage index for rural areas in the State in which the county is located' under 42 U.S.C. § 1395ww(d)(8)(C)(iii) (collectively, the "rural floors") for FFYs 2020 through 2022. *See Citrus HMA, LLC, d/b/a Seven Rivers Regional Medical Center v. Becerra*, 597 F. Suipp.3d 450 (D.D.C. 2022) (finding that the statute required that the rural wage index and rural floor be one and the same). In FYs 2020 through 2022, the *rural wage index* included

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

> both geographically rural hospitals and reclassified rural hospitals, but the *rural floor* included only geographically rural hospitals.[40]

2. Providers' Request for EJR

The Consolidated Petition for EJR describes the issue as follows:

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

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

3. Medicare Contractor's Position

On **May 4, 2026**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a timely response to the Consolidated Requests for Expedited Judicial Review. It took no position on the Request for EJR, but noted that it ***had already filed*** Substantive Claim Challenges in the following cases:

- 24-2001G
- 24-2002G
- 24-2102GC

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[40] *E.g.,* Case No. 24-2001G, Issue Statement at 1 (June 24, 2024).
[41] Consolidated Petition for Expedited Judicial Review at 1 (Apr. 27, 2026).
[42] *Id.* at 2.
[43] *Id.* (citing 88 Fed. Reg. 58640, 58972 (Aug. 28, 2023)).
[44] *Id.* at 3.
[45] *Id.* at 3-7.

- 24-2251GC
- 24-2297GC
- 24-2566G
- 24-2799GC

The Response also indicated that FSS ***would be filing*** a Substantive Claim and/or Jurisdictional Challenge in the following cases:

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

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

On **May 5, 2026**, FSS filed a second, ***untimely*** Revised Response to the Consolidated Request for EJR. This response was also identical to the two previous responses except that it indicated FSS would be filing a Substantive Claim Challenge in Case 25-4702GC. The group in Case 25-4702GC was fully formed and the participants were fully populated in OH CDMS as of **April 27, 2026**, and the EJR Request was received the same day. Since the EJR Request was filed less than sixty (60) days prior to the final schedule of providers in this case being certified,[46] Board Rule 44.6 (Dec. 2023) applies to Substantive Claim challenges. It reads:

> If the final schedule of providers for a group appeal is filed concurrently with an EJR request, or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then the Medicare contractor (or any other moving party) 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).

[46] Board Rule 20 allows the Provider Representative to file a certification in lieu of a hard copy Final Schedule of Providers if "***all*** the participants in a fully-formed group are ***populated*** . . . in OH CDMS . . . ."

Since the EJR Request was filed on **Monday, April 27**, any certification that a Substantive Claim Challenge was forthcoming would be due no later than close of business **Monday, May 4**. The certification for Case 25-4702GC was not filed until **Tuesday, May 5**, with no mention of good cause for the delay. Since the certification was untimely, the Board declines to consider any challenges filed in Case 25-4702GC and will proceed to rule on the Request for EJR.

Decision of the Board:

1. Jurisdiction and Request for EJR

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

With regard to jurisdiction, the Board finds that all the Providers in these groups made timely appeals from their original NPRs and were directly added or transferred to the groups. The total amounts in controversy, as listed on the Schedules of Providers, meet the $50,000 threshold for a group appeal in each case.[47] The Providers have filed Preliminary Position Papers, which elaborate on the calculation used to determine the amounts in controversy:

> Exhibit P-2 shows by example the effect of CMS's policies on the calculation of the rural wage index and rural floor for California in FFY 2020. That year, Calculation 3 produced the highest AHW ($58.40) for purposes of calculating California's rural wage index. After dividing that number by the national AHW and multiplying it by the rural floor budget neutrality adjustment, the California rural wage index for FFY 2020 was 1.3189. The rural floor calculation was deflated even further because reclassified rural hospitals were categorically excluded from Calculation 3. This meant that the rural floor was instead calculated based on Calculation 1 ($55.99), which produced a rural floor of 1.2645. Had CMS treated reclassified rural hospitals exactly the same as geographically rural hospitals for wage index purposes in FFY 2020, the highest AHW in California would have been Calculation 1 ($64.82), which would have yielded a rural wage index and rural floor of 1.4593.[48]

The Board also finds that its review of the matter in these appeals is not precluded by statute or regulation. 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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[47] *See* 42 C.F.R. § 405.1837.
[48] *E.g.*, Case No. 24-2001G, Providers' Preliminary Position Paper at 10 (Aug. 21, 2025).

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[49] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[50] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). All of the participants in these cases have fiscal years that began on or after January 1, 2016, so the claim-specific dissatisfaction requirement is not applicable to the Board's analysis regarding **jurisdiction**. The Board must, however, prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

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

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

[49] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[50] *Id.* at 70555.

> authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[51]

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-*
>
> ***

[51] (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**.[52]

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

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

As previously noted, Substantive Claim Challenges were filed in seven (7) of the eight (8) cases noted in **Appendix A**, and these are discussed below. The Providers encompassed in these seven (7) challenges will be collectively referred to as "the Challenged Providers."

[52] (Bold and underline emphasis added.)

i. Case 24-2001G

FSS filed a Substantive Claim Challenge on **October 13, 2025**. The challenge argues that none of the Providers in this group made an appropriate claim on their cost reports for the issue being appealed. While some Providers did file their cost reports with items under protest, none of them included the issue under appeal. Indeed, the Providers' Representative acknowledged that "none of the providers in this group included the issue in their protested items."[53]

ii. Case 24-2002G

FSS filed a Substantive Claim Challenge on **October 9, 2025**. The challenge argues that seven of the Providers in this group did not make an appropriate claim on their cost reports for the issue being appealed:

Prov No.	**Provider Name**	**FYE**
05-0039	Enloe Medical Center	06/30/2020
05-0292	Riverside University Health System – Medical Center	06/30/2020
05-0067	Oak Valley Hospital District	06/30/2020
03-0006	Tucson Medical Center	12/31/2020
05-0030	Oroville Hospital	11/30/2020
33-0241	University Hospital SUNY Health Science Center	12/31/2020
45-0869	Doctors Hospital at Renaissance	12/31/2020

None of the audit adjustments cited by these Providers were related to the rural floor wage index calculation. Additionally, while all these Providers did file their cost reports with items under protest, none of them included the issue under appeal except for Provider 45-0869. This Provider did list the issue as a protested issue, but the amount listed was $0. Indeed, the Providers' Representative acknowledged that none of the providers in this group included the issue in their protested items.[54]

iii. Case 24-2102GC

FSS filed a Substantive Claim Challenge on **November 4, 2025**. The challenge argues that MemorialCare Orange Coast Medical Center (Prov. No. 05-0678, FYE 6/30/2020) failed to make an appropriate claim on its cost report for the issue being appealed. None of the audit

[53] Medicare Administrative Contractor's Substantive Claim Challenge at 5-6 and Ex. C-3 (Oct. 13, 2025).
[54] Medicare Administrative Contractor's Substantive Claim Challenge at 5-6 and Ex. C-3 (Oct. 9, 2025).

adjustments cited by this Provider were related to the rural floor wage index calculation. While this Provider did file its cost report with items under protest, none of them included the issue under appeal. Indeed, the Providers' Representative acknowledged that "[t]here was not a protest item for the Rural Floor Wage Index issue for this provider."[55]

iv. Case 24-2251GC

FSS filed a Substantive Claim Challenge on **December 2, 2025**. The challenge argues that none of the Providers in this group made an appropriate claim on their cost reports for the issue being appealed. None of the audit adjustments cited by these Providers were related to the rural floor wage index calculation. While two Providers did file their cost reports with items under protest, neither of them included the issue under appeal.[56]

v. Case 24-2297GC

FSS filed a Substantive Claim Challenge on **December 3, 2025**. The challenge argues that none of the Providers in this group made an appropriate claim on their cost reports for the issue being appealed. None of the audit adjustments cited by these Providers were related to the rural floor wage index calculation. While the Providers filed their cost reports with items under protest, none of them included the issue under appeal.[57]

vi. Case 24-2566G

FSS filed a Substantive Claim Challenge on **December 18, 2025**. The challenge argues that none of the Providers in this group made an appropriate claim on their cost reports for the issue being appealed. None of the audit adjustments cited by these Providers were related to the rural floor wage index calculation. While some of the Providers filed their cost reports with items under protest, none of them included the issue under appeal.[58]

vii. Case 24-2799GC

FSS filed a Substantive Claim Challenge on **January 21, 2026**. The challenge argues that none of the Providers in this group made an appropriate claim on their cost reports for the issue being appealed. None of the audit adjustments cited by these Providers were related to the rural floor wage index calculation. While some of the Providers filed their cost reports with items under protest, none of them included the issue under appeal. Indeed, the Providers' Representative acknowledged that "the Provider did not include a protested item for Rural Floor Wage Index calculation."[59]

[55] Medicare Administrative Contractor's Substantive Claim Challenge at 4 and Ex. C-2 (Nov. 4, 2025).
[56] Medicare Administrative Contractor's Substantive Claim Challenge at 4-6 (Dec. 2, 2025).
[57] Medicare Administrative Contractor's Substantive Claim Challenge at 4-8 (Dec. 3, 2025).
[58] Medicare Administrative Contractor's Substantive Claim Challenge at 4-9 (Dec. 18, 2025).
[59] Medicare Administrative Contractor's Substantive Claim Challenge at 4-5 and Ex. C-3 (Jan. 21, 2026).

viii. Non-Challenged Participants

For all remaining participants in these cases (collectively "the Non-Challenged Participants"), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[60] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the Non-Challenged Participants.

ix. Providers' Responses

The Providers filed timely, materially identical responses to all the Substantive Claim Challenges outlined above. The Providers do not dispute that they failed to include an appropriate cost report claim for the issue under appeal. Instead, they argue that the regulations requiring an appropriate cost report claim are unlawful and unenforceable. They cite *Bethesda Hosp. Ass'n v. Bowen*[61] and *Banner Heart Hospital v. Burwell*[62] in support of their position that these regulations are unlawful.[63]

x. 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))"[64] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

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

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

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[60] 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."
[61] 485 U.S. 399 (1988).
[62] 201 F.Supp.3d 131 (D.D.C. 2016)
[63] *E.g.*, Case No. 24-2001G, Response to MAC's Substantive Claim Challenge at 4-6 (Nov. 10, 2025).
[64] (Emphasis added.)

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). . . ."[65] was made through notice and comment in the form of an uncodified regulation.[66]

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.[67]

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.[68]

As noted *supra*, CMS has continued the application of the FY 2020 IPPS Final Rule's policy in the FY 2021[69] and FY 2022[70] IPPS Final Rules. CMS has also adopted the FY 2020 IPPS Final

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[65] 84 Fed. Reg. 42044 at 42336.
[66] *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."
[67] 84 Fed. Reg. at 42336.
[68] 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 . . . ."
[69] 85 Fed. Reg. 58432, 58766 (Sept. 18, 2020).
[70] 86 Fed. Reg. 44774, 45175 (Aug. 13, 2021).

Rule's policy in its OPPS Final Rules for FYs 2020,[71] 2021,[72] and 2022. [73] The continued application of this policy means that, for FFYs 2020-2022, CMS will calculate the rural floor in a state without reference to the wage index that applies for any hospitals in that state which were reclassified as rural pursuant to Section 401 for both IPPS and OPPS. The Prospective Payment System for inpatient hospital capital costs is also calculated using the hospital wage index values applicable to the hospital under IPPS.[74]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 IPPS Final Rule (and as continued for FYs 2021 and 2022) and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulations on Rural Floor Calculation and Wage Index which they allege (1) does not treat reclassified "Section 401" hospitals as being located in a rural are as required by 42 U.S.C. § 1395ww(d)(8)(E), and (2) permits the assignment of a wage index to urban hospitals that is lower than the wage index assigned to rural hospitals in the same state in violation of 42 U.S.C. § 1395ww (note).[75] As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in the eight (8) cases listed in **Appendix A**.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the Uncodified Regulations on Rural Floor Calculation and Wage Index Issue for the subject years in the eight (8) cases listed in **Appendix A** and that the Providers in the group appeals are entitled to a hearing before the Board;

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

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

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

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

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

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

6) It is without the authority to decide the legal question of whether the codified Regulations on Rural Floor Calculation and Wage Index published in the FFY 2020 IPPS Final Rule (and carried forward into FFY 2021 and 2022) are valid.

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the eight (8) 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:

5/19/2026

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Paul Zarling, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Scott Berends, Esq., Federal Specialized Services

Appendix A

Case Number	**Case Name**
24-2001G	*Toyon Associates CY 2019 Rural Floor Wage Index Group*
24-2002G	*Toyon Associates CY 2020 Rural Floor Wage Index Group*
24-2102GC	*MemorialCare CY 2020 CA Rural Floor Wage Index CIRP Group*
24-2251GC	*Surgery Partners CY 2020 Rural Floor Wage Index CIRP Group*
24-2297GC	*Cleveland Clinic Fdn. CY 2020 Rural Floor Wage Index CIRP Group*
24-2566G	*Toyon Associates CY 2021 Rural Floor Wage Index Group*
24-2799GC	*Emanate Health CY 2020 Rural Floor Wage Index CIRP Group*
25-4702GC	*Surgery Partners CY 2021 Rural Floor Wage Index CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Mr. Jacob Harris
Partner
Husch Blackwell, LLP
2309 West Lawn Avenue
Madison, WI 53711

RE: **Determination re: Filing Requirements**
Sequoia Hospice East Bay (B2-1761)
Appealed Period: FFY 2026
PRRB Case No.: 26-2490

Dear Mr. Harris:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") via the Office of Hearings Case and Document Management System ("OH CDMS"). After review of the facts outlined below, the Board has determined that the appeal request was not filed in accordance with the Board Rules and regulations. The Board's review and determination is set forth below.

BACKGROUND:

On May 11, 2026, on behalf of the subject Provider, Husch Blackwell, LLP filed the above referenced appeal request based on the final decision regarding the reconsideration request for the Quality Reporting Program ("QRP"). The appeal request identified a sole issue in dispute:

Quality Reporting Program Payment Reduction

The final determination date was entered into OH CDMS as 11/12/2025. However, the Board notes that the support document uploaded for the final determination is a copy of the initial non-compliance notice issued by the Centers for Medicare and Medicaid Services ("CMS"). A copy of the final determination dated 11/12/2025, to which the Provider indicates the appeal is based, could not be found in the filed case record.

RULES/REGULATIONS:

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

> A copy of the determination, including any other documentary

evidence the provider considers necessary to satisfy the hearing request requirements.

Board Rule 4.1 General Requirements

See 42 C.F.R. §§ 405.1835 - 405.1840.

The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements. A jurisdictional challenge (see Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements.

Board Rule 6.1 Initial Filing

6.1.1 **Request and Supporting Documentation** To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. **The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.**

Board Rule 7.1 Final Determination

7.1.1. **General Requirements**

Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and
ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination.

Example: Provider has a 6/30 FYE and is appealing a Federal Register notice applicable to 9/30/18. The impacted cost reporting periods would be FYE 6/30/18 (based on the portion of the FFY from 10/1/17 through 6/30/18) and FYE 6/30/19 (based on the remainder of the FFY from 7/1/18 through 9/30/18).

Include a copy of the final determination, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or quality reporting payment reduction decision. **Note that preliminary determinations are not appealable.** (See Rule 7.5 for appeals based on the lack of a timely issued determination.)

Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.

***

Board Rule 7.1.2.4 Quality Reporting Payment Reduction Decision

Identify the type of quality reporting payment program. Also provide the original decision from CMS in which the payment reduction was identified (preliminary decision) and the **final reconsideration decision** on which the appeal is based.

BOARD DECISION:

The Board has determined that the appeal, as filed, is deficient and does not meet the regulatory requirements for filing since the Provider failed to submit the ***correct final determination*** (the Quality Reporting Program final decision dated 11/12/2025) on which the appeal is based. The Board notes that the document uploaded as the final determination is the preliminary non-compliance notification from the MAC advising the Provider of its right to request reconsideration of the non-compliance notification. The MAC's letter states, "If you have any questions regarding the reconsideration process, please email the following CMS address: HospiceQRPReconsiderations@cms.hhs.gov." The Board requires the final determination on which the appeal is based in order to determine whether the appeal is jurisdictionally valid.

The Board has determined that the Provider failed to meet the minimum filing requirements as set forth in 42 C.F.R. §§ 405.1835 - 405.1840 and the Board Rules cited above. As a result, the Board hereby dismisses case number 26-2490, in its entirety, and removes it from its docket.

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

Board Members:

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

FOR THE BOARD:

5/21/2026

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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***

Case Number: 25-3480GC - Memorial Hermann CY 2008 DSH Medicare Part C CIRP Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on **May 1, 2026** in the above-referenced group appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received a request to establish a Common Issue Related Party group on **March 3, 2025**. The group contains providers appealing from revised Notices of Program Reimbursement ("RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Years Ended ("FYEs") in 2008.

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] Statement of Group Issue (Mar. 3, 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]

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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 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.[51]

The "Statement of Group Issue" included with the appeal requests state that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[52] The Providers contend that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

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

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[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] 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' 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.[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 [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] Appeal Request, Statement of Issue at 1 (citing to 139 S. Ct. at 1816).
[55] *Id.* (citing 4 U.S.C. § 706(2)).
[56] Providers' Petition for Expedited Judicial Review at 13 (May 1, 2026).
[57] *Id.* at 16.
[58] *Id.* at 1-2.
[59] 42 C.F.R. § 405.1867.

The Medicare Contractor's representative, Federal Specialized Services, filed a timely response to the Request for EJR on **May 8, 2026** simply advising that it "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 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 this group, 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 of the providers were directly added to the group within 180 days of the issuance of their RNPRs and the amount in controversy exceeds $50,000.

The Board finds that the Providers in Case 25-3480GC have all filed timely appeals from their revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

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[60] Response to Provider's Request for Expedited Judicial Review at 1 (May 8, 2026).
[61] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[62] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject year in Case 25-3480GC and that the Providers are entitled to a hearing before the Board;

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

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

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

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.

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 group case, the Board hereby closes Case No. 25-3480GC 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:

5/27/2026

X Kevin D. Smith, CPA

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

Enclosure: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
San Angelo Community Medical Center (Prov. No. 45-0340), FYE 08/31/2019
Case No. 23-0034

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0034. Set forth below is the decision of the Board to dismiss the two remaining issues in this appeal: the SSI Provider Specific and Medicaid Eligible Days issues.

Background

A. *Procedural History for Case No. 23-0034*

On **April 18, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2019.

On **October 6, 2022**, Community Health Services ("CHS") filed the Provider's individual appeal request. The Appeal Request included five (5) issues:

1. SSI (Provider Specific)
2. SSI Systemic Errors[1]
3. Medicaid Eligible Days
4. Medicare Managed Care Part C Days -SSI & Medicaid Fractions[2]
5. Dual Eligible Days – SSI & Medicaid Fractions[3]

[1] On May 30,2023, this issue was transferred to CIRP Group 22-1031GC.
[2] On May 30,2023, this issue was transferred to CIRP Group 23-0078GC.
[3] On May 18, 2023, CHS requested the bifurcation of the Dual Eligible Days issue into separate issues for the SSI Fraction and Medicaid Fraction. Prior to the Board rendering a determination on the bifurcation, on May 30, 2023, CHS transferred the Dual Eligible Days – SSI & Medicaid Fractions issue to CIRP Group 23-0080GC. On June 14, 2023, the Board denied the requested bifurcation, in part because by transferring the combined fraction issue to the SSI Fraction Dual Eligible Days CIRP group issue, CHS abandoned the Medicaid Fraction aspect of the Dual Eligible issue.

On **October 13, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (*hereinafter* "PPP").[4] This Notice also gave the following instructions to the Provider regarding the content of its PPP:

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

On May 30, 2023, CHS transferred Issues 2, 4 and 5 to common issue related party ("CIRP") groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there are two (2) remaining issues in this appeal: Issue 1: SSI Provider Specific and Issue 3: Medicaid Eligible Days.

On **June 5, 2023**, CHS filed the Provider's PPP. On **September 22, 2023**, the MAC filed its PPP.

On **December 8, 2025**, the Board issued a Notice of Hearing scheduling the case for a June 11, 2026 hearing.

On **February 27, 2026**, CHS requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS"). The Board acknowledged the change of representative on March 2, 2026.

On **April 8, 2026**, the MAC filed a Jurisdictional Challenge over the SSI Provider Specific and DSH Medicaid Eligible Days issues, including Section 1115 Waiver Days.

On **April 9, 2026**, the MAC filed its final PP.[6]

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-1031GC - CHS CY 2019 DSH SSI Percentage CIRP Group

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

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[4] On March 16, 2023, a Critical Due Dates notice with new deadlines was issued.
[5] Board Rules v. 3.1 (Nov. 2021). (Emphasis added.)
[6] Based on the appeal filing date, a final PP filing is optional. The Provider did not file a final PP.

> 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 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.[7]

The Group issue Statement in Case No. 22-1031GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon

[7] Issue Statement at 1 (Oct. 6, 2022).

covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[8]

On June 5, 2023, the Board received the Provider's PPP in Case No. 23-0034. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

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

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the

[8] Group Appeal Issue Statement in Case No. 22-1031GC.

> 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). [9]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $22,041.

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

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

> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 4, 21, 23, S-D
>
> Estimated Reimbursement Amount: $27,454

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

The Provider goes on to state:

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[9] Provider's PPP at 8-9 (June 5, 2023).
[10] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[11] Provider's PPP at 10 (June 5, 2023).

> Under section 1886(d)(5)(F)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(F)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible days (including section 1115 waiver days, which are paid under waiver authority of section 1115 of the Social Security Act and regarded as and treated as Medicaid eligible days] are to be included in the numerator of the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Administrative Contractor (MAC) included in the Provider's [or Providers'] Medicaid Fraction of the disproportionate patient percentage all Medicaid eligible days (including section 1115 waiver days).[12]

MAC's Contentions - Issue 1 –SSI Provider Specific

In its jurisdictional challenge, the MAC argues that the Board lacks jurisdiction over the SSI Provider Specific issue, which has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2 which was transferred to a CIRP group (Case No. 22-1031GC). The component related to SSI realignment should be considered abandoned because the Provider did not brief it in the PPP. Alternatively, the Board should find that it lacks jurisdiction over the realignment portion of the issue because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[13]

MAC's Contentions - Issue 3 – Medicaid Eligible/Section 1115 Waiver Days

In its Jurisdictional Challenge, the MAC advised that the Provider failed to include a list of additional Medicaid eligible days it expected to be included (even though the Provider's PPP included a statement indicating a listing of additional Medicaid eligible days would be sent under separate cover.)[14]

In addition, the MAC challenged jurisdiction over the Section 1115 Waiver Days issue, arguing that the Provider attempted to untimely and improperly add the issue in its PPP filed on June 5, 2023, which was beyond the due date to add issues to the case based on the NPR date of April 18, 2022.[15]

The MAC also asserted that the Section 1115 waiver days is one component of the DSH issue that must be appealed as a separate issue. The MAC referenced Board Rule 8 which explains that

[12] Provider's PPP at 9-10 (June 5, 2023).
[13] MAC's Jurisdictional Challenge at 2 (April 8, 2026).
[14] MAC's Jurisdictional Challenge at 10. (April 8, 2026)
[15] MAC's jurisdictional challenge at 14 (April 8, 2026).

one issue can have multiple components. Within Board Rule 8, some of the disproportionate share hospital (DSH) components are identified. Specifically, the Board identifies Section 1115 waiver days as a distinct DSH component that the Provider must appeal separately. [16]

Finally, the MAC contends that the Provider has failed to file a complete PPP in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25."[17]

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.[18] The Provider failed to file a timely 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."

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 SSI Provider Specific and Medicaid Eligible Days issues.

A. SSI Provider Specific

The Provider's main argument regarding Issue No. 1 concerns its disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage. This issue appears to be duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 22-1031GC.

The SSI 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."[19] Per the appeal request, the Provider's legal basis for its DSH SSI Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the

[16] MAC's jurisdictional challenge at 15 (April 8, 2026).
[17] *Id*. at 17.
[18] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[19] Issue Statement at 1.

Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[20] In the issue statement filed with the appeal request, the Provider argued, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[21]

The DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-1031GC, in which San Angelo Community Medical Center is a participant, also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

The Board has previously noted that CMS' interpretation of the SSI percentage regulation 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 the group case in which the Provider is a participant, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 22-1031GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 22-1031GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, the Provider fails to explain how it can ascertain from State records, the entitlement of individuals, how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2. Moreover, the Board finds that the Provider's PPP failed to comply with Board Rule 25 (Nov. 2021) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Nov. 2021), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" and include *all* exhibits.

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

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[20] *Id.*
[21] *Id.*
[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).

> **25.2.2 Unavailable and Omitted Documents (Nov. 21, 2021)**
>
> 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

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

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[24]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific

[23] (Italics and underline emphasis added.)
[24] Last modified May 14, 2026.

codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on, or discuss claims that it should have access to, or why this is not a common issue already covered by the CIRP group under Case No. 22-1031GC.

Accordingly, *based on the record before it*,[25] the Board finds that the SSI Provider Specific issue in Case No. 23-0034 and the group issue in the CHS CIRP group under Case No. 22-1031GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the ***Board dismisses this component of the SSI Provider Specific*** issue from Case No. 23-0034.

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

B. DSH Payment – Medicaid Eligible Days

1. *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 included as a cost issue in the appeal, nor was it 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 October of 2022 and the regulations required the following:

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

[25] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge so the Board must make its determination based on the record before it.

> including an account of…
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[26]

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

> The following information and supporting document must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>   - the adjustment, including the adjustment number,
>   - the controlling authority,
>   - why the adjustment is incorrect,
>   - how the payment should be determined differently,
>   - the reimbursement effect, and
>   - the basis for jurisdiction before the Board.[27]

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

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

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[29]
42 C.F.R. § 405.1835(e) provides in relevant part:

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

[26] 42 C.F.R. § 405.1835(b).
[27] v. 3.1 (Nov. 2021).
[28] (Bold and italic emphasis added).
[29] *See* 73 Fed. Reg. 30190 (May 23, 2008).

> 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 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.[30] Rather, they relate to Medicaid expansion program(s) and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to Section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying 1115 expansion program ***and*** not every inpatient day associated with beneficiary enrolled in an 1115 waiver program qualifies to be included in the Medicaid fraction.[20] In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

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

Because the Provider did not raise the Section 1115 waiver days prior to the deadline to add issues, and it is a distinct issue, the Board finds that the issue was not properly or timely appealed. The 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 the Section 1115 waiver days issue in its appeal request (which it did not), the Provider failed to properly develop the issue in its PPP filing. The Provider's PPP does not identify the specific 1115 waiver day program(s) at issue) notwithstanding its obligations to do so pursuant to 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (2021). Pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." Similarly, 42 C.F.R. § 405.1871(a)(3) confirms that the Provider has the "burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." The Provider's briefing fails to establish the merits of its position on the *alleged* Section 1115 waiver days sub-issue.

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

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[31] No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sep. 30, 2022).
[32] *Id*. at *11.
[33] *Id.*
[34] *Id.*

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.[35] In the alternative, the Board finds that, even if it had been included as part of the appeal, the issue was not properly developed in the PPP process.

2. *Medicaid Eligible Days*

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

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

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

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

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

[35] If section 1115 waiver days were found to be part of the appeal request and had been properly briefed, the Board would still need to address an additional jurisdictional issue – review whether it had jurisdiction over the section 1115 waiver days. For example, the Board has found that when a class of days (*e.g.*, 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report, then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a). *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 061852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions is not applicable).

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[36]

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

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

> **Rule 25 Preliminary Position Papers**[37]
>
> **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.

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The October 13, 2022 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[38]

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

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

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

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

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

On June 5, 2023, the Provider filed its PPP paper in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[39] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather the exhibit at P-2 continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $27,454- which according to the issue statement filed with the appeal, was based on an estimated 50 days). The Provider's complete briefing of this issue in its PPP is as follows:

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[38] (Emphasis added.)
[39] Provider's PPP at 10 (June 5, 2023).

Calculation of Medicaid Eligible Days

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

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

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

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

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

> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2019 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[40]

In its April 8, 2026 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid Eligible Days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its PPP in violation of Board Rule 25. Thus, the MAC asserts that the Provider failed 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.[41] As noted, the Provider failed to respond to the Jurisdictional Challenge within the 30-day time period, which expired on May 8, 2026.

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

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures regarding filing its position papers and supporting documentation. Specifically, the

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[40] Provider PPP at 9-10 (June 5, 2023).
[41] *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.
[42] (Emphasis added.)

Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[43]

* * * * *

Based on the foregoing, the Board is ***dismissing the SSI Provider Specific and Medicaid Eligible Days/Section 1115 Waiver Days issues*** in this case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

5/29/2026

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

[43] *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.