DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd.
Suite 700
Los Angeles, CA 90064-1582

RE: ***Expedited Judicial Review Determination***
Case Number 24-2581GC *UnityPoint Health CY 2013 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' Petition for Expedited Judicial Review ("EJR") filed on **September 30, 2025** in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **September 19, 2024**, the Board received a request to establish a Common Issue Related Party ("CIRP") group. The nine (9) Providers in this group 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' FYEs 10/31/2013 and 12/31/2013.

The Providers in this appeal argue that "inpatient days attributable to Medicaid-eligible patients enrolled in Medicare HMO plans, Medicare Advantage Plus, or Medicare Part C plans (collectively "Part C Days") should be reflected in the Medicaid percentage rather than the Medicare/SSI fraction."[2] The Providers also allege that CMS Rule 1739-F is contrary to the statutory language and is invalid as a matter of law.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Case No. 24-2581GC Statement of Issue at 1 (Sept. 19, 2024).
[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]

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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

[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.

> 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]

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

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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).

Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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

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[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).
[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).

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

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

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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.

whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

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

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern 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]

[38] 139 S.Ct. at 1814.
[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).

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

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

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending 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]

[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).

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.

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal request argues that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[47] It seeks to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[48] The Provider argues that the Final Rule "is contrary the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)" and that the Secretary's interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[49]

The Provider recounts 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.

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[46] *Id.* (emphasis added).
[47] Statement of Issue at 1.
[48] *Id.* at ¶ 3.
[49] *Id.* at ¶¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).

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.[50]

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their 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.[51] It notes 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.[52]

On October 6, 2025, the Medicare Contractor's representative, Federal Specialized Services, filed a response to the Request for EJR simply advising that "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[53]

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; [54]

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[50] *Id.* at ¶¶ 6-18.
[51] Providers' Petition for Expedited Judicial Review at 1-4 (Sept. 30, 2025).
[52] *Id.* at 11.
[53] Response to Provider's request for Expedited Judicial Review at 1 (Oct. 6, 2025).
[54] 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 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.[55]

For this CIRP Group, the providers all appealed from revised NPRs which implemented 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 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 NPRs. The Board also finds that the amount in controversy $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 year in this case and that the Providers are entitled to a hearing before the Board;

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

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

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

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.

[55] 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.

Board Members Participating:

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

FOR THE BOARD:

11/4/2025

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

25-5620	New York Presbyterian/Queens (33-0055), FYE 12/31/2007
25-5742	Henry Ford Health Hospital (23-0053), FYE 12/31/1999
25-5828	Montefiore Medical Center (33-0059), FYE 12/31/2011
25-5830	Montefiore Medical Center (33-0059), FYE 12/31/2012
25-4069GC	Univ. of Florida Health CY 2009 Post-Allina II DSH Part C Days CIRP Group
25-4071GC	Univ. of Florida Health CY 2010 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 on **September 30, 2025** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received the four (4) individual appeal requests and the two (2) requests to establish a Common Issue Related Party ("CIRP") group between March and September, 2025. The Providers are all appealing from original or revised Notices of Program Reimbursement ("NPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' FYEs spanning from 12/31/1999 to 12/31/2012. Individual Case Nos. 25-5620 and 25-5742 contain just one issue, while Individual Case Nos. 25-5828 and 25-5830 have a second issue related to the retroactive recoupment of outlier payments. Both CIRP group cases (Case Nos. 25-4069GC and 25-4071GC) properly contain only one issue.

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* 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

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *E.g.,* Case No. 25-5620, Statement of Issue for Issue 1 at 1 (Aug. 27, 2025).

June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

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

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

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

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits*

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

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

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

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

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[27]

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[23] *Id.* (emphasis added).
[24] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[25] *Id*. at 47411.
[26] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[27] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[29] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[30] However, the Secretary has not acquiesced to that decision.

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

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

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[28] 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] *Id.* at 2011.
[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)* as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[34] 139 S.Ct. 1804 (2019).
[35] *Id.* at 1817.
[36] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[37] 139 S.Ct. at 1814.
[38] 85 Fed. Reg. 47723 (Aug. 6, 2020).

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

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

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

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

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***

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

those periods are still open or have <u>not</u> yet been <u>finally settled</u>, encompassing thousands of cost reports. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***<u>each</u>*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[42]

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

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

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by <u>appealing</u> those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[45]

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

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

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their original or revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[46]

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

The 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."[48]

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.[49]

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, exceeded the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[50]

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[46] *E.g.,* Case No. 25-5620, Appeal Request, Statement of Jurisdiction (citations omitted).
[47] *E.g.*, Case No. 25-5620, Appeal Request, Statement of Issue at 1.
[48] *Id.* at 1 (citing to 139 S. Ct. at 1816).
[49] *Id.*
[50] *Id.* at 2 (citing 5 U.S.C. § 706(2)).

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's final rule published in the Federal Register on June 9, 2023."[51] It seeks a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[52] "The Provider[s] contend that the new, post-*Allina* retroactive part C days rule, applied in the NPR[s] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[53] Since the Board is bound by this regulation,[54] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **October 6, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all six (6) cases. It simply advised that, in each case, "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[55]

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 their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [56]

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[51] *E.g.*, Case No. 25-5620, Provider's Petition for Expedited Judicial Review at 13 (Sept. 30, 2025).
[52] *Id.* at 16-17.
[53] *Id.* at 1-2.
[54] 42 C.F.R. § 405.1867.
[55] *E.g.*, Case No. 25-5620, Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 6, 2025).
[56] 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 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.[57]

For these six (6) appeals, the providers all appealed from original and revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All of the Providers in Cases 25-5620, 25-5742, 25-5828, and 25-5830, filed their appeals within 180 days of the issuance of their NPRs and RNPRs and the amount in controversy exceeds $10,000. Likewise, all of the providers in Cases 25-4069GC and 25-4071GC were directly added to the group within 180 days of the issuance of their NPRs and RNPRs and the amount in controversy exceeds $50,000.

The Board finds that the Providers in Cases 25-5620, 25-5742, 25-5828, 25-5830, 25-4069GC, and 25-4071GC have all filed timely appeals from their original and revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs and RNPRs. The Board also finds that the amount in controversy in each individual appeal exceeds $10,000 as required by 42 C.F.R. § 405.1835(a)(2), and for the two group appeals 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. 25-5620, 25-5742, 25-5828, 25-5830, 25-4069GC, and 25-4071GC 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

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.

[57] 42 U.S.C. § 1395oo(a)(2) and (b); 42 C.F.R. §§ 405.1835 – 1840.

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as 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. 25-5620, 25-5742, 25-4069GC, and 25-4071GC, the Board hereby closes these four (4) cases and removes them from its docket. Since an additional issue remains in Cases 25-5828 and 25-5830, these two (2) cases will remain open on the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

11/4/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedule of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Byron Lamprecht, WPS Government Health Administrators (J-8)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Michael Newell
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RE: ***Expedited Judicial Review Determination***
Southwest Consulting Medicare Part C Days CIRP Groups
Case Numbers: 25-1184GC *et al.* (12 Cases – *See* **Appendix A**)

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **October 1, 2025** in the above-referenced group appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish Common Issue Related Party ("CIRP") groups for these twelve (12) groups between September, 2024 and July, 2025. All twelve (12) CIRP 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' FYEs spanning from 2005 to 2013.

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] *See, e.g.*, Case No. 25-1184GC, Statement of Group Issue at 1 (Dec. 26, 2024).
[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]

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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 that 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.

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.[47]

The "Statement of Group Issue" included with the appeal requests states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina II* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[48]

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 policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[49]

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

[46] *Id.* (emphasis added).
[47] *E.g.*, Case No. 25-1184GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[48] *E.g.*, Case No. 25-1184GC, Appeal Request, Statement of Group Issue at 1.
[49] *Id.* at 1 (citing to 139 S. Ct. at 1816).

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, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[50]

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's final rule published in the Federal Register on June 9, 2023."[51] 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.[52] "The 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."[53] Since the Board is bound by this regulation,[54] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **October 6, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all twelve (12) cases. They simply advised that, in each case, "no substantive claim challenge has been filed, no jurisdictional challenge has been filed, and the MAC does not oppose the request for EJR."[55]

Decision of the Board:

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

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[50] *Id.* (citing 4 U.S.C. § 706(2)).
[51] *E.g.*, Case No. 25-1184GC, Providers' Petition for Expedited Judicial Review at 12 (Oct. 1, 2025).
[52] *Id.* at 15.
[53] *Id.* at 1-2.
[54] 42 C.F.R. § 405.1867.
[55] *E.g.,* Case No. 25-1184GC, Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 6, 2025).

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; [56]
- 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.[57]

For these CIRP 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 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 the twelve (12) cases listed in **Appendix A** 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 the twelve (12) Cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;

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

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[56] 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).
[57] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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 years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes all twelve (12) 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:

11/4/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Danelle Decker, National Government Services, Inc. (J-K)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Scott Berends, Federal Specialized Services

Appendix A

24-2598GC	*Banner Health CY 2013 Medicare Part C Pre-10/01/2013 CIRP Group*
25-4990GC	*Baystate Health CY 2005 DSH Medicare Part C CIRP Group*
24-2680GC	*UMass Memorial Health CY 2013 Medicare Part C CIRP Group*
24-2677GC	*UMass Memorial Health CY 2012 Medicare Part C Days CIRP Group*
24-2524GC	*UMass Memorial Health CY 2011 Medicare Part C CIRP Group*
25-1184GC	*Tufts Medicine CY 2013 Medicare Part C CIRP Group*
25-4048GC	*Allegheny Health CY 2008 DSH Medicare Part C CIRP Group*
25-4009GC	*Univ. of PA Health System CY 2008 DSH Medicare Part C CIRP Group*
25-4008GC	*Univ. of PA Health System CY 2007 DSH Medicare Part C CIRP Group*
25-4006GC	*Summit Health CY 2013 DSH Medicare Part C CIRP Group*
25-4004GC	*Summit Health CY 2011 DSH Medicare Part C CIRP Group*
25-4001GC	*Summit Health CY 2008 DSH Medicare Part C CIRP Group*

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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Los Angeles, CA 90064-1582

RE: ***Expedited Judicial Review Determination***
Case Number: 24-2769GC - *SSM Health CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number: 24-2772GC - *SSM Health CY 2011 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 **October 8, 2025** in the above-referenced appeals.[1] The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **September 27, 2024**, the Board received two requests to establish Common Issue Related Party ("CIRP") groups. The Providers in both 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")[2] as it pertains to the Providers' Fiscal Years Ending ("FYE") 12/31/2010 and 12/31/2011.

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

[1] While the Petition for EJR was filed on **October 8, 2025**, the Office of Hearings was furloughed beginning on **October 1** and did not reopen until **October 27**. Pursuant to 42 C.F.R. § 405.1801(d)(2), "in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as . . . furlough. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner." Thus, as the request was submitted during the furlough, the time period for the Board to evaluate whether it has jurisdiction and subsequently issue a decision on the Requests for EJR did not begin until **October 27, 2025**.

[2] 88 Fed. Reg. 37772 (June 9, 2023).

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."

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

[3] *E.g.,* Case No. 24-2769GC, Statement of Issue at 1 (Sept. 27, 2024).
[4] *Id.* at 2.
[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).

> 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 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

[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).
[16] of Health and Human Services.

> qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that 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 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

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[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.*
[22] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[23] 69 Fed. Reg. 28196, 28286 (May 18, 2004).

C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[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 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]

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[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.
[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).

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. 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

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[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 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.

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 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]

[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).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

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 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]

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

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 impermissible retroactive,[49] and arbitrary and capricious.[50] The court required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[51]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal requests argue that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[52] It seeks to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[53] The Provider argues 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.*[54]

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.

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[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] *E.g.*, Case No. 24-2769GC, Statement of Issue at 1.
[53] *Id.* at 2, ⁋ 3.
[54] *Id.* at ⁋ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).

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.[55]

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their RNPRs; that the amount in controversy exceeds $50,000; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[56] It notes that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[57]

On **October 14, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed responses to the Requests for EJR simply advising that "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[58]

Decision of the Board:

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

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[55] *Id.* at ¶¶ 6-18.
[56] *E.g.*, Case No. 24-2769GC, Providers' Petition for Expedited Judicial Review at 1-4 (Oct. 8, 2025).
[57] *Id.* at 11.
[58] Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 14, 2025).

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [59]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[60]

For these two (2) CIRP 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 and the amount in controversy exceeds $50,000.

The Board finds that the Providers in Cases 24-2769GC and 24-2772GC 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 Cases 24-2769GC and 24-2772GC 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;

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[59] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[60] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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 Cases 24-2769GC and 24-2772GC 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:

11/6/2025

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)
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nathan Summar, Vice President, Revenue Management
Community Health Services, Inc.
4000 Meridian Boulevard
Franklin, TN, 37067

RE: ***Notice of Dismissal***
Heart of Lancaster Medical Center (Prov. No. 39-0068), FYE 06/30/2017
(*a/k/a as UPMC Lititz as of 11/1/2019*)
PRRB Case No. 21-0299

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0299. 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") SSI Provider Specific issue.

Background:

A. *Procedural History for Case No. 21-0299*

On **May 4, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **October 19, 2020**, CHS filed the Provider's individual appeal request which included seven (7) issues:

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

[1] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1332GC.
[2] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1333GC.
[3] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1334GC.
[4] On November 5, 2025, this issue was withdrawn.
[5] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1335GC.

7. DSH Medicaid Fraction Dual Eligible Days[6]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **March 30, 2021**, CHS transferred Issues 2, 3, 5 and 6 to CHS CIRP groups. As a result of the transfers, and after the recent withdrawal of Issue 5, there is one (1) remaining issue in this appeal: Issue 1 - DSH Payment/SSI Percentage (Provider Specific).

On **November 30, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers paper (*hereinafter* "PPP").

On **June 11, 2021**, CHS timely filed the Provider's PPP.

On **September 23, 2021**, the MAC filed a jurisdictional challenge, requesting the dismissal of Issue 1. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **October 4, 2021**, the MAC timely filed its PPP.

On **May 19, 2025**, the Board scheduled Case No. 21-0299 for a hearing on February 6, 2026.

On **November 5, 2025**, CHS withdrew the Medicaid Eligible Days issue.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1332GC (which was subsequently closed and consolidated into a duplicate group under Case No. 20-997GC)

In its Individual Appeal Request, the Provider summarizes its DSH- SSI Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider 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.[7]

[6] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1336GC.
[7] Issue Statement at 1 (Oct. 19, 2020).

The Group issue Statements in both Case Nos. 21-1332GC to which the Provider transferred Issue 2 (the SSI Percentage) and the consolidated group, Case No. 20-997GC, reads in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[8]

On June 11, 2021, the Board received the Provider's PPP in Case No. 21-0299. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).

[8] Group Issue Statements, Case Nos. 20-1332GC and 20-0997GC.

> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services,* No. CV-94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. See *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[9]

The amount in controversy listed for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $7,000.

MAC's Contentions: Issue 1 – SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the SSI Percentage (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 the SSI Percentage issue (No. 2) which was transferred to a CIRP group. 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.[10] For these reasons, the MAC requests dismissal of the SSI Percentage (Provider Specific) issue.

Provider's Jurisdictional Response: Issue 1- SSI Percentage (Provider Specific)

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] The Provider 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

[9] Provider's PPP at 8-9 (June 11, 2021).
[10] MAC's Jurisdictional Challenge at 2 (Sept. 23, 2021).
[11] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue No. 1.

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 20-1332GC (and later consolidated into Case No. 20-0997GC).

The SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[12] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14]

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case Nos. 21-1332GC and 20-997GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Percentage

[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*

(Provider Specific) issue in Case No. 21-0299 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 21-1332GC which ended up being consolidated into Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[15], the Board dismisses this aspect of the SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in the CIRP Groups, Case No. 21-1332GC and 20-0997GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case Nos. 21-1332GC and 20-0997GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeals. Moreover, although not specifically challenged by the MAC, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[17]

[15] PRRB Rules v. 2.0 (Aug. 2018).
[16] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[17] (Italics and underline emphasis added.)

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

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

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[18]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to send a request via email to access their DSH data."[19]

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case Nos. 21-1332GC and 20-0997GC are the same issue.[20] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

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[18] Last accessed November 6, 2025.
[19] Emphasis added.
[20] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

2. Second Aspect of Issue 1

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

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

****

Based on the foregoing, the Board is dismissing the last remaining issue in this case: DSH Payment SSI Percentage (Provider Specific) - Issue No. 1. As no issues remain, the Board hereby closes Case No. 21-0299 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:

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Ratina Kelly, CPA
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For the Board:

11/10/2025

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)
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
25-0901GC UMass Memorial Health CY 2008 Medicare Part C CIRP Group
24-2508G Southwest Consulting CY 2011 Medicare Part C Days Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **October 9, 2025** in the above-referenced group appeals.[1] The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish an optional group on **September 16, 2024**, and a request to establish a Common Issue Related Party ("CIRP") group on **November 25, 2024**. 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")[2] as it pertains to the Providers' Fiscal Years Ending ("FYE") in 2008 and 2011.

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

[1] While the Petitions for EJR were filed on **October 9, 2025**, the Office of Hearings was furloughed beginning on **October 1** and did not reopen until **October 27**. Pursuant to 42 C.F.R. § 405.1801(d)(2), "in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as . . . furlough. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner." Thus, as the request was submitted during the furlough, the time period for the Board to evaluate whether it has jurisdiction and subsequently issue a decision on the Requests for EJR did not begin until **October 27, 2025**.

[2] 88 Fed. Reg. 37772 (June 9, 2023).

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."

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]

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[3] *E.g.*, Case 24-2508G, Statement of Group Issue (Sept. 16, 2024).
[4] *Id.* at 1-2.
[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] (Emphasis added.)

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 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

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

> 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 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:

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[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.*
[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).

> *. . . 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 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.

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[25] *Id.* (emphasis added).
[26] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[27] *Id*. at 47411.
[28] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

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. 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]

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[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 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.

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 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":

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[40] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[41] CMS Ruling 1739-R at 1-2.
[42] 88 Fed. Reg. 37772 (June 9, 2023).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

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 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

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

> 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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[51]

Providers' Position:

A. Providers' Appeal Requests

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

The "Statement of Group Issue" included with the appeal 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* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's

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[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] *E.g.*, Case No. 24-2508G, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[53] *E.g.,* Case No. 24-2508G, Appeal Request, Statement of Group Issue at 1.

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 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.

On **October 14, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in both cases. They simply advised that, in each case, "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[60]

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[54] *E.g.*, Case No. 24-2508G, 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. 24-2508G, Providers' Petition for Expedited Judicial Review, 13 (Oct. 9, 2025).
[57] *Id.* at 16.
[58] *Id.* at 1-2.
[59] 42 C.F.R. § 405.1867.
[60] *E.g.*, Case No. 24-2508G, Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 14, 2025).

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 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 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 Cases 25-0901GC & 24-2508G 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:

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[61] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[62] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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 25-0901GC & 24-2508G and that the Providers in each group appeal are entitled to a hearing before the Board;

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

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

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

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes Cases 25-0901GC & 24-2508G 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:

11/12/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

Case Number 25-0111GC:	*Northern Light Health CY 2006 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number 25-0171GC:	*SSM Health CY 2012 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number 25-0168GC:	*SSM Health CY 2013 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number 25-0175GC:	*Health Quest CY 2013 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 **October 10, 2025** in the above-referenced appeals.[1] The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **October 8 and 11, 2024**, the Board received four (4) requests to establish Common Issue Related Party ("CIRP") groups. The Providers in all four (4) 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")[2] as it pertains to the Providers' Fiscal Years Ending ("FYE") in 2006, 2012, and 2013.

The issue in these appeals is the proper treatment in the Medicare disproportionate share hospital

[1] While the Petitions for EJR were filed on **October 10, 2025**, the Office of Hearings was furloughed beginning on **October 1** and did not reopen until **October 27**. Pursuant to 42 C.F.R. § 405.1801(d)(2), "in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as . . . furlough. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner." Thus, as the request was submitted during the furlough, the time period for the Board to evaluate whether it has jurisdiction and subsequently issue a decision on the Requests for EJR did not begin until **October 27, 2025**.

[2] 88 Fed. Reg. 37772 (June 9, 2023).

("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).[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."

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

[3] *E.g.*, Case No. 25-0111GC, Statement of Issue at 1 (Oct. 8, 2024).
[4] *Id.* at 2-5.
[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).

> 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 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

[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).
[16] of Health and Human Services.

> 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 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

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[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.*
[22] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[23] 69 Fed. Reg. 28196, 28286 (May 18, 2004).

C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[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 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]

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[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.
[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).

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. 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

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[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 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.

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 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]

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[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).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

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 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

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

> [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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[51]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal requests argue that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[52] It seeks to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[53] The Provider argues 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.*[54]

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

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[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] *E.g.*, Case No. 25-0111GC, Statement of Issue at 1.
[53] *Id.* at ¶ 3.
[54] *Id.* at ¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).

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.[55]

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their RNPRs; that the amount in controversy exceeds $50,000; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[56] It notes that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[57]

On **October 14 and 15, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed responses to the Requests for EJR simply advising that "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[58]

Decision of the Board:

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

A. Jurisdiction

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

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[55] *Id.* at ¶¶ 6-18.
[56] *E.g.*, Case No. 25-0111GC, Providers' Petition for Expedited Judicial Review at 1-4 (Oct. 10, 2025).
[57] *Id.* at 11.
[58] *E.g.,* Case No. 25-0111GC, Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 14, 2025).

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [59]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[60]

For these four (4) CIRP 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 and the amount in controversy exceeds $50,000.

The Board finds that the Providers in Cases 25-0111GC, 25-0171GC, 25-0168GC, and 25-0175GC 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 $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 25-0111GC, 25-0171GC, 25-0168GC, and 25-0175GC 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

[59] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[60] 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 these group cases, the Board hereby closes Cases 25-0111GC, 25-0171GC, 25-0168GC, and 25-0175GC 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:

11/13/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Danelle Decker, National Government Services, Inc. (J-K)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Southwest Consulting Medicare Part C Days Groups
Case Numbers: 25-0148GC *et al.* (11 Cases – *See* **Appendix A**)

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **October 14, 2025** in the above-referenced group appeals.[1] The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received requests to establish optional and Common Issue Related Party ("CIRP") groups for these eleven (11) groups between September, 2024 and March, 2025. All eleven (11) 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")[2] as it pertains to the Providers' Fiscal Years Ending ("FYE") between 2006 and 2013.

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."[3] The Providers are seeking to challenge the CMS policy adopted in the June 2023

[1] While the Petition for EJR was filed on **October 14, 2025**, the Office of Hearings was furloughed beginning on **October 1** and did not reopen until **October 27**. Pursuant to 42 C.F.R. § 405.1801(d)(2), "in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as . . . furlough. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner." Thus, as the request was submitted during the furlough, the time period for the Board to evaluate whether it has jurisdiction and subsequently issue a decision on the Requests for EJR did not begin until **October 27, 2025**.
[2] 88 Fed. Reg. 37772 (June 9, 2023).
[3] *E.g.*, Case No. 25-0148GC, Statement of Group Issue at 1 (Oct. 10, 2024).

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."

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]

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[4] *Id.* at 1-2.
[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] (Emphasis added.)

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 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

[13] 42 C.F.R. § 412.106(b)(2)-(3).
[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).
[16] 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].[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 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:

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[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.*
[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).

> *. . . 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 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.

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[25] *Id.* (emphasis added).
[26] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[27] *Id*. at 47411.
[28] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

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. 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]

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[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 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.

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 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":

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[40] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[41] CMS Ruling 1739-R at 1-2.
[42] 88 Fed. Reg. 37772 (June 9, 2023).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

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 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

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

> 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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[51]

Providers' Position:

A. Providers' Appeal Requests

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

The "Statement of Group Issue" included with the appeal 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* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[53]

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's

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[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] *E.g.*, Case No. 25-0148GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[53] *E.g.*, Case No. 25-0148GC, Appeal Request, Statement of Group Issue at 1.

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 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.

On **October 20 and 21, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all eleven (11) cases. They simply advised that, in each case, "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[60]

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[54] *Id.* at 1 (citing to 139 S. Ct. at 1816).
[55] *Id.* (citing 4 U.S.C. § 706(2)).
[56] *E.g.*, Case No. 25-0148GC, Providers' Petition for Expedited Judicial Review at 13 (Oct. 14, 2025).
[57] *Id.* at 16.
[58] *Id.* at 1-2.
[59] 42 C.F.R. § 405.1867.
[60] *E.g.,* Case No. 25-0148GC, Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 20, 2025).

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 eleven (11) 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 the groups within 180 days of the issuance of their RNPRs and the amount in controversy exceeds $50,000.

The Board finds that the Providers in the eleven (11) cases listed in **Appendix A** 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:

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[61] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[62] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in the eleven (11) Cases listed in **Appendix A** and that the Providers in each group appeal are entitled to a hearing before the Board;

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

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

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

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes all eleven (11) 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:

11/13/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Danelle Decker, National Government Services, Inc. (J-K)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)

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

Appendix A

25-0148GC	*Banner Health CY 2009 Medicare Part C CIRP Group*
25-0311GC	*Banner Health CY 2006 Medicare Part C CIRP Group*
25-0149GC	*Banner Health CY 2010 Medicare Part C CIRP Group*
25-0288GC	*RegionalCare Hosp Part CY 2011 Medicare Part C CIRP Group*
25-0121GC	*SUNY CY 2008 Medicare Part C CIRP Group*
24-2790G	*Southwest Consulting CY 2013 Medicare Part C Group*
24-2788G	*Southwest Consulting CY 2012 Medicare Part C Group*
25-3999GC	*Summit Health CY 2007 DSH Medicare Part C CIRP Group*
25-4003GC	*Summit Health CY 2010 DSH Medicare Part C CIRP Group*
25-0289GC	*Inova Health CY 2011 Medicare Part C CIRP Group*
25-0283GC	*Inova Health CY 2012 Medicare Part C CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd.
Suite 700
Los Angeles, CA 90064-1582

RE: ***Expedited Judicial Review Determination***
Case Number: 25-0249GC *LCMC Health CY 2012 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' Petition for Expedited Judicial Review ("EJR") filed on **October 21, 2025** in the above-referenced appeal.[1] The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **October 16, 2024**, the Board received a request to establish a Common Issue Related Party ("CIRP") group. The Providers 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")[2] as it pertains to the Providers' Fiscal Year Ended ("FYE") 12/31/2012.

The issue in these appeals 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).[3] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied

[1] While the Petition for EJR was filed on **October 21, 2025**, the Office of Hearings was furloughed beginning on **October 1** and did not reopen until **October 27**. Pursuant to 42 C.F.R. § 405.1801(d)(2), "in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as . . . furlough. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner." Thus, as the request was submitted during the furlough, the time period for the Board to evaluate whether it has jurisdiction and subsequently issue a decision on the Request for EJR did not begin until **October 27, 2025**.
[2] 88 Fed. Reg. 37772 (June 9, 2023).
[3] Statement of Issue at 1 (Oct. 16, 2024).

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."

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]

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

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 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

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

> 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 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

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[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.*
[22] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[23] 69 Fed. Reg. 28196, 28286 (May 18, 2004).

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 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]

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[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.
[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).

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. 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

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[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 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.

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 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]

[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).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

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 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]

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

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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[51]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal request argues that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[52] It seeks to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[53] 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.*[54]

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.

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[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] Statement of Issue at 1.
[53] *Id.* at ¶ 3.
[54] *Id.* at ¶ 4-5 (citing *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024)).

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.[55]

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their RNPRs; that the amount in controversy exceeds $50,000; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[56] They note that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[57]

On **October 27, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed responses to the Requests for EJR simply advising that "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[58]

Decision of the Board:

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

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[55] *Id.* at ¶¶ 6-18.
[56] Providers' Petition for Expedited Judicial Review at 1-4 (Oct. 21, 2025).
[57] *Id.* at 11.
[58] Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 27, 2025).

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [59]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[60]

For this CIRP 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 their respective groups 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 25-0249GC 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 year in Case 25-0249GC 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;

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[59] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[60] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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 25-0249GC 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:

11/17/2025

X Kevin D. Smith, CPA

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

Enclosure: Schedule of Providers

cc: Michael Redmond, 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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Isaac Blumberg
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RE: ***Expedited Judicial Review Determination***
Case Number: 25-0307GC *UnityPoint Health CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number: 25-0371GC *SSM Health CY 2009 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 **October 20, 2025** in the above-referenced appeals.[1] The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **October 20, 2024**, the Board received two (2) requests to establish Common Issue Related Party ("CIRP") groups. The Providers in both 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")[2] as it pertains to the Providers' Fiscal Years Ending ("FYE") in 2009 and 2010.

The issue in these appeals 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

[1] While the Petitions for EJR were filed on **October 20, 2025**, the Office of Hearings was furloughed beginning on **October 1** and did not reopen until **October 27**. Pursuant to 42 C.F.R. § 405.1801(d)(2), "in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as . . . furlough. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner." Thus, as the request was submitted during the furlough, the time period for the Board to evaluate whether it has jurisdiction and subsequently issue a decision on the Requests for EJR did not begin until **October 27, 2025**.

[2] 88 Fed. Reg. 37772 (June 9, 2023).

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."

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

[3] *E.g.*, Case No. 25-0307GC, Statement of Issue at 1 (Oct. 19, 2024).
[4] *Id.* at 2-5.
[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).

> 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 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

[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).
[16] of Health and Human Services.

> 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 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

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[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.*
[22] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[23] 69 Fed. Reg. 28196, 28286 (May 18, 2004).

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 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.

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[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.
[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).

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. 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]

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[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 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.

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 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":

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[40] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[41] CMS Ruling 1739-R at 1-2.
[42] 88 Fed. Reg. 37772 (June 9, 2023).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

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 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

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

> 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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[51]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal requests argue that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[52] It seeks to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[53] The Provider argues 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.*[54]

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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[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] *E.g.*, Case No. 25-0307GC, Statement of Issue at 1.
[53] *Id.* at ¶ 3.
[54] *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.[55]

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their RNPRs; that the amount in controversy exceeds $50,000; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[56] They note that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[57]

On **October 27, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed responses to the Requests for EJR simply advising that "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[58]

Decision of the Board:

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

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to

[55] *Id.* at ⁋⁋ 6-18.
[56] *E.g.*, Case No. 25-0307GC, Providers' Petition for Expedited Judicial Review at 1-4 (Oct. 20, 2025).
[57] *Id.* at 11.
[58] *E.g.* Case No. 25-0307GC, Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 27, 2025).

their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [59]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[60]

For these two (2) CIRP 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 and the amount in controversy exceeds $50,000.

The Board finds that the Providers in Cases 25-0371GC and 25-0307GC 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 Cases 25-0371GC and 25-0307GC 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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[59] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[60] 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. 25-0371GC and 25-0307GC 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:

11/17/2025

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)
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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Los Angeles, CA 90064-1582

RE: ***Expedited Judicial Review Determination***
Case Number: 25-0533GC *LCMC Health CY 2011 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number: 25-0530GC *LCMC Health CY 2010 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number: 25-0640GC *Northern Light Health CY 2012 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 **October 30, 2025** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **October 30, 2024**, the Board received three (3) requests to establish Common Issue Related Party ("CIRP") groups. The Providers in all three (3) 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 Ending ("FYE") in 2010, 2011, and 2012.

The issue in these appeals 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. 25-0533GC, Statement of Issue at 1 (Oct. 31, 2024).
[3] *Id.* at 2-5.

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[28] In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive,[48] and arbitrary and capricious.[49] The court required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[50]

Providers' Position:

A. Providers' Appeal Request

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 the 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.

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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. 25-0533GC, 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)).

§ 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]

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their 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]

On **November 6, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed responses to the Requests for EJR simply advising that "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[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;

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[54] *Id.* at ¶¶ 6-18.
[55] *E.g.*, Case No. 25-0533GC, Providers' Petition for Expedited Judicial Review at 1-4 (Oct. 30, 2025).
[56] *Id.* at 11.
[57] *E.g.,* Case No. 25-0533GC, Response to Provider's Request for Expedited Judicial Review at 1 (Nov. 6, 2025).

- 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; [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 three (3) CIRP 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.

The Board finds that the Providers in Cases 25-0533GC, 25-0530GC, and 25-0640GC 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 Cases 25-0533GC, 25-0530GC, and 25-0640GC 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.

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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.

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 Cases 25-0533GC, 25-0530GC, and 25-0640GC 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:

11/17/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
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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 Numbers: 25-1029GC *et. al* (20 Cases, *See* – **Appendix A**)

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **October 31, 2025** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received the individual appeal requests or requests to establish a Common Issue Related Party ("CIRP") group for these twenty (20) cases between **October, 2024** and **October, 2025**. The Providers are all appealing from original or revised Notices of Program Reimbursement ("NPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYE") spanning the years from 2005 to 2012. The Board also notes that the nine (9) individual appeals listed in **Appendix A** have a single issue that is materially identical to the group issue presented in the eleven (11) CIRP group cases.

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. 25-1029GC, Statement of Issue for Issue at 1 (Dec. 11, 2024).
[3] *Id.* at 2-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[50]

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their original or revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

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

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

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[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.,* Case No. 25-1029GC, Appeal Request, Statement of Jurisdiction (citations omitted).
[52] *E.g.,* Case No. 25-1029GC, Statement of Group Issue at 1. The Board notes that the Statement of Issue included with each individual appeal is materially identical to the Statement of Group Issue included with each CIRP group appeal.
[53] *Id.*
[54] *E.g.,* Case No. 25-1029GC, Appeal Request, Statement of Group Issue at 1 (citing to 139 S. Ct. at 1816).

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[55]

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[56]

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks "the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023."[57] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[58] "The Provider[s] contend that the new, post-*Allina* retroactive part C days rule, applied in the NPR[s] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[59] Since the Board is bound by this regulation,[60] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **November 6 and 7, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all twenty (20) cases. It simply advised that, in each case, "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[61]

Decision of the Board:

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

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[55] *Id.*
[56] *Id.* (citing 4 U.S.C. § 706(2)).
[57] *E.g.*, Case No. 25-1029GC, Provider's Petition for Expedited Judicial Review at 13 (Oct. 31, 2025).
[58] *Id.* at 16-17.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.
[61] *E.g.,* Case No. 25-1029GC, Response to Provider's Request for Expedited Judicial Review at 1 (Nov. 6, 2025).

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [62]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[63]

For these twenty (20) appeals, the providers all appealed from original and revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All of the Providers in the individual appeals listed in **Appendix A** filed their appeals within 180 days of the issuance of their RNPRs and the amount in controversy exceeds $10,000. Likewise, all of the providers in the group appeals listed in **Appendix A** were directly added to the group within 180 days of the issuance of their NPRs and RNPRs and the amount in controversy exceeds $50,000.

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

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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

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

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in the Cases listed in **Appendix A**, the Board hereby closes these twenty (20) 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:

11/17/2025

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)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Scott Berends, Federal Specialized Services

Appendix A

25-1029GC	*Allina Health CY 2011 Post-Allina II DSH Part C Days CIRP Group*
25-1030GC	*Allina Health CY 2012 Post-Allina II DSH Part C Days CIRP Group*
25-5250GC	*Allina Health CY 2007 Post-Allina II DSH Part C Days CIRP Group*
25-1028GC	*Allina Health CY 2010 Post-Allina II DSH Part C Days CIRP Group*
25-1026GC	*Allina Health CY 2008 Post-Allina II DSH Part C Days CIRP Group*
25-1027GC	*Allina Health CY 2009 Post-Allina II DSH Part C Days CIRP Group*
25-0494GC	*Univ of Rochester CY 2008 Post-Allina II DSH Part C Days CIRP Group*
25-0875GC	*Univ of Rochester CY 2006 Post-Allina II DSH Part C Days CIRP Group*
25-0298GC	*Univ of Rochester CY 2009 Post-Allina II DSH Part C Days CIRP Group*
26-0082	*New York Presbyterian/Queens (33-0055), FYE 12/31/2008*
26-0081	*New York-Presbyterian Brooklyn Methodist Hospital (33-0236), FYE 12/31/2008*
26-0084	*New York Presbyterian/Queens (33-0055), FYE 12/31/2010*
26-0083	*New York Presbyterian/Queens (33-0055), FYE 12/31/2009*
26-0079	*Kaleida Health (33-0005), FYE 12/31/2008*
26-0080	*New York-Presbyterian Brooklyn Methodist Hospital (33-0236), FYE 12/31/2006*
26-0131	*Lutheran Medical Center (33-0306), FYE 12/31/2006*
26-0130	*Kingsbrook Jewish Medical Center (33-0201), FYE 12/31/2006*
26-0171GC	*Univ of Rochester Med Ctr CY 2005 Post-Allina II DSH Part C Days CIRP Group*
26-0078	*Kaleida Health (33-0005), FYE 12/31/2006*
25-5985GC	*Univ of Florida Health CY 2008 Post-Allina II DSH Part C Days CIRP Group*

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: ***EJR Determination and Notice of Dismissal***
Case Number: 25-3074GC - *Southern Illinois FFY 2025 Reasonable Cost to IPPS Budget Neutrality Adjustment CIRP Group*

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request and Petition for Expedited Judicial Review ("EJR") filed by the Providers in the above-referenced Common Issue Related Party ("CIRP") group case.[1] The issue in this case relates to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1986 as it allegedly impacts their FFY 2025 IPPS rates. As set forth below, the Board Majority has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and, therefore, is dismissing the group case in its entirety. This decision is consistent with prior Board Majority decisions where the Board found it lacks *substantive* jurisdiction over the same issue.[2]

In summary, the Board Majority finds that it lacks substantive jurisdiction over the issue raised in this group appeal because the standardized amount used for IPPS rates for FFY 1986 is based on the rates from FFY 1985, which included the budget neutrality adjustment ("BNA"). The Board also finds that the *final* FFY 1985 standardized amount (on which the FFY 1986 standardized amount was based) is *inextricably intertwined* with the FFY 1985 BNA.[3] The Board Majority has also included at **Appendix A** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1985 BNA. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the

[1] While the Petition for EJR was filed on **October 9, 2025**, the Office of Hearings was furloughed beginning on **October 1** and did not reopen until **October 27**. Pursuant to 42 C.F.R. § 405.1801(d)(2), "in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as . . . furlough. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner." Thus, as the request was filed during the furlough, the time period for the Board to evaluate whether it has jurisdiction and subsequently issue a decision on the Request for EJR did not begin until **October 27, 2025**.
[2] Case No. 25-1141GC.
[3] *See infra* note 70 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts.

Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1985 BNA, the Board Majority finds that it may not review the standardized amount used for the FFY appealed as it relates to the common issue in this appeal. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates (the final rates, after adjustment for the BNA). Accordingly, the Providers' assertion that the initial FFY 1985 standardized amount continues to serve as the base for all future calculations is incorrect as the causal link is broken.[4]

PROCEDURAL BACKGROUND:

A. Group Issue –Alleged Improper Carry-forward of FFY 1985 Adjustments

1. Initial Appeal and Issue Statement

The Board received a request, filed by the Providers' designated representative, Toyon Associates, Inc. ("Providers' Representative"), to establish this CIRP group appealing from the Federal Register published on **August 28, 2024**.

The Providers' appeal challenge their FY 2025 IPPS payments, arguing that CMS "unlawfully applied a pair of budget neutrality adjustments that, by statute, could only apply to IPPS rates ***for FY 1985***."[5] They note that 42 U.S.C. § 1395ww(d)(3)(C) directed CMS' predecessor, the Health Care Financing Administration ("HCFA"), "to adjust the 'average standardized amounts as may be required under [§ 1395ww(e)(1)(B)] for that fiscal year.'"[6] The Providers argue that Section § 1395ww(e)(1)(B) requires, for discharges occurring in FY 1984 or 1985, equal proportional adjustments in each of the average standardized amounts as may be necessary to assure that:

> (i) The aggregate payment amounts provided under [IPPS] *for that fiscal year* for operating costs of inpatient services of hospitals,
>
> are not greater or less than –

[4] *See also* **Appendix A** outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.
[5] Issue Statement at 1 (Feb. 20, 2025) (Emphasis added).
[6] *Id.*

> (ii) . . . the payment amounts which would have been payable for such services for those same hospitals *for that fiscal year* under the law as in effect before April 20, 1983.[7]

Pursuant to his authority at 42 U.S.C. §§ 1395ww(d)(3)(C) and (e)(1)(B), the Secretary implemented two adjustments that resulted in a reduction of IPPS payments by 5.59% in FY 1985.[8] The Providers argue that these budget neutrality adjustments were not to be applied in future years, and that the statute includes instructions for calculating the standardized amount for FY 1986 and all years thereafter. For FY 1986, the amount was to start with the "average standardized amount computed for the previous fiscal year under [§ 1395ww(d)(3)(A)]."[9] The Providers interpret the statute to require the standardized amount computed under this section be the amount *after* it was adjusted for inflation but before it was adjusted under §§ 1395(d)(3)(B) (for outliers), 1395(d)(3)(C) and (e)(1)(B) (for budget neutrality).[10]

The Providers continue by explaining that "for FY 1986, HCFA decided that the 'budget-neutrality adjusted rates for FY 1985 are…to be used as the basis for the determination of rates for later years.'"[11] They argue that calculating FY 1986 rates by preserving these ***FY 1985*** budget neutrality adjustments is unlawful and has been carried forward every year since, resulting in a present day IPPS payment understatement of 0.9441, "which could be corrected by an adjustment of 5.92% . . . ."[12] They "challenge the continued application of these budget neutrality adjustment because the statute says that they should have sunset at the end of FY 1985."[13]

2. Request for EJR

The Providers' **October 9, 2025** Request for EJR makes the same arguments found in their Issue Statement, with some elaboration. They discuss how the FY 1984 standardized amount was set using FY 1981 data. They also note that this amount was later adjusted pursuant to 42 U.S.C. § 1395ww(d)(2)(E) to account for outliers, and again pursuant to § 1395ww(d)(2)(F) to adjust the standardized amount "as may be required under subsection (e)(1)(B)." This budget neutrality adjustment "adjusted the FY 1984 standardized amount by a factor of 0.97, which translated to a 3 percent decrease."[14] The Request for EJR also describes a "second adjustment [which] required the Secretary to ensure that aggregate payments for FY 1984 did not exceed aggregate payments for services had he continued to make them under the prior reasonable cost payment system."[15]

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[7] Quoting 42 U.S.C. § 1395ww(e)(1)(B).
[8] Issue Statement at 1 (citing 49 Fed. Reg. 34728, 34771 34796, (Aug. 31, 1984)).
[9] *Id.* at 2.
[10] *Id.*
[11] *Id.* (citing 50 Fed. Reg. 35646, 35695 (Sept. 3, 1985)).
[12] *Id.*
[13] *Id.*
[14] Petition for Expedited Judicial Review at 4 (Oct. 9, 2025) (citing 49 Fed. Reg. 234, 334 (Jan 1. 1984)).
[15] *Id.* at 3.

The Providers then repeat the same arguments found in their Issue Statement with regard to the FY 1985 rate setting being unlawfully carried forward into FY 1986 and beyond.[16] The Request for EJR claims that "the FY 2025 rates continue to include the 0.954 adjustment to the standardized amount and the 1.05 percent adjustment to the DRG weights from FY 1985, effectively reducing those rates by a factor of 0.9441."[17]

The Providers request the Board grant EJR in this case, first noting the Board has jurisdiction over the appeal. They claim that each Provider is "dissatisfied with the Secretary's final payment determination in the FY 2025 IPPS final rule – specifically the Secretary's refusal to correct the rates to remove the budget neutrality adjustment he adopted in FY 1985."[18] They also argue that the challenge is not precluded from administrative and judicial review (specifically 42 U.S.C. § 1395ww(d)(7)(A)), but acknowledge that the Board has previously found that it lacked subject matter jurisdiction over an appeal brought by a different group of providers challenging the same issue.[19] The Providers argue that "the Board interpreted § 1395ww(d)(7)(A) too broadly" because the action challenged is not the type of action shielded from review in that statue.[20] Section 1395ww(d)(7)(A) bars review of adjustments "effected pursuant to" 42 U.S.C. § 1395ww(e)(1), which does not encompass the Secretary's decision to base the 1986 standardized amounts based on the prior year's budget-neutralized rates.[21] They also discuss the Board's rationale that the decision to carry forward the FY 1985 budget neutrality adjustment to FY 1986 and onward was "inextricably intertwined" to the original calculation and application of that adjustment in FY 1985, but note that the court in *St. Mary's* rejected this proposition.[22] The Providers conclude that 42 U.S.C. § 1395ww(d)(7)(A) was intended to "preclude review of the Secretary's application of the budget neutrality adjustments in FYs 1984 and 1985 and nothing more."[23]

With regard to the Request for EJR, since the Board is bound to comply with all provisions of Title XVIII of the Social Security Act and regulations issued thereunder,[24] the Board is bound by the rates published in the FY 2025 IPPS final rule and cannot declare them unlawful. Thus, the Providers argue that the Board does not have authority to resolve this dispute and EJR is appropriate.[25]

Finally, assuming the Board will once again find it lacks subject matter jurisdiction in this case, the Providers request the Board also make a finding with regard to whether it has the authority to grant the relief sought. They argue that this would serve the interest of judicial economy to

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[16] *Id.* at 4-8.
[17] *Id.* at 8.
[18] *Id.* at 14-15.
[19] *Id.* at 15-16 (quoting PRRB Case 25-1141GC, EJR Determination and Notice of Dismissal (Jan. 17, 2025) (copy at Ex. P-8)).
[20] *Id.* at 16.
[21] *Id.* (citing .*St. Mary's Regional Medical Center v. Becerra*, 2024 WL 5186641 (D.D.C. 2024) ("*St. Mary's*")).
[22] *Id.* at 20-21.
[23] *Id.* at 17, n.6.
[24] 42 U.S.C. § 405.1867.
[25] Petition for Expedited Judicial Review at 21-22.

avoid a remand for this limited purpose, and that the Board has done so in analogous cases in the past.[26]

The Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a Response to Provider's Request for Expedited Judicial Review on **October 16, 2025**. It reiterates its view that the Board lacks subject matter jurisdiction, as first argued in its Jurisdictional Challenge (which is detailed below).

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

The D.C. District Court's decision in *St. Mary's Regional Medical Center v. Becerra*,[27] involves a different substantive issue than the instant group appeals – namely whether the Secretary miscalculated the standardized amount in FY 1984 by including transfer cases in the denominator – but it does discuss as *dicta* whether section 1395ww(d)(7)(A) bars review of the Secretary's decision to apply the 1985 budget neutrality adjustment to the present-day rates.

In *St. Mary's*, a group of providers challenged their FY 2019 IPPS payments, alleging that when calculating "allowable operating costs per discharge" in calculating the IPPS, "the Secretary erroneously counted inter-hospital transfers as 'discharges,' . . . [which] depressed the inaugural standardized amounts and, . . . has perpetuated chronic underpayment up to the present day."[28] While there are time limits on when a provider can challenge their payment determinations, providers are generally permitted to challenge "predicate facts" – courts have permitted providers to modify "predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[29] Predicate fact challenges are permitted "no matter how long ago the facts were established, so long as the providers raise their challenge in a timely administrative appeal and seek damages only for underpayment during an open cost year."[30]

In April 2023, the Board dismissed the underlying providers' appeals in *St. Mary's* for lack of subject matter jurisdiction, finding the standardized amounts at issue were inextricably intertwined with the budget neutrality adjustments which were precluded from administrative review.[31] With regard to whether the providers had standing to bring their case, the court in *St. Mary's* addressed the Board's arguments and rejected them all. The Board had noted that the original standardized amount calculations were actually inflated, rather than deflated, but this did not obviate "the independent, judicially cognizable injury which the plaintiffs now allege—to wit, that the Secretary's supposedly unlawful categorization of transfers as discharges exerted downward pressure on their compensation." This injury is not erased by "some unrelated benefit

[26] *Id.* at 2, 14, 22-23.
[27] 2024 WL 5186641 (D.D.C. 2024).
[28] *St. Mary's.* at *4.
[29] *Id.* (citing *Kaiser Found. Hosps. v. Sebelius*, 708 F.3d 226, 232-233 (D.C. Cir. 2013)).
[30] *Id.* (citing *St. Francis Med. Ctr. v. Azar*, 894 F.3d 290, 294 (D.D.C. 2018)).
[31] Case No. 19-1723GC *et al.*

of equal or greater value" – which would be relevant to the issue of damages, but not jurisdiction.[32]

The court also rejected the notion that other adjustments to the standardized amount "between 1985 and 1997 may have broken the chain between the inaugural calculations and the allegedly depressed 2019 standardized amounts."[33] The court seemed skeptical,[34] and while it did not outright reject this argument, it was not sufficiently explored to defeat the Provider's jurisdictional claim of standing.[35]

While stated as *dicta* in the *St. Mary's* decision, but relevant to the instant cases, the court did explicitly state "no part of the IPPS statute, including the budget neutrality provisions, authorized the Secretary to carry forward the 1985 budget neutrality adjustment to the following year; in fact, the statute forbade him from doing so."[36]

The court then looked to whether the statutory preclusion provisions actually precluded review of the 1984 standardized amounts. It found that the statutes did not explicitly preclude review,[37] and also found that the calculation of the 1984 standardized amounts is not "inexplicably intertwined" with the budget neutrality adjustments, especially in light of the Administrative Procedure Act's strong presumption of judicial review.[38] The court ultimately remanded the case for further proceedings.[39] The Secretary then filed a motion for clarification or partial reconsideration of the Court's decision. On September 26, 2025, the Court issued a Memorandum & Order granting the Secretary's motion to confirm that the Court's holdings are limited to the Board's jurisdiction over the dispute and denying the motion for partial reconsideration.[40] Thus, the decision is not yet final and the Secretary may still opt to appeal to the D.C. Circuit Court. The Board Majority notes that this District Court decision is not binding on the Board and, given the recent issue of the Order, is still subject to appeal. Based on the foregoing, the Board Majority declines to follow the holdings in *St. Mary's*.

4. Jurisdictional Challenges

The Medicare Contractor filed a Jurisdictional Challenge in this case on **July 31, 2025**. The Jurisdictional Challenge argues that the Board lacks subject matter jurisdiction, citing the Board's previous decisions dismissing cases which implicated a challenge to the standardized amount(s). It importantly notes the Secretary's position in 1984 that increasing the base

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[32] *St. Mary's* at *7.
[33] *Id.*
[34] *Id.* ("[T]he Secretary himself reiterated that the current standardized amount is the result of adjusting and updating the original standardized amounts, necessarily—if implicitly—disclaiming the possibility that subsequent statutory or regulatory changes have washed away any trace of the inaugural calculations.") (citing 83 Fed. Reg. 41144, 41713 (Aug. 17, 2018)).
[35] *Id.*
[36] *Id.* at *9.
[37] *Id.* at *11-12.
[38] *Id.* at *13-17.
[39] *Id.* at *19.
[40] *St. Mary's Reg'l Med. Ctr. v. Kennedy*, No. 1:23-cv-01594-RCL (Sept. 26, 2025).

standardized amount would have been offset or neutralized by a corresponding increase in the subsequent budget neutrality adjustment.[41] It also notes that the decision in *St. Mary's* is still not final and litigation is ongoing and did not specifically rule on the budget neutrality adjustment issue present in this case.[42]

The Providers filed a timely response to the jurisdictional challenge on **August 28, 2025**. They imply that the Jurisdictional Challenge describes a different issue relate to the standardized amount.[43] They claim the Medicare Contractor's argument that certain "intervening events" have broken the causal chain between the alleged error and the harm to Providers was rejected by the court in *St. Mary's*.[44] They also address an argument made in previous Jurisdictional Challenges that was ***not*** present in the instant challenge: that the Providers have failed to demonstrate the "actual extent of their harm." They note that this argument was rejected by *St. Mary's* as conflating the determination of harm for purposes of jurisdiction versus calculating damages with regard to a remedy.[45] The remainder of the response reiterates points made by the court in *St. Mary's* which rejected the Board's analysis in dismissing challenges to the standardized amounts.

BOARD DECISION:

As described more fully below, the Board Majority finds that it lacks substantive jurisdiction over these groups because: (1) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs;[46] and (2) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs.

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[47] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[48]

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[41] Medicare Administrative Contractor's Jurisdictional Challenge at 6-7 (July 31, 2025) (49 Fed. Reg. 234 (Jan. 3, 1984)).
[42] *Id.* at 9.
[43] Providers' Response to MAC's Jurisdictional Challenge at 1 (Aug. 28, 2025).
[44] *Id.* at 1-2.
[45] *Id.* at 2-4.
[46] *But see* **Appendix A**. The Board has not traced the standardized amount after FFY 1986 all the way up to the each of the years in question. **Appendix A** highlights how, in addition to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and forward, there could be other intervening statutory or regulatory events (whether discretionary or mandatory) that could break the Providers' alleged causal link between the alleged error in the initial FFY 1984 rates and the standardized amounts used in the years at issue.
[47] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[48] *Id.*

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[49] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain base period cost data be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[50] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1981 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount and then *updated* by an inflationary factor to bring it forward to FFY 1984.[51] The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[52] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary (*see also* **Appendix A**). In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the BNA for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and

[49] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[50] *Id.* (emphasis added).
[51] *Id*. at 39763-64.
[52] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> > (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[53]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 and 1985 rate years, respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[54]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

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[53] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[54] (Italics emphasis in original and bold and underline emphasis added.)

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[55]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[56] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the BNA).

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[55] (Italics emphasis in original and bold and underline emphasis added.)

[56] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board Majority's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1/2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,
>
> (VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

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aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

> (VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 percentage point for hospitals located in a rural area,
>
> (IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,
>
> (X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[57]

[57] (Emphasis added.)

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) for years after 1984, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 BNAs (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, **it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs**. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and

(D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.

(ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—

(A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.

(3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making

> this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[58]

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

While the Providers in this case claim they are not specifically challenging the FY 1984 and 1985 standardized amounts, these amounts and their associated BNAs are implicated in their appealed issue and the preclusion on their review discussed below is still relevant.

The published standardized amount for the FFY in this appeal reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the BNAs for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used for the very first year of IPPS and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage

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[58] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[59] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, **the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs**.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***roughly 40 years*** to increase the FFY 1985 budget-neutrality adjusted rate to exclude the BNA and then use that increased rate to calculate the 1986 standardized amount. They would then simply carry or flow that *increase forward by the relevant 40 years*. However, in order to peel the amalgamated standardized amounts for the FFY at issue *as used in the IPPS rates for each FFY* back to the standardized amount***s*** (plural) used in FFY 1986, and then carry/flow any change forward *to the FFY at issue*, this necessarily implicates the FFY 1985 budget neutrality adjustment, as the providers are requiring that adjustment be excluded in the calculation of the 1986 rate.

However, they cannot do so because this BNA had the effect of ***fixing*** the pie for FFY 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[60] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 BNA and the IPPS rates paid for FFY 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1985.[61]

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[59] *See* **Appendix A.**

[60] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[61] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the BNAs would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from

Accordingly, the Board Majority finds that the Providers' challenge to the standardized amounts at issue are *inextricably* tied to the BNA made for FFY 1985.[62][63]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1985 BNA. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and judicial review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[64]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

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which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[62] The Board Majority notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 BNAs given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[63] The Board majority also recognizes the recent D.C. District Court decision in *St. Mary's Reg'l Med. Ctr. v. Becerra*, 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024) ("*St. Mary's*") and the Providers' position that, while that case involves a different substantive issue - whether the Secretary miscalculated the standardized amount in FY 1984 by including transfer cases in the denominator –that it "held that section 1395ww(d)(7)(A) does not bar review of the Secretary's decision to apply the 1985 budget neutrality adjustment to the present-day rates." *See* Notice of Supplemental Authority (Dec. 31, 2024). The Board Majority notes that this District Court decision is not binding on the Board and, given its recent issuance, is still subject to appeal. Based on the foregoing, the Board declines to follow the holdings in *St. Mary's*.

[64] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1985 BNA is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the Board Majority finds that the FFY 1985 BNA effectively fixed the standardized amounts from that point forward for use in the IPPS system.[65]

1. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget-neutrality-adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[66]

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[65] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

[66] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[67] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix A**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification ***specified by Congress***:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[68]

The Board Majority has set forth in **Appendix B** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that:

- The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and
- The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.
- Congress was both aware and involved in the final rates used in FFY 1986, and therefore, aware that those rates were based upon the FFY 1985 budget-neutrality adjusted rates.

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the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

[67] *Id.* (emphasis added).

[68] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

Given the incorporation of the FFY 1985 budget-neutrality-adjusted rates into subsequent years, the Board Majority finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 BNA.

* * * * *

The Board Majority finds that it lacks substantive jurisdiction over the issue raised in this appeal because the ***prospectively-set*** standardized amount used for IPPS rates for FFY 1985 is based on the BNA made for that FFY.[69] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable BNAs.[70] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1985 BNA and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward in the determination of the rates for FFY 1986 and succeeding FFYs, the Board Majority finds that it may not review the standardized amount

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[69] The Board Majority has included at **Appendix A** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1985 BNA. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts.

[70] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board Majority notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board Majority's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts (and, as discussed *supra*, any future FFY standardized amounts, since the incorporation of the FFY 1985 budget-neutrality-adjusted rates into subsequent years leaves them inextricably tied, at a minimum, to the FFY 1985 BNA) would be *inextricably* tied to the ensuing BNAs made for FFYs 1984 and 1985.

used for the FFY being appealed as it relates to the common issue in this appeal.[71] In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates and the Providers may not simply pass through, or over, the BNA for FFY 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise would impact the very integrity of IPPS.

Further, a review of the Providers' calculations of the Amounts in Controversy filed with the original appeals, shows that these calculations are single-page summaries which identify IPPS payments and simply inflate them by 5.92%.[72] There is no evidence that the numerous adjustments made in the intervening years, some of which were required to be budget neutral, and some of which were discretionary, have been properly accounted for. As addressed above, the causal link between the 1986 rates and the 2025 rates is not clearly delineated, and cannot be verified. The effect of the intervening multiple changes noted in **Appendix A** have not been addressed in the calculations of the Amounts in Controversy.

Accordingly, the Board Majority finds that: (1) the appealed issue is *inextricably* tied with the FFY 1985 BNA to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[73]) prohibit administrative and judicial review of those BNAs. Based on these findings, the Board Majority concludes that it does not have substantive jurisdiction over the issue this group case, denies the Petition for EJR, and hereby closes the case and removes it from the Board's docket.

C. Finding re: Authority to Grant Relief Requested

Even if the Board finds that it lacks jurisdiction over the issue under appeal, for the sake of judicial economy the Providers have asked the Board to decide whether it has the authority to grant the relief requested.[74] If, on appeal to federal court, the Board is overruled on its substantive jurisdiction determination, this would eliminate the need for the cases to be remanded just for the Board to address this limited issue. The Providers argue that the Board has done this in the past for different issues where the Administrator disagreed with the Board's findings on a particular issue. This request, however, is specifically prohibited by the regulation governing EJRs. 42 C.F.R. § 405.1842(b)(1) specifically states:

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[71] *But see supra* note 46.
[72] *See, e.g.*, Herrin Hospital (Prov. No. 14-0011).
[73] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).
[74] Petition for Expedited Judicial Review at 2, 14, 22-23.

> ***Prerequisite of Board jurisdiction.*** The Board (or the Administrator) must find that the Board has jurisdiction over the specific matter at issue ***before***[75] the Board may determine its authority to decide the legal question.

Thus, the Board hereby ***denies*** the request to make such a finding in the event that a court, on appeal, finds it does have substantive jurisdiction over these appeals.

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. (dissenting)

For the Board:

11/18/2025

X Kevin D. Smith, CPA

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

Appendices A – Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue
B – Additional Excepts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.
C – Pending appeals on Standardized Amount

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Scott Berends, FSS

[75] (Emphasis added).

Dissenting

The Board has seen numerous appeals regarding the standardized amount issue (see Appendix C) beginning with the "errors in the 1981 cost-reporting data that were used to calculate the standardized amounts in 1983 [and affecting] payment decisions ever since" (the "Transfer Policy" issue)[76] evolving to unlawful preservation of 1985 budget neutrality adjustments in establishing 1986 payment rates (the "Unlawful Application of Budget Neutrality Adjustments" issue) leading to understated IPPS payment rates.[77] In the FY 2025 IPPS final rule, commenters urged the Secretary to "remove those adjustments so that they do not continue to unlawfully reduce IPPS payments to hospitals in FY 2025 and onward."[78] Those comments were not addressed. The standardized amount issue will continue to evolve and be challenged until payment rates are updated, or a final determination is made in this chain of cases.[79]

The instant appeal concerns the issue Unlawful Application of Budget Neutrality Adjustments ("BNA").[80] The FY 1985 BNA included: a reduction to the FY 1985 standardized amount;[81] and an adjustment to the diagnosis related group ("DRG") weights[82] (these two adjustments being "the pair of budget neutrality adjustments" to which the Providers refer). As the FY 1986 IPPS payment rates form the basis for all subsequent years, the Providers believe that FY 2025 payments rates remain understated.[83] They request either the removal of the FY 1985 BNA from the FY 2025 standardized amounts or an adjustment to the DRG rates to remove the FY 1985 BNA.[84]

After filing their appeal, the Providers submitted a Petition for Expedited Judicial Review ("EJR") of this issue.[85] A provider may "seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter […] and the Board determines it lacks the authority to decide the legal question […]."[86] The Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the

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[76] *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 at 293 (D.C. Cir. 2018).
[77] *See* Notice of Dismissal for Case 25-1141GC (Univ. of KS Health Sys. FFY Reasonable Cost-to-IPPS BNA CIRP Group) (Jan. 17, 2025) (available on the Board's website, *see* footnote 1, *supra*.)
[78] Exhibit P-4 to Petition for Expedited Judicial Review (Oct. 9, 2025). On June 10, 2024, King & Spalding (a provider representative in many appeals of this ilk) submitted a comment to the FY 2025 IPPS Proposed Rule. That comment is substantively the same as the issue statement commencing the instant appeal. That comment and others are available at available at https://www.regulations.gov/document/CMS-2024-0131-0025/comment.
[79] *See e.g.*, *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018), which "opened the door to predicate fact challenges, no matter how long ago the facts were established, so long as the administrative appeal and seek damages only for underpayment during an open cost year." *St. Mary's* at *4. For a more fulsome discussion of the history of the standardized amount issues, *see St. Mary's* at *4-*5.
[80] *See* Issue Statement (Feb. 20, 2025).
[81] *See id.*, *citing* 49 Fed. Reg. 34728 at 34796 (Aug. 31, 1984).
[82] *See id.*, *citing* 49 Fed. Reg. 34728 at 34771 (Aug. 31, 1984).
[83] *See id.* at 2.
[84] *See id*.
[85] Petition for Expedited Judicial Review (Oct. 9, 2025).
[86] 42 C.F.R. § 405.1842(a).

matters at issue in the appeal *before* determining its authority to decide a legal question relevant to a matter at issue. [87]

Jurisdiction. To find that it has jurisdiction, the Board must find that a provider has met all claims-filing requirements and has a right to a hearing.

> (a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—
>
> (1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3).
>
> (2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
>
> (3) *The amount in controversy is, in the aggregate, $50,000 or more*, as determined in accordance with § 405.1839 of this subpart.[88]

The necessary requirements for a Board hearing under § 405.1835(a)[89] are:

> (a) Right to hearing on final contractor determination. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if—

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[87] 42 C.F.R. § 405.1840(a)(2). Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a)-(b). While 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction," 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*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[88] 42 C.F.R. § 405.1837(a) (emphasis added).

[89] 42 C.F.R. § 405.1835(c) relates to the right to a hearing when a final contractor determination is not issued within twelve months after the contractor receives the provider's perfected or amended cost report. As that is not an issue in the instant case, I will not address those factors.

> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. ***Exception***: If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) [omitted]
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[90]

The following facts related to fulfilling the requirements for a Board hearing are undisputed. The Providers are dissatisfied with the Secretary's determination of the FY 2025 Final Rule. The Providers filed their appeals within 180 days after the Secretary's determination (the August 28, 2024 publication of the Final Rule).[91] The matter at issue, Unlawful Application of Budget Neutrality Adjustments, is a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in this group.

Substantive Jurisdiction. Certain matters are not subject to administrative and judicial review under the prospective payment system. One of those matters is "[t]he determination of the requirement, or the proportional amount, of the *budget neutrality adjustment* in the prospective payment rates required under section 1886(e)(1) of the Social Security Act."[92] The Majority concludes that the final FFY 1985 standardized amount (on which the FFY 1986 standardized amount was based) is inextricably intertwined with the FFY 1985 budget neutrality adjustment for which administrative and judicial review is prohibited, thus precluding Board review of the appealed issue. The D.D.C. in *St. Mary's* summarizes "Preclusion Provisions" such as this one:

> Congress also made several of the Secretary's calculations unreviewable. 42 U.S.C. § 1395ww(d)(7) provides that "[t]here shall be no administrative or judicial review . . . of . . . any adjustment effected pursuant to subsection (e)(1) . . . ." Subsection (e)(1)(B), in turn, refers to and cross-references the budget neutrality adjustments described in step 6, above. Thus, the combined effect of § 1395ww(d)(7) and § 1395ww(e)(1)(B) is to immunize the Secretary's budget neutrality adjustments from judicial or administrative review. The non-reviewability of the budget

[90] 42 C.F.R. § 405.1835(a) (emphasis in original).
[91] *See* 89 Fed. Reg. 68986 at 69941-48, 69962-63 (Aug. 28, 2024).
[92] 42 C.F.R. § 405.1804(a) (emphasis added).

> neutrality adjustment is also enshrined in the organic statute of the Provider Reimbursement Review Board, the administrative body to which healthcare providers may appeal to challenge a reimbursement determination. That statute provides that "[t]he determinations and other decisions described in section 1395ww(d)(7) . . . shall not be reviewed by the Board or by any court . . . ." 42 U.S.C. § 1395oo(g)(2). Again, § 1395ww(d)(7) does not contain a cross-reference to any other statutory provision of relevance to this dispute; for purposes of the litigation, its sole referent is the budget neutrality adjustments. Finally, CMS's own regulations state that judicial and administrative review is unavailable for budget neutrality adjustments and the creation of DRGs, but do not identify any other aspects of the Secretary's calculations as non-reviewable. 42 CFR § 405.1804. These provisions barring review of the Secretary's budget neutrality adjustments are hereafter referred to as the "Preclusion Provisions."[93]

I respectfully ***dissent*** from the Majority opinion and instead agree with Provider's conclusion that "the agency action challenged in these appeals is not the same action that [42 U.S.C. § 1395ww(d)(7)(A)] shields from review."[94] Indeed, the court in *St. Mary's* echoes this reasoning:

> [T]he Preclusion Provisions bar review of "the requirement, or the proportional amount, of any adjustment *effected pursuant to subsection (e)(1)*," which refers to the budget neutrality adjustments. The plaintiffs are not challenging the "requirement" or "proportional amount" of the 1985 budget neutrality adjustment itself; rather, they are asserting that the outputs of this adjustment should not have been used as the basis of the subsequent year's standardized amount calculation. Under a plain textual reading of the statute, the Preclusion Provisions simply have no bearing on a challenge of that nature.[95]

The recent District Court decision in *St. Mary's* (albeit non-binding) is instructive in its methodology to determine whether one agency decision is inextricably intertwined with another.[96]

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[93] *St. Mary's* at *3.
[94] Petition for Expedited Judicial Review at 17. *See id.* at footnote 6, "The legislative history further confirms that Congress only intended section 1395ww(d)(7)(A) to preclude review of the Secretary's application of the budget neutrality adjustments in FYs 1984 and 1985 and nothing more."
[95] *St. Mary's* at *9 (internal citations omitted).
[96] "First, one agency decision is inextricably intertwined with another if the former is entirely subsumed within or practically indistinguishable from the latter, i.e. because the former constitutes the entire factual or methodological basis for the latter. Second, textual clues, such as whether the two agency processes appear in the same or different subsections of the controlling statute and the presence or absence of internal cross-references, may suggest whether the processes are inextricably intertwined. Third, agency actions are not inextricably intertwined if the means of implementing them are very different in practice, such as if they entail distinct rulemaking processes, impose different

Approaching the Unlawful Application of Budget Neutrality Adjustments issue in the same manner that the D.D.C. approached the Transfer Policy issue, I find that FFY 1986 IPPS Rates are not inextricably intertwined with the 1985 budget neutrality adjustment. First, the 1985 budget neutrality adjustment does not constitute the entire methodological basis for the FFY 1986 IPPS Rates. While, as highlighted by the Majority, the Secretary confirmed that the FFY 1985 budget-neutrality-adjusted federal rates would be the basis for determining the FFY 1986 federal rates,[97] it is also true that the Secretary "will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality"[98] and "the Secretary will consider the recommendations of the Prospective Payment Assessment Commission."[99] Continuing the analysis, the agency actions occur at different times (1985 versus 1986) and entail distinct rulemaking processes (each FFY has its own IPPS Final Rule). A challenge to one does not necessarily constitute a challenge to the other.

Finding that the issues are not inextricably intertwined (i.e., review is not precluded), I find that Providers have established their right to a Board hearing. However, the Board must comply with all the provisions of Medicare statutes and regulations, as well as CMS Rulings.[100] "Since the Board is bound by the rates the Secretary published in the FY 2025 IPPS final rule and cannot declare them unlawful, it cannot grant the relief requested by the Providers."[101] Therefore, the Board should grant EJR.[102]

11/18/2025

X Nicole E. Musgrave

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Board Member
Signed by: Nicole Musgrave-burdette -A

obligations on private parties, or occur at different times. Fourth, lest a plaintiff circumvent Congress's intent to preclude review through artful pleading, agency decisions are inextricably intertwined if a challenge to one necessarily constitutes a challenge to the other." *St. Mary's* at *15.

[97] *See* 50 Fed. Reg. 35646 at 35697 (Sept. 3, 1985), which Provider cites in its Petition for Expedited Judicial Review at 7 to illustrate that the Secretary ignored the limits imposed by the statute.

[98] 42 C.F.R. § 405.473(c)(3) (1983).

[99] *Id*.

[100] 42 C.F.R. § 405.1867.

[101] Petition for Expedited Judicial Review at 22.

[102] 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 expedited judicial review ("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. *See* 42 C.F.R. §§ 405.1842, 405.1867. *See also* Board Rule 42.

APPENDIX A
Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1985 to the fiscal years at issue

Set forth below are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments ("BNAs") and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). These other examples raise questions about the causal link between the standardized amount rates at issue and the standardized amounts set for FFY 1985.

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[103] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[104]

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[103] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[104] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

c. BNAs made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[105]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[106] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[107]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[108]

Id. at 35655-56.

[105] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[106] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A).

[107] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[108] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[109] and 1997[110] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[111]

To illustrate the complex nature of these issues, the Board Majority points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[112] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[113] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment*

[109] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."
[110] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).
[111] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").
[112] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).
[113] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

for inpatient hospital services furnished to beneficiaries. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport*

with the statutory requirement that the rates represent payment for efficiently delivered care.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[114]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates*. In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[114] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[115] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[116] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[117]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[118] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[119] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

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[115] *Id.* at 35703-04 (bold and underline emphasis added).
[116] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[117] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[118] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[119] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions.

APPENDIX B
Additional Excerpts from FFY 1985 IPPS Final Rule
Affirming Application of FFY 1985 budget-neutrality-adjusted rates to
FFY 1986 and subsequent years.

In its decision, the Board Majority has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to various IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue. Further, it is clear from the fact that the comments and responses quoted below from the various final rules directly address the use of the budget-neutrality-adjusted FFY 1985 rates in the development of future rates and that proper notice-and-comment rulemaking was followed in the development of these rates. The Providers were aware of the Secretary's handling, with no ambiguity, as early as 1986.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 BNA accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments

> to the Federal rates for this factor for either FY 1986 or FY 1987.[120]

2. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary addresses the issue of using the pre-BNA or post-BNA FFY 1985 rate for the development of the FFY 1986 rate:

> We have also considered the commenter's position that FY 1984 and FY 1985 standardized rates be recalculated to remove the entire effect of budget neutrality prior to developing the FY 1986 payment rates. We do not agree that the prior years' standardized rates before budget neutrality should serve as the basis for updating the FY 1986 rates. Since the budget-neutralized standardized amounts represent the actual payment rates used to pay hospitals in FY 1985, we believe the 'percentage change' for FY 1986 should be applied to these amounts. In addition, section 1886(d)(3)(A) and (C) of the Act does not explicitly require that the update factor apply to the FY 1985 payment rates prior to the adjustments for budget neutrality in FY 1985.[121]

3. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her BNAs for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section

---

[120] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). The Board Majority notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 BNA accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.
> For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

[121] 50 Fed. Reg. at 35697.

> 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**
>
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**[122]

4. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 BNA to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician

[122] 51 Fed. Reg. at 31505-31506.

> anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[123]

[123] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

Appendix C

Pending cases involving standardized amounts vis-à-vis and FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

In its dissent, the Board Minority has noted that numerous challenges to the present-day IPPS rates stemming from perceived errors in the 1981 discharge data, 1984 and 1985 standardized amounts and adjustments, and 1986 standardized amounts are before the courts. At present, only one case (*St. Mary's)* has received a decision, and that decision is still within the time period where it may be appealed. Many of the others are stayed pending its resolution. Below is a sampling, where "*" designates a case in which the Board dismissed the 1986 issue.

St. Mary's Reg'l Med. Ctr. v. Becerra[124], 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024), *appealed from* Board dec. dated Apr. 6, 2023 (lead Case No. 19-1723GC);

Nea Baptist Mem'l Hosp. et al v. Becerra, 1:24-cv-00419 (D.D.C. filed Feb. 12, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Dec. 14, 2023 (lead Case No. 19-0520GC);

Baystate Franklin Med. Ctr. et al v. Becerra, 1:24-cv-00822 (D.D.C. filed Mar. 22, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC);

Acadia Gen. Hosp., Inc. et al v. Becerra, 1:24-cv-00936 (D.D.C. filed Apr. 1, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC);

Catholic Med. Ctr. et al v. Becerra, 1:24-cv-01231 (D.D.C. filed Apr. 26, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 28, 2024 (lead Case No. 19-0696GC);

Capital Health Med. Ctr. Hopewell et al v. Becerra, 1:24-cv-01240 (D.D.C. filed Apr. 26, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 28, 2024 (lead Case No. 19-0695GC);

Alameda Health Sys. et al v. Becerra, 1:24-cv-01259 (D.D.C. filed Apr. 29, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 28, 2024 (lead Case No. 19-0355GC);

Washington Hosp. Ctr. Corp. et al v. Becerra, 1:24-cv-01243 (D.D.C. filed Apr. 26, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 29, 2024 (lead Case No. 19-0456GC);

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[124] On Sept. 26, 2025, Judge Lamberth issued an order in *St. Mary's*, granting the Secretary's motion in part, confirming that the Court's holdings are limited to the Board's jurisdiction over the dispute, and denying the Secretary's motion in part, insofar as it seeks partial reconsideration of the Court's decision.

Albany Med. Ctr. et al v. Becerra, 1:24-cv-01258 (D.D.C. filed Apr. 29, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 29, 2024 (lead Case No. 19-0212G);

New York City Health and Hosp. Corp. et al v. Becerra, 1:24-cv-01302 (D.D.C. filed May 3, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Mar. 4, 2024 (lead Case No. 19-1643GC);

Northwestern Mem'l Hosp. et al v. Becerra, 1:24-cv-01309 (D.D.C. filed May 3, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Mar. 4, 2024 (lead Case No. 19-0295);

**Adena Reg'l Med. Ctr. et al v. Becerra*, 1:24-cv-03336 (D.D.C. filed Nov. 26, 2024) *appealed from* Board dec. dated Sept. 27, 2024 (lead Case No. 18-1646G);

**Christus St. Frances Cabrini Hosp. et al v. Becerra*, 1:24-cv-03355 (D.D.C. filed Nov. 27, 2024) *related case St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 20-2104GC);

**Armstrong County Mem'l Hosp. et al v. Becerra*, 1:24-cv-03359 (D.D.C. filed Nov. 27, 2024) *related case, St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 24-1601G);

**Alameda Health Sys. et al v. Becerra*, 1:24-cv-03357 (D.D.C. filed Nov. 27, 2024) *related case St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 19-0354GC); and

St. Barnabas Med. Ctr. et al v. Becerra, 1:24-cv-03363 (D.D.C. filed Nov. 29, 2024) *related case St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 19-1143GC).

*Univ. of Kansas Hosp. Auth. et al v. Kennedy, 1:25-cv-00603 (D.D.C. filed Feb. 28, 2025) *related case St. Mary's*, *appealed from* Board dec. dated Jan. 17, 2025 (lead Case No. 25-1141GC).

* Capital Health System, Inc. et al v. Kennedy, Jr., 1:25-cv-03073 (D.D.C. filed Sept. 8, 2025) *related case, University of Kansas Health Sys.*, *appealed from* Board dec. dated July 10, 2025 (lead Case No. 25-1403GC).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Danbury Medical Center (Provider Number 07-0033)
FYE: 09/30/2018
Case Number: 22-0050

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0050. Set forth below is the decision of the Board to dismiss the two (2) remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 22-0050*

On **April 29, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **October 13, 2021**, the Provider filed this individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

1. SSI Percentage (Provider Specific)
2. SSI Percentage – ***transferred May 9, 2022***
3. Medicaid Eligible Days
4. Part C Days – SSI & Medicare Fraction – ***transferred May 9, 2022***
5. Dual Eligible Days (Exhausted Part A Benefit, Medicare Secondary Payor, No-Pay Part A Days) – SSI & Medicare Fraction – bifurcated to Medicaid Fraction Case (***transferred May 9, 2022***) and SSI Fraction Case (***transferred May 10, 2022***)
6. Standardized Payment Amount – ***transferred May 9, 2022***
7. ATRA IPPS Payment Reduction – ***withdrawn May 9, 2022***

On **October 29, 2021**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position

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

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

On **June 2, 2022**, the Provider filed its Preliminary Position Paper

On **September 23, 2022**, the Medicare Contractor timely filed its Preliminary Position Paper. With regard to Issue 1 (SSI Percentage – Provider Specific), the Medicare Contractor said it "contends that the underlying facts of this issue are the same as that appealed in Group Case No. 22-1001GC, Nuvance Health CY 2018 DSH SSI Percentage CIRP Group, of which this provider is a member. In accordance with Board Rule 4.6.1, 'A Provider may not appeal an issue from a single final determination in more than one appeal.' Therefore, the MAC will file a formal Jurisdictional Challenge on this issue."[2] With regard to Issue 3 (Medicaid Eligible Days), the Medicare Contractor noted the Provider was seeking 100 additional Medicaid days, but that it was still requesting a listing of days to consider any allowable days,[3] but that no listing was included with the Provider's Preliminary Position Paper in violation of the Board's Rules.[4]

On **March 21, 2025**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave instructions to the Provider regarding the content of its final position paper, which stated:

> [T]he final position paper is an optional filing, intended to hone/refine the issue(s), if necessary, but it is not required. See 42 C.F.R. § 405.1853(b)(2)-(3) and **Board Rule 27** for more specific content and exhibit requirements. If the Provider opts not to file a final position paper, then the arguments and exhibits related to the issue(s) under appeal may be limited to those set forth in the preliminary position paper. *See* **Board Rules 27.4** and **35.3**.[5]

Neither party opted to file a Final Position Paper.

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[1] (Emphasis added.)
[2] MAC Preliminary Position Paper at 8 (Sept. 23, 2022).
[3] *Id.* at 15-16.
[4] *Id.* at 18-20.
[5] (Emphasis in original.)

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-1001GC - Nuvance Health CY 2018 DSH SSI Percentage CIRP Group

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

> **Statement of Issue**
>
> Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § l395ww(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.[6]

[6] Appeal Request, Issue 1 (Oct. 13, 2021).

The Group Issue Statement in Case No. 22-1001GC, to which the Provider transferred Issue No. 1, reads:

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 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.

Covered Days vs. Total Days

The statutory language defines the Medicare/SSI fraction as consisting solely of days for patients who were "entitled to benefits under part A" of Medicare. The numerator includes only those Part A days for patients who are also entitled to SSI benefits. The denominator of the Medicare/SSI fraction includes all Part A days. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both eligible for medical assistance under Title XIX, or Medicaid, and not entitled to benefits under Part A of Title XVII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period.

> CMS considers an individual to be "entitled to benefits under Part A" regardless of whether the days were "covered" or paid by Medicare. This means that now Part C days, Exhausted Benefit days, and Medicare Secondary Payer ("MSP") days are included in the denominator of the Medicare/SSI fraction even when there is no payment by Medicare, which is a departure from the treatment of these days as excluded from the Medicare/SSI fraction prior to the 2004 rule.
>
> The Provider(s) contend(s) that if CMS includes unpaid Medicare Part A days in the denominator of the Medicare/SSI fraction, then unpaid SSI eligible patient days must be included in the numerator of the Medicare/SSI fraction, utilizing SSI payment codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments, as a matter of statutory consistency.[7]

On **June 2, 2022**, the Board received the Provider's preliminary position paper in Case 22-0050. 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. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Connecticut and has learned that similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[8]

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[7] Group Issue Statement for Case No. 22-1001GC (Apr. 13, 2022).
[8] Provider's Preliminary Position Paper at 8-9 (June 2, 2022).

The amount in controversy listed for Issue 1 in the initial appeal request for Case 22-0050 is $173,000. The Provider lists the same amount in controversy as a participant in Case 21-1001GC.

C. Description of Issue 3 – Medicaid Eligible Days in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 3, 21, S-D
>
> Estimated Reimbursement Amount: $79,000[9]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper 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]

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

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. The MAC contends that Issue 1 should be dismissed because it is duplicative of Issue 2, which was transferred to PRRB Case No. 22-1001GC.[12] The portion of Issue 1 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, and it abandoned the issue by not briefing it in its Preliminary Position Paper. Also, "the cost reporting period in dispute ended on September 30, 2018, which coincides with the Federal fiscal year. Thus, the issue of SSI realignment is moot."[13]

Issue 2 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board dismiss this issue for failure to comply with the Board's Rules. While the Provider's Preliminary Position Paper indicates that a listing of Medicaid Eligible Days was being provided under separate cover, none was ever furnished to the Medicare Contractor. Additionally, the MAC requested a listing on July 26, 2022, but none was furnished.[14] It also explains that the Board's Rules require that supporting documentation be included in Preliminary Position Papers, and the Provider's failure to submit a listing with the position paper warrants dismissal of the issue.[15]

Decision of the Board

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

As set forth below, the Board hereby ***dismisses*** the Provider's two (2) remaining issues.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

[12] MAC Preliminary Position Paper at 8.
[13] *Id.* at 7.
[14] MAC Preliminary Position Paper at 15-16.
[15] *Id.* at 18-20.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that is being appealed in Case No. 21-1001GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[16] 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)."[17] The Provider argues in its issue statement, included in the original 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."[18]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1001GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 22-0050 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1001GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] Accordingly, the Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping the issue 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, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1001GC.

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[16] Appeal Request at Issue 1.
[17] *Id.*
[18] *Id.*
[19] PRRB Rules v. 2.0 (Aug. 2018).
[20] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1001GC but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, or to explain how that information is relevant, and whether such a review was done for purposes of the year in question, consistent with its obligations under Board Rule 25.2. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[21]

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.[22]

[21] (Italics and underline emphasis added.)
[22] 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005).

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.[23]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to send a request via email to access their DSH data."[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 codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the group under Case No. 21-1001GC.

Accordingly, *based on the record before it*, the Board finds that the SSI Provider Specific issue in Case No. 22-0050 and the group issue from the Nuvance CIRP group under Case No. 21-1001GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal. Additionally, the Board notes that the Provider did not brief this aspect of Issue 1 in its Preliminary Position Paper and thus, pursuant to Board Rule 41.2, the Board finds that it has been abandoned and that this is an independent, alternative basis for dismissal of this aspect of Issue 1. Finally, the Board also finds that the Provider's fiscal year end (September 30, 2018) coincides with the federal fiscal year end, so realignment of its SSI percentage would have no impact on the Provider's SSI percentage and thus no reimbursement impact, making this aspect of Issue 1 moot.

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[23] Last accessed Nov. 19, 2025.
[24] (Emphasis added).

B. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (2018) states, at 7.3.2:

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[25]

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

[25] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[26]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

* * *

25.2 Position Paper Exhibits

25.2.1 General

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

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on **October 19, 2021** included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 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) (2021) 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.[27]

[27] (Emphasis added.)

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

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

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

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

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

On **June 2, 2022**, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was "being sent under separate cover."[28] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (*i.e.*, the estimated impact of $78,925 based on an estimated 100 days). The Provider's complete briefing of this issue in its preliminary position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984

[28] Provider's Preliminary Position Paper at 8.

> (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 <u>being sent under separate cover</u>, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[29]

In its Preliminary Position Paper, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. It notes that the June 2, 2022 Preliminary Position Paper noted that an eligibility listing was being sent under separate cover, and that despite a request made on July 26, 2022 for such a listing, none was ever furnished. Notably, this request for a listing was sent to the Provider *nearly four years after the end of the Provider's cost reporting period*.[30]

The Medicare Contractor's Preliminary Position Paper requests dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (*e.g.*, a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The Medicare Contractor essentially asserts that the Provider has abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[31]

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[29] (Underline emphasis added.)
[30] MAC Preliminary Position Paper at 15-21.
[31] *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

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

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(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 to describe why said evidence is unavailable.[33]

* * * * *

Based on the foregoing, the Board has dismissed the two (2) remaining issues in this case – (Issues 1 and 3). As no issues remain, the Board hereby closes Case No. 22-0050 and removes it

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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.

[32] (Emphasis added.)

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

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

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:

11/19/2025

X Kevin D. Smith, CPA

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

cc: Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Determination: Request for Reinstatement of Issue***
Naples Community Hospital (Provider Number 10-0018)
FYE: 09/30/2018
Case Number: 24-2565

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the September 4, 2025 reinstatement request from Quality Reimbursement Services, Inc. ("QRS") with regard to the Provider's previous withdrawal of the Standardized Payment Amount issue in the subject appeal. The pertinent facts considered by the Board and the Board's determination are set forth below.

Background:

On **September 19, 2024**, QRS timely filed an individual appeal for Naples Community Hospital's ("Naples"/Prov. No. 10-0018) FYE 09/30/2018 based on a March 28, 2024 Notice of Program Reimbursement ("NPR"). The appeal included seven (7) issues:

1. SSI (Provider Specific)
2. SSI Unduly Narrow Definition of SSI Entitlement
3. Medicaid Eligible Days
4. SSI MCD PT C
5. Improper Rulemaking – SSI Medicare Fraction Dual Eligible Days
6. Improper Rulemaking – Medicaid Medicare Fraction Dual Eligible Days
7. Standardized Payment Amount

On **April 30, 2025**, Issues 2, 4, 5 and 6 were transferred to common issue related party ("CIRP") groups, leaving only the SSI (Provider Specific), Medicaid Eligible Days and Standardized Payment Amount issues.

On **August 28, 2025**, QRS withdrew the SSI (Provider Specific) issue.

On **September 2, 2025**, QRS withdrew the Medicaid Eligible Days issue.

On **September 4, 2025**, QRS withdrew the Standardized Payment Amount issue, which resulted in the closure of the case.

On **September 4, 2025**, (about an hour later), QRS filed a request to reinstate the Standardized Payment Amount issue. In its request, QRS indicates that it inadvertently withdrew issue #7.

Board Determination:

Board Rule 47.1 governs motions for reinstatement of an issue or case:

> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement *(see* Rule 44 governing motions). **The Board will not reinstate an issue(s)/case if the provider was at fault. . . .**
>
> . . . .
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> **Upon written motion demonstrating good cause**, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, **administrative oversight**, settlement negotiations or a change in representative **will not be considered good cause to reinstate**. . . .[1]

Board Rule 47.1 makes clear that the Board will not reinstate a case or issue **if the provider was at fault.** Additionally, the Board refers QRS to Board Rule 47.3, which is specific to dismissals due to failure to comply with Board procedures. Although Naples' withdrawal of the Standardized Payment Amount issue was not a matter of the Provider's failure to comply with a Board procedure, this Rule is still pertinent because it details what the Board **does not consider to be good cause for reinstatement**, specifically, *administrative oversight*.

Further, the PRRB External User Manual at 3.3.2.2 directs the Provider on how to withdraw an issue in OH CDMS.[2] The Provider/Representative is directed to "***Select the Withdraw button for the issue you wish to withdraw***. The Withdraw Issue confirmation window is displayed." Then the Provider/Representative is directed to "Enter Yes in the field to ***confirm the withdrawal*** and select the Proceed button."

---

[1] (Italics emphasis in original, and bold emphasis added except the titles had bold emphasis in original.)
[2] https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/downloads/oh-cdms-prrb-external-user-manual-v-10.pdf

After review of the facts in this case, the Board finds that there is no basis for good cause to justify reinstatement of the Standardized Payment Amount issue in Naples' individual appeal. The Case Issues page in OH CDMS has separate Transfer and Withdraw "buttons" for each issue and makes the user confirm the action before proceeding.

The Board notes that QRS is more than familiar with the Board Rules and procedures.[3] The Rules in this situation, specifically Board Rule 47, are clear that "administrative error" is not considered good cause for reinstatement. Therefore, the Board rejects QRS' explanation as a justification for good cause to reinstate the Standardized Payment Amount issue and denies the request for it to be reinstated in the Provider's individual appeal. Case No. 24-2565 remains closed.

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

For the Board:

11/21/2025

X Kevin D. Smith, CPA

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

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

[3] QRS was the authorized representative in Case No. 19-2073 which had similar circumstances. The Board denied reinstatement of the issue in that case, as well.

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***
Munroe Regional Medical Center (Prov. No. 10-0062), FYE 09/30/2017
Case No. 22-0686

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0686. Set forth below is the decision of the Board to dismiss the two (2) issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") SSI Provider Specific and DSH- Medicaid Eligible Days issues.

Background:

A. ***Procedural History for Case No. 22-0686***

On **August 17, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017. The Provider is commonly owned by Community Health Systems, Inc. ("CHS") so it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1).

On **December 22, 2020**, CHS filed the Provider's individual appeal request. The appeal request included five (5) issues:

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

On **September 22, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary

[1] On September 8, 2022, this issue was transferred to Case No. 20-0997GC.
[2] On September 8, 2022, this issue was transferred to Case No. 19-2620GC.
[3] On September 8, 2022, this issue was transferred to Case No. 20-1383GC.

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.[4]

On **September 21, 2022**, CHS timely filed the Provider's PPP in which it briefed the two remaining issues SSI Provider Specific and Medicaid Eligible Days.

On **December 5, 2022**, the Medicare Contractor ("MAC") filed a jurisdictional challenge over the DSH SSI Provider Specific & Medicaid eligible days issues in the case. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge.

On **January 12, 2023**, the MAC timely filed its PPP. The MAC indicated that it had still not received a list of additional Medicaid eligible days even though the Provider indicated one would be sent under separate cover at the time it filed its PPP.

On **November 3, 2023**, CHS requested a change of representation to Quality Reimbursement Services, Inc. ("QRS"), which the Board acknowledged on **November 6, 2023**.

On **November 7, 2023**, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission." The 26-page listing, showing roughly 6763 eligible days, included a *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[5]

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 20-0997GC

In its Individual Appeal Request, the Provider summarizes its DSH- SSI Provider Specific issue as follows:

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

[4] (Emphasis added).
[5] (Emphasis added.)

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i)[6]

The Group issue Statement in Case No. 20-0997GC, to which the Provider transferred Issue 2 (the DSH SSI), reads in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[7]

[6] Issue Statement at 1 (Feb. 8, 2022).
[7] Group Issue Statement, Case No. 20-0997GC.

In the Provider's September 21, 2022 PPP in Case No. 22-0686, the following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Florida and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Florida and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[8]

The amount in controversy listed for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $110,272.

C. Description of Issue 3 in the Individual Appeal Request

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

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

[8] Provider's PPP at 8-9 (Sept. 21, 2022).

Statement of the Legal Basis

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

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

Audit Adjustment Number(s): 4, 6, 22, 23, 24, 29, 30, S-D
Estimated Reimbursement Amount: $97,745

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

MAC's Contentions Issue 1 – DSH SSI Provider Specific

In both its PPP and its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. The MAC argues that two of the sub-issues are duplicative of the SSI Systemic Errors issue that was transferred to a CIRP group. In addition, the MAC maintains that the realignment aspect of the issue should be considered abandoned as the Provider failed to file a complete PPP with all supporting documents. Finally, the MAC noted that the Provider already has a September 30 cost report end so it is already aligned with the Federal fiscal year ("FFY").[11]

MAC's Contentions Issue 3 – DSH Medicaid Eligible Days

The MAC argues that the Provider abandoned the Medicaid eligible days issue when it failed to properly develop its arguments within the PPP in accordance with Board Rule 25. Additionally, the Provider failed to provide a list of additional Medicaid eligible days or any other supporting

[9] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[10] Provider's PPP at 7-8 (Sept. 21, 2022).
[11] MAC's Jurisdictional Challenge at 2 (Dec. 5, 2022).

documents and did not provide an explanation for why it could not produce those documents, even after the MAC.[12]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider failed to file its response to the jurisdictional challenge over the SSI Provider Specific and Medicaid eligible days issues by the deadline and the time for doing so elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

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

A. SSI Provider Specific

The analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 20-0997GC.

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."[14] Per the appeal request, the Provider's legal basis for its SSI Provider Specific issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42

[12] MAC's Jurisdictional Challenge at 11-13 (Dec. 5, 2022).
[13] Board Rules v. 3.1 (Nov. 2021).
[14] Issue Statement at 1.

U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case No. 20-0997GC also alleges that the MAC and CMS improperly determined the SSI Percentage, the SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Provider Specific issue in Case No. 22-0686 is duplicative of the SSI Percentage (*Systemic Errors*) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[17], the Board dismisses this aspect of the SSI Provider Specific issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

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[15] *Id.*
[16] *Id.*
[17] PRRB Rules 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).

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[19]

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

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

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[20]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to send a request via email to access their DSH data."[21]

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[19] (Italics and underline emphasis added.)
[20] Last accessed September 23, 2025.
[21] Emphasis added.

Accordingly, *based on the record before it*, the Board finds that SSI Provider Specific issue in the instant appeal and the group issue in Case No. 20-0997GC are the same issue.[22] 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.

2. Second Aspect of Issue 1

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

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

Finally, the Board notes that the Provider's cost report year end is September 30, which is the same as the FFY. Therefore, the result of a Medicare computation based on the Provider's FYE would be the same as the Medicare computation based on the FFY.

B. Medicaid Eligible Days

The Provider's appeal request 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*. Neither the Provider's appeal request, nor the PPP, included a list of the specific additional Medicaid eligible days that are in dispute in this appeal.

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:

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

> 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:

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

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[23]

Similarly, with regard to position papers,[24] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[25] 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*.

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

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

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

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

This appeal was initiated on February 8, 2022 (more than 3.5 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[26]

On December 5, 2022, the MAC filed a Jurisdictional Challenge, requesting dismissal of both remaining issues, including the Medicaid eligible days issue. Specifically, the MAC contends that: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable) in its appeal request; and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its PPP in violation of Board Rules 25.2.1 and 25.2.2. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[27]

Pursuant to Board Rule 44.4.3, the Provider had 30 days to respond to the challenge to jurisdiction. However, the Provider failed timely respond by the January 4, 2023 filing deadline (i.e., 30 days after December 5, 2022). Ten months after the deadline, on November 7, 2023, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 26 pages with roughly 6,763 Medicaid eligible days. QRS' filing did not explain why the listing, which included substantially more than the 200 days noted

[26] Provider's PPP at 8 (Sept. 21, 2022).
[27] See also Board's jurisdictional decision in Lakeland Regional Health (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

in the initial appeal, was being submitted at this late date or why it was not final despite having been submitted more than 6 years after the fiscal year at issue had closed. Regardless, this filing was 10 months past the deadline for responding to the jurisdictional challenge and, more importantly, was more than 13 months past the deadline for including it with its PPP since that deadline was October 6, 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)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less provide any supporting documentation for those days).

The fact that the Listing was filed 4 days after the Provider requested the change of its designated representative to QRS does not excuse the Provider for its failure to include the information with its PPP or its failure to timely respond to the jurisdictional challenge. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 7, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed 13 months after the deadline for that exhibit to be included with its PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's jurisdictional challenge and the alleged "Supplement" was filed 10 months after the deadline for filing a response to the challenge.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.,* upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 6,763 days was not previously available, in whole or in part (*i.e.,* it is not clear why the Provider failed to identify a single day at issue until more than 1.5 years after this appeal was filed and more than 6 years after the fiscal year at issue had closed); and (c) why the listing still was not a "final" listing at this late date.

3. Neither the Board Rules nor the February 9, 2022 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the "Supplement" filing that they do).

4. Given that the *material* facts (e.g., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP (indeed the *tentative* 6,763 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 200 days included with the appeal request).[28]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[29] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provided the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)- (3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[30]

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[28] See, e.g., Board Rule 27.3 (Nov. 2021) which indicates that, except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence.

[29] (Emphasis added).

[30] 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

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Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: DSH – SSI Provider Specific (Issue 1) and DSH - Medicaid Eligible Days (Issue 3). As no issues remain, the Board hereby closes Case No. 22-0686 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:

11/21/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Geoff Pike, First Coast Service Options, Inc. (J-N)
Wilson C. Leong, Esq., Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Case Number: 25-0012GC - *Scripps Health CYs 2006 - 2012 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' Petition for Expedited Judicial Review ("EJR") filed on **November 6, 2025** in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **October 1, 2024**, the Board received a request to establish a Common Issue Related Party ("CIRP") group. The Providers are appealing from revised Notices of Program Reimbursement ("RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYE") spanning 2006 to 2012.

The issue in these appeals 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] Statement of Issue at 1 (Oct. 1, 2024).
[3] *Id.* at 2-5.

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[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.

> 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]

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

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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).

Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

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

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[23] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).
[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).

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

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate 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

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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.

proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

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

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern 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

[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).
[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).

> the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[42]

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

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

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending 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

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

action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[45]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled, however, that the June 9, 2023 Final Rule is both impermissibly retroactive,[48] and arbitrary and capricious.[49] The court required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[50]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal request argues that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[51] It seeks 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,

[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] 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)).

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]

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their 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]

On **November 12, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed a response to the Request for EJR simply advising that "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[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

[54] *Id.* at ¶¶ 6-18.
[55] Providers' Petition for Expedited Judicial Review at 1-4 (Nov. 6, 2025).
[56] *Id.* at 11.
[57] Response to Provider's 11/6/2025 Request for Expedited Judicial Review at 1 (Nov. 12, 2025).

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; [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 this CIRP 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 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.

The Board finds that the Providers in Case 25-0012GC 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 25-0012GC and that the Providers are entitled to a hearing before the Board;

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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.

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 these group cases, the Board hereby closes Case 25-0012C 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:

11/21/2025

X Kevin D. Smith, CPA

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

Enclosure: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Case Numbers: 25-0202GC *et al.* (15 Cases, *See* – **Appendix A**)

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **November 3, 2025** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received the individual appeal requests or requests to establish a Common Issue Related Party ("CIRP") group for these fifteen (15) cases between **September, 2024** and **October, 2025**. The Providers are all appealing from original or revised Notices of Program Reimbursement ("NPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYE") spanning from 2005 to 2014. The Board also notes that Case 25-3961 has a single issue that is materially identical to the group issue presented in the thirteen (13) CIRP group cases. Finally, Case 25-3569 contains two issues, one of which is materially identical to the group issue presented in the thirteen (13) CIRP group cases.

The issue in these appeals for which the Providers seek EJR 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. 25-0202GC, Statement of Issue at 1 (Oct. 14, 2024).
[3] *Id.* at 2-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[50]

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their original or revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

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

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

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[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.,* Case No. 25-0202GC, Appeal Request, Statement of Jurisdiction (citations omitted).
[52] *E.g.,* Case No. 25-0202GC, Statement of Group Issue at 1. The Board notes that Statement of Issue included with each individual appeal is materially identical to the Statement of Group Issue included with each CIRP group appeal.
[53] *Id.*
[54] *E.g.,* Case No. 25-0202GC, Appeal Request, Statement of Issue (citing to 139 S. Ct. at 1816).

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[55]

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[56]

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[57] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[58] "The Provider[s] contend that the new, post-*Allina* retroactive part C days rule, applied in the NPR[s] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[59] Since the Board is bound by this regulation,[60] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **November 6 and 7, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all fifteen (15) cases. It simply advised that, in each case, "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[61]

Decision of the Board:

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

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[55] *Id.*
[56] *Id.* (citing 4 U.S.C. § 706(2)).
[57] *E.g.*, Case No. 25-0202GC, Provider's Petition for Expedited Judicial Review at 13 (Nov. 3, 2025).
[58] *Id.* at 16-17.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.
[61] *E.g.,* Case No. 25-0202GC, Response to Provider's Request for Expedited Judicial Review at 1 (Nov. 7, 2025).

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [62]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[63]

For these fifteen (15) appeals, the providers all appealed from original and revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the Providers in the individual appeals listed in **Appendix A** filed their appeals within 180 days of the issuance of their NPRs and RNPRs and the amount in controversy exceeds $10,000. Likewise, all the providers in the group appeals listed in **Appendix A** were directly added to the group within 180 days of the issuance of their NPRs and RNPRs and the amount in controversy exceeds $50,000.

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

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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

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

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in Case 25-3961 and the thirteen (13) CIRP Group Cases listed in **Appendix A**, the Board hereby closes these fourteen (14) cases and will remove them from its docket. Since Case 25-3569 has a second issue, it will remain open on the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

11/21/2025

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)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Byron Lamprecht, WPS Government Health Administrators (J-8)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Scott Berends, Federal Specialized Services

Appendix A

26-0276GC	*Allina Health CY 2006 Post-Allina II DSH Part C Days CIRP Group*
26-0228GC	*Allina Health CY 2005 Post-Allina II DSH Part C Days CIRP Group*
24-2642GC	*Henry Ford Health CY 2011 Post-Allina II DSH Part C Days CIRP Group*
24-2780GC	*Henry Ford Health CY 2012 Post-Allina II DSH Part C Days CIRP Group*
25-0998GC	*Henry Ford Health CY 2013 Post-Allina II DSH Part C Days CIRP Group*
25-0203GC	*Henry Ford Health CY 2009 Post-Allina II DSH Part C Days CIRP Group*
25-0204GC	*Henry Ford Health CY 2010 Post-Allina II DSH Part C Days CIRP Group*
25-0202GC	*Henry Ford Health CY 2008 Post-Allina II DSH Part C Days CIRP Group*
25-2792GC	*Methodist Health System FFY 2013 Post-Allina II DSH Part C Days CIRP Group*
25-2384GC	*Methodist Health System CY 2011 Post-Allina II DSH Part C Days CIRP Group*
25-2789GC	*Methodist Health System CY 2012 Post-Allina II DSH Part C Days CIRP Group*
25-5187GC	*Methodist Health System CY 2008 Post-Allina II DSH Part C Days CIRP Group*
25-1085GC	*Methodist Health System CY 2010 Post-Allina II DSH Part C Days CIRP Group*
25-3569	*Kaleida Health (33-0005), FYE 12/31/2005*
25-3961	*North Carolina Baptist Hospital (34-0047), FYE 06/30/2014*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Case Numbers: 25-1433GC *et al.* (20 Cases – *See* **Appendix A**)

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **November 11, 2025** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received the requests to establish Common Issue Related Party ("CIRP") groups for these twenty (20) cases between **October, 2024** and **October, 2025**. The Providers 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 Year Ends ("FYE") spanning from 2005 to 2014.

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. 25-1433GC, Statement of Group Issue at 1 (Jan. 15, 2025).
[3] *Id.* at 2-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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

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

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

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

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

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

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

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

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in

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[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)* as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

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

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

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

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

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

*fractions for **each** applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

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

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

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled,

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[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

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

Providers' Position:

A. Providers' Appeal Requests

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

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

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

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[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.,* Case No. 25-1433GC, Appeal Request, Statement of Jurisdiction (citations omitted).
[52] *E.g.,* Case No. 25-1433GC, Statement of Group Issue at 1.
[53] *Id.*
[54] *Id.* (citing to 139 S. Ct. at 1816).

vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[55]

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[56]

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[57] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[58] "The Provider[s] contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[59] Since the Board is bound by this regulation,[60] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **November 18, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all twenty (20) cases. It simply advised that, in each case, "a jurisdictional challenge will not be filed, a substantive claim challenge will not be filed, and the MAC does not oppose the request."[61]

Decision of the Board:

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

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[55] *Id.*
[56] *Id.* (citing 4 U.S.C. § 706(2)).
[57] *E.g.*, Case No. 25-1433GC, Providers' Petition for Expedited Judicial Review at 13 (Nov. 11, 2025).
[58] *Id.* at 16-17.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.
[61] *E.g.,* Case No. 25-1433GC, Response to Provider's Request for Expedited Judicial Review at 1 (Nov. 18, 2025).

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [62]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[63]

For these twenty (20) 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 group appeals listed in **Appendix A** 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 the Cases listed in **Appendix A** 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 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 the Cases listed in **Appendix A**, 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;

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

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 all twenty (20) Cases listed in **Appendix A**, the Board hereby closes these twenty (20) 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:

11/21/2025

X Kevin D. Smith, CPA

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

Enclosures: Schedules of Providers

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Dean Wolfe, Noridian Healthcare Solutions (J-F_
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Scott Berends, Federal Specialized Services

Appendix A

PRRB Case Number	PRRB Case: Case Name
25-0637GC	*Legacy Health CY 2014 Post-Allina II DSH Part C Days CIRP Group*
25-0840GC	*Legacy Health CY 2012 Post-Allina II DSH Part C Days CIRP Group*
25-0861GC	*Legacy Health CY 2010 Post-Allina II DSH Part C Days CIRP Group*
25-0860GC	*Legacy Health CY 2011 Post-Allina II DSH Part C Days CIRP Group*
25-0862GC	*Legacy Health CY 2009 Post-Allina II DSH Part C Days CIRP Group*
25-0636GC	*Legacy Health CY 2013 Post-Allina II DSH Part C Days CIRP Group*
25-4964GC	*Legacy Health CY 2008 Post-Allina II DSH Part C Days CIRP Group*
26-0094GC	*Legacy Health CY 2005 Post-Allina II DSH Part C Days CIRP Group*
25-2501GC	*Baptist Health South FL CY 2008 Post-Allina II DSH Part C Days CIRP Group*
25-2502GC	*Baptist Health South FL CY 2009 Post-Allina II DSH Part C Days CIRP Group*
25-2503GC	*Baptist Health South FL CY 2010 Post-Allina II DSH Part C Days CIRP Group*
25-2505GC	*Baptist Health South FL CY 2011 Post-Allina II DSH Part C Days CIRP Group*
25-2506GC	*Baptist Health South FL CY 2012 Post-Allina II DSH Part C Days CIRP Group*
25-2507GC	*Baptist Health South FL CY 2013 Post-Allina II DSH Part C Days CIRP Group*
25-0619GC	*Sentara Healthcare CY 2012 Post-Allina II DSH Part C Days CIRP Group*
25-0337GC	*Sentara Healthcare CY 2010 Post-Allina II DSH Part C Days CIRP Group*
25-0338GC	*Sentara Healthcare CY 2011 Post-Allina II DSH Part C Days CIRP Group*
25-0583GC	*Sentara Healthcare CY 2008 Post-Allina II DSH Part C Days CIRP Group*
25-1793GC	*Sentara Healthcare CY 2007 Post-Allina II DSH Part C Days CIRP Group*
25-1433GC	*Sentara Healthcare CY 2009 Post-Allina II DSH Part C Days CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd.
Suite 700
Los Angeles, CA 90064-1582

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

Case Number: 25-0368GC	*CHSLI CY 2008 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number: 25-0226GC	*CHSLI CY 2009 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number: 25-0229GC	*CHSLI CY 2012 CMS1739F Challenge: MCR Part C Days in the Medicare Fraction CIRP Group*
Case Number: 25-0223GC	*Continuum Health CYs 2005-2013 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 **October 20 and 21, 2025** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **October 15 and 22, 2024**, the Board received four (4) requests to establish Common Issue Related Party ("CIRP") groups. The Providers in all four (4) groups are appealing from revised Notices of Program Reimbursement ("RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYE") spanning from 2005 to 2013.

The issue in these appeals 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] *See e.g.*, Case No. 25-0368GC, Statement of Group Issue at 1 (Oct. 22, 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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[50]

Providers' Position:

A. Providers' Appeal Request

The Providers' appeal requests argue that Medicare Part C days "should be reflected in the Medicaid percentage rather than the Medicare/SSI Fraction."[51] They seek to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule.[52] The Providers argue that the Final Rule is contrary the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[53]

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

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

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

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

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[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).
[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.*, Case No. 25-0368GC, 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' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their RNPRs; that the amount in controversy exceeds $50,000; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[55] They note that the June 2023 Final Rule affords appeal rights from RNPRs implementing the retroactive Part C Days policy even if a Provider's SSI Ratio does not change numerically.[56]

The Medicare Contractor's representative, Federal Specialized Services ("FSS"), filed responses to the Requests for EJR on **October 27, 2025**. In Case 25-0223GC, it argues:

> [T]he appeal contains an SSI No Pay Days issue that was dismissed in 25-0224GC. As the group appeal contains multiple issues, EJR is not appropriate.[57]

Similarly, in Case 25-0229GC, FSS argues there are multiple issues in the case. It notes that the issue statement in Case 25-0229GC encompasses challenges to (1) an unreasonable delay in administering payment of claims, and (2) SSI data problems in the calculation of the Medicare fraction, both of which are identical to the issues presented in cases 25-0231GC and 25-0230GC.[58]

In Cases 25-0368GC and 25-226GC, FSS' response simply stated that "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[59]

In all four cases, however, the Medicare Contractor's comments submitted in response to the formation of the groups in November, 2024 raise the same concerns about the Part C cases containing additional challenges to unreasonable delay and SSI data problems, both of which were being pursued in separate cases with the same providers and RNPRs.

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[54] *Id.* at ¶¶ 6-18.
[55] *E.g.*, Case No. 25-0368GC, Providers' Petition for Expedited Judicial Review at 1-4 (Oct. 20, 2025).
[56] *Id.* at 11.
[57] Case No. 25-0223GC, Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 27, 2025).
[58] Case No. 25-0229GC, Response to Provider's Request for Expedited Judicial Review at 1 (Oct. 27, 2025).
[59] *E.g.*, Case No. 25-0368GC, Response to Provider's Request for Expedited Judicial Review at 1 (Oct, 27, 2025).

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; [60]
- 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.[61]

For these four (4) CIRP 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.

The Board finds that the Providers in Cases 25-0368GC, 25-0226GC, 25-0229GC, and 25-0223GC 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.

With regard to the arguments raised by FSS and the Medicare Contractor that these four (4) appeals concern multiple issues which are duplicated in other appeals, the Board notes that the companion cases have been all dismissed. Also, the Board notes that 42 U.S.C. § 1395oo(b), 42 C.F.R. § 405.1837(a)(2), and Board Rule 12.2 all require a group to involve a ***single*** question of fact or interpretation of law. The Requests for EJR in these four (4) cases **only** seek to challenge

[60] 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).
[61] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

the validity of the June 23, 2023 Final Rule, and the Board hereby grants EJR as to that issue ***only***.

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 25-0368GC, 25-0226GC, 25-0229GC, and 25-0223GC and that the Providers in each group appeal are entitled to a hearing before the Board;

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

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

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

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes Cases 25-0368GC, 25-0226GC, 25-0229GC, and 25-0223GC 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:

11/24/2025

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

James Ravindran, President
Quality Reimbursement Services, Inc.
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RE: ***Dismissal of Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Groups***
Case Numbers: 25-1549 *et al.* (*See* Attached Listing of 6 Cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the appeal requests in the six (6) above-referenced cases. Set forth below is the decision of the Board to dismiss these individual appeals. The pertinent facts and the Board's determination are set forth below.

Introduction

Quality Reimbursement Services, Inc. ("QRS") filed the referenced individual appeals in the Office of Hearings Case & Document Management System ("OH CDMS"). The issue statements in these appeals are materially identical. The Providers contend that the that the Medicare/SSI Fractions published on CMS' website on July 26, 2024 (which was subsequently corrected in the August 13, 2024 CMS transmittal 12785), were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction, and . . . exclusion of days from the numerator of the Medicare Fraction associated with individuals who were entitled to Supplemental Security Income (SSI) during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02."[1]

Background

A. Medicare DSH Payment and Realignment

Part A of the Medicare statute 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").[2] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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[1] *See e.g.*, Case No. 25-1549, Provider's Issue Statement at 1 (Jan. 22, 2025).
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific disproportionate share hospital ("DSH") adjustment, which requires the Secretary to provide increased PPS payments to hospitals that "serve [] a significantly disproportionate number of low-income patients."[5]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and the amount of the DSH payment to be paid to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction."

This matter concerns the Medicare/SSI fraction.[9] 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 . . . .

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 eligibility for and if eligible, the amount of any DSH payment adjustment.[10] CMS calculates the Medicare/SSI Fractions used to calculate Medicare DSH payments based on discharges in the respective federal fiscal year, but hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or "realign," their Medicare/SSI Fractions based on discharges in the hospital's cost reporting period.

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[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] The other component of the DPP not at issue in this matter is the "Medicaid Fraction" which is the number of hospital patient days for patients eligible for medical assistance under a State Medicaid plan (*i.e.* a plan approved by the Secretary under 42 U.S.C. § 1396 *et* seq.) but who were not entitled to Medicare Part A, divided by the total number of hospital patient days. 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). *See also* 42 C.F.R. § 412.106(b)(4).
[10] 42 C.F.R. § 412.106(b)(2)-(3).

B. Appeal of Publication of Medicare/SSI Fraction Data Pursuant to CMS Transmittals 12747 and 12785

The Providers in these appeals state that they are appealing from the publication of Medicare/SSI Fractions on CMS' website in Transmittal 12747 that was originally issued on July 26, 2024. Transmittal 12747 announced that CMS was resuming the processing of realignment requests for cost reporting periods starting before October 1, 2013. With realignment, hospitals are permitted under 42 C.F.R. § 412.106(b)(3) to request that CMS recalculate, or "realign," their Medicare/SSI Fractions based on discharges in the hospital's cost reporting period, rather than CMS' calculated Medicare/SSI Fractions based on discharges in the respective federal fiscal year. On August 13, 2024, CMS issued CMS Transmittal 12785, to replace Transmittal 12747 also titled "Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013."

The original Transmittal 12747, which was replaced by Transmittal 12785 describes how CMS temporarily halted the processing of realignment requests for cost reporting periods starting before October 1, 2013, due "to a lack of policy established through notice-and-comment rulemaking regarding the treatment of Part C days for that period of time."[11] However, on June 9, 2023, CMS issued Final Rule CMS-1739-F, finalizing the treatment of Medicare Part C days in determining a hospital's DPP, whereby such days are to be included in the Medicare/SSI Fraction and excluded from the numerator of the Medicaid fraction. Both transmittals announce that with the issuance of final rule CMS-1739-F, and the publication of provider Medicare/SSI Fractions on the CMS website, the agency was resuming the processing of realignment requests for such cost reporting periods.

The original Transmittal 12747 states that the Medicare/SSI Fractions available on the CMS website for cost reporting periods starting before October 1, 2013, like the federal fiscal year Medicare/SSI Fractions for the same period, were determined pursuant to final rule CMS-1739-F. The transmittal directs MACs to use such fractions to determine DSH payments for realignment requests in appropriate cases. The Transmittal explains that for realignment requests for such cost reporting periods, "CMS will calculate cost reporting period SSI ratios for all periods, for all hospitals, and post those ratios to the CMS DSH website . . . ."[12] Both Transmittal 12785 and the earlier Transmittal 12747 which it updates are nearly identical and focused on the realignment process. The ***only*** change in Transmittal 12785 from the earlier Transmittal 12747 is addressing a formatting change "to update the DSH Adjustment and Realignment files years 1988-2013, so that the SSI Ratio column is consistently rounded to four (4) decimals in all files. All other information remains the same."[13]

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[11] CMS Transmittal 12747 at 3 (July 26, 2024).
[12] *Id*.
[13] CMS Transmittal 12785 at 1 (Aug. 13, 2024).

Board Determination:

A. Transmittals 12747 and 12785 Are Not Appealable Final Determinations

In these cases, the Providers maintain that CMS' publication of Medicare Fraction data on its website pursuant to Transmittal 12747 and 12785, "constitutes 'a final determination of the Secretary as to the amount of the payment under subsection . . . (d) of section 1886' of the Social Security Act (the Act)" and because the Provider "is dissatisfied with this determination . . . the PRRB has jurisdiction over this appeal."[14] However, the publication of Medicare/SSI Fractions in conjunction with Transmittal 12747 (and later in Transmittal 12785, which merely requires a formatting change to the Medicare/SSI Fraction data posted on CMS' website so that the "SSI Ratio column is consistently rounded to four (4) decimals in all files") are not a "final determination" from which a provider may appeal. As explained below, the Board dismisses this matter for lack of jurisdiction over the Providers' appeals in these 6 cases.

The Medicare statute authorizes providers to seek hearings before the PRRB in two sets of circumstances: First, where the provider is dissatisfied with "the amount of total program reimbursement" as set forth in a Notice of Program Reimbursement (NPR);[15] and second, where the provider is dissatisfied with a "final determination" "as to the amount of the payment" under the prospective payment system.[16] In these cases, the Providers have not yet received NPRs and have based their appeals, pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), on their dissatisfaction with Medicare/SSI Fraction data that was published on the CMS website in conjunction with CMS Transmittals 12747 and 12785.

The Providers, in their Issue Statements, acknowledge that the Board "has taken the position that publication of [Medicare/SSI Fraction data on CMS' website] is not a final determination."[17] But the Providers also note disagreement with the Board's position, citing *Battle Creek Health Sys. v. Becerra*,[18] and *Baylor All Saints Med. Ctr. v. Becerra*,[19] decisions where courts held that providers met the requirements for a Board appeal before receiving a final appealable determination as to the amount of DSH payment.[20]

The Board has continued to find that the district court's decision in *Battle Creek* is inapposite because, unlike in the instant cases, the challenged Transmittal and publication of data in that case was described by the court as being a "*fait accompli*."[21] The district court in *Battle Creek* observed that the challenged Transmittal and publication of data there "provided, with some finality, advance knowledge of the amount of [the DSH] payment."[22] On appeal, however, the

[14] *See e.g.* Case No 25-1549, Provider's Issue Statement at 1.
[15] 42 U.S.C. § 1395oo(a)(1)(A)(i).
[16] *Id*. § 1395oo(a)(1)(A)(ii).
[17] *See e.g.* Case No. 25-1549, Provider's Issue Statement at 1.
[18] 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *rev'd*, No. 23-5310, 2025 WL 2423686 (D.C. Cir. Aug. 22, 2025).
[19] 745 F.Supp.3d 464 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 34-10934 (5th Cir. Oct. 17, 2024).
[20] *See e.g.* Case No 25-1549, Provider's Issue Statement at 1.
[21] *Battle Creek*, 2023 WL 7156125 at *5.
[22] *Id*.

Court of Appeals for the D.C. Circuit very recently disagreed with the lower court's reasoning, and reversed that decision finding:

> According to the Board, the hospitals needed to wait until they knew the final amount of their DSH adjustment rather than just the determination of one component of it. The district court disagreed and concluded that the hospitals' challenge could go forward. Because we agree with the Board, we reverse the district court.[23]

The Court also distinguished *Battle Creek* from *Washington Hospital Center*, and continued:

> This case is different. Here, the Medicare fraction had been published and the hospitals sought to challenge its calculation. But other components of the DSH adjustment (and thus of the per-patient payment amount) had yet to be finalized. Indeed, the hospitals could not know that they would be eligible for a DSH adjustment based on the Medicare fraction alone. The Medicaid fraction remained outstanding, and so too, therefore, did the disproportionate-patient percentage, and ultimately the hospitals' eligibility for, and amount of, any DSH adjustment. *See* pp. —— – ——, ——, *supra*. Those are finally settled upon issuance of an NPR. Unlike in *Washington Hospital Center*, then, in this case there had been no "final determination of the Secretary as to the amount of the payment" under the PPS. 42 U.S.C. § 1395oo(a)(1)(A)(ii).[24]

The Board agrees, and has found that the publication of the challenged Transmittal and accompanying Medicare/SSI Fraction data, provided by CMS for the purpose of informing provider choice as to whether to request realignment of the Medicare/SSI Fraction, does not definitively inform whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive.

In recent Board decisions, the Board has continued to notice its disagreement with the district court decision in *Battle Creek* and by extension, other court decisions like *Baylor All Saints*.[25] The Board maintains that *Memorial Hospital v. Becerra*,[26] and now the Court of Appeals decision *Battle Creek* are better-reasoned decisions. In *Memorial Hospital*, a group of providers filed an appeal similar to the Providers' appeals in these 6 cases. The *Memorial Hospital* providers challenged CMS' publication of Medicare/SSI Fraction data, arguing that there are certain instances where a provider can file a Board appeal prior to receiving an NPR. The court in *Memorial Hospital* ultimately agreed with the Board that CMS' publication of Medicare/SSI Fractions was not an appealable final determination.

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[23] *Battle Creek Health Sys. v. Kennedy*, No. 23-5310, 2025 WL 2423686, at *1 (D.C. Cir. Aug. 22, 2025).
[24] *Id.* at *6.
[25] *See, e.g.*, Board decisions in Case Nos. 24-0491, 24-1531GC, and 24-0413GC.
[26] 2022 WL 888190 (D.D.C. Mar. 25, 2022).

The court distilled the parties' positions as "boil[ing] down to a dispute about whether Plaintiffs have conflated a determination by the Secretary about one of several undetermined elements that eventually flows into the amount of payment and 'a final determination of the Secretary as to the amount of payment.'"[27] The court held that CMS' publication of Medicare/SSI Fractions, even if the publication of such fractions had been issued as "final," could and would not be a final determination "as to the amount of payment" because the Medicare/SSI Fractions are "just one of the variables that determines whether hospitals receive a DSH payment and, if so, for how much."[28] For the court, a challenge to an element of payment under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is only appropriate if, as the D.C. Circuit has explained, "the Secretary ha[s] firmly established 'the only variable factor in the final determination as to the amount of payment under § 1395ww(d).'"[29]

Using the reasoning in *Battle Creek* and *Memorial Hospital*, given the nature of the DSH adjustment, the publication of hospitals' Medicare/SSI Fractions on CMS' website is not a final determination as to the amount of payment due to any provider because the Medicare/SSI Fraction alone does not determine the amounts hospitals will be paid under the adjustment. Instead, the Medicare/SSI Fraction is incorporated, along with the Medicaid Fraction, into the DPP, which is ultimately the calculation that determines eligibility for and the amount of any DSH adjustment. The DPP must also exceed certain thresholds to qualify for any DSH adjustment.[30] Thus, although CMS calculates and publishes the Medicare/SSI Fraction for every hospital that receives Medicare reimbursement, the determination of whether a hospital receives reimbursement is made only after the hospital submits its year-end cost report.

In this matter, the Providers contend that the Medicare/SSI Fractions published on CMS' website on July 26, 2024 and August 13, 2024, pursuant to CMS transmittals 12747 and 12785, were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction" and . . . "exclusion of days from the numerator of the Medicare Fraction associated with individuals who were entitled to Supplemental Security Income (SSI) during their hospital stay but who were not in SSI pay status during such stays, or were in SSI pay status during their hospital stay but were not assigned payment status code C01, M01 or M02."[31] The CMS Transmittals 12747 and 12785 bear no connection to the issue under appeal as Transmittal 12747

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[27] *Id*. at *8.
[28] *Id*. at *9
[29] *Id*. at *8 (quoting *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").
[30] 42 C.F.R. § 412.106(d)(2)(i)-(ii).
[31] *See e.g.* Case No. 25-1549, Providers' Issue Statement at 1. Although the Providers characterize this as the "sole issue" under appeal, the issue statement appears to encompass two separate and distinct issues: 1) the inclusion of Medicare Part C days in the denominator of the Medicare/SSI Fraction; and 2) the exclusion of patient days for individuals eligible for both Medicare and SSI from the numerator of the Medicare/SSI Fraction. This conflation of issues is contrary to 42 C.F.R. § 405.1837(a)(2) which restricts a group appeal to a 'single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." *See also* PRRB Rule 13.

was published so that providers have sufficient information available to inform whether they want to request realignment and Transmittal 12785 merely implements a formatting change to the SSI Fraction data previously made available in order to ensure that the SSI Ratio column is consistently rounded to four decimals in all files. Providers cannot claim that with publication of Medicare/SSI Fraction data on CMS' website pursuant to the two Transmittals, they are somehow "dissatisfied with a final determination of Secretary as to the amount of payment."[32]

Neither the publication of the Medicare/SSI Fraction data, nor the decimal formatting change described in Transmittal 12785 informs whether a provider qualifies for the DSH adjustment, much less the amount of DSH reimbursement that a provider could receive. The Providers here have included no proof that they have requested realignment, nor even that with realignment they would be eligible for DSH reimbursement (changes in either the Medicare/SSI or Medicaid fractions could potentially result in a DPP below that required to qualify for the DSH adjustment). That CMS is providing such information to inform a provider's choice as to whether to request realignment of the Medicare/SSI Fraction that will be calculated for use in determining the DPP that ultimately determines whether a provider qualifies for DSH and how much they could receive, clearly indicates that the publication of SSI Fraction data is not a final determination as to the amount of payment.

Conclusion

As the Medicare/SSI Fraction data published pursuant to Transmittals 12747 and 12785 are not an appropriately appealable final determination, the Providers have failed to meet the jurisdictional requirements for a hearing. Thus, the Board hereby dismisses the six appeals and removes them from the Board's docket.

Review of this determination may be available under the provision 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:

11/25/2025

X Kevin D. Smith, CPA

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

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

Enclosures: Appendix A – Listing of 6 Cases

[32] *See* 42 U.S.C. § 1395oo(a)(1)(A)(ii).

Appendix A

Listing of 6 Cases

Case No.	Provider Name, No., FFY
25-1549	The Hospital of Central Connecticut (Prov. No. 07-0035) FFY 2012
25-1545	The Hospital of Central Connecticut (Prov. No. 07-0035) FFY 2011
25-1533	The Hospital of Central Connecticut (Prov. No. 07-0035) FFY 2010
25-1536	The Hospital of Central Connecticut (Prov. No. 07-0035) FFY 2009
25-1525	Bridgeport Hospital (Prov. No. 07-0010) FFY 2011
25-1518	Bridgeport Hospital (Prov. No. 07-0010) FFY 2008

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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 09/30/2020, Case No. 25-2509

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 25-2509. Set forth below is the decision of the Board to dismiss the sole issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days issue.

Background:

A. ***Procedural History for Case No. 25-2509***

On **August 14, 2024**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2020.

On **February 11, 2025**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request included one issue – DSH Medicaid Eligible Days.

On **February 14, 2025**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

[1] (Emphasis added.)

On **February 14, 2025**, the Medicare Administrative Contractor ("MAC") uploaded its request for information in OH CDMS, asking that the Provider submit a list of eligible days and auditable support for such days. The MAC also asked the Provider to advise if information remained unavailable, and if so, to identify what information is unavailable, why the information is unavailable, and to document the efforts made to obtain the unavailable information, in accordance with PRRB Rules 7.3.1.2 and 25.2.2.

On **October 1, 2025**, the Provider timely filed its PPP. The Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the PPP filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2020 cost report does not reflect an accurate number of Medicaid eligible days." As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $578,526 based on an *estimated* 1563 days.

On **October 15, 2025**, FSS filed a Motion to Dismiss the Medicaid Eligible Days Issue (the only issue in the case) to which QRS did not respond. The MAC contends the Provider failed to respond to the MAC's request for documentation despite its claim in its PPP that a listing would be filed directly with the MAC. The MAC argues that the Provider's failure to furnish this documentation is in violation of Board Rules 7, 25.2.1 and 25.2.2 and based on its failure to provide the necessary documentation, the Provider has abandoned its claim for additional Medicaid Eligible Days.

Board Analysis and Decision:

Pursuant to Board Rule 44.3, "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." Accordingly, the Provider's response to the MAC's Motion to Dismiss filed on October 15, 2025, was due on November 14, 2025. However, the Provider ***failed*** to timely respond and this matter is now ripe for ruling.

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

As set forth below, the Board hereby dismisses the Provider's only appealed issue.

A. DSH Payment – Medicaid Eligible Days

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

With regard to the filing of an individual appeal, Board Rule 7.3.1.2 (No Access to Data) (Dec. 2023) states:

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

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

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

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

[2] (Bold emphasis added.)

Rule 25 Preliminary Position Papers[3]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on February 14, 2025, 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 the Medicaid Eligible Days issue, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[4]

[4] (Emphasis added.)

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

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

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

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

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

On October 1, 2025, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[5] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $578,526 based on an estimated 1,563 days). The Provider's complete briefing of this issue in its PPP is as follows:

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

[5] Provider's PPP at 8 (Oct. 1, 2025).

> 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)(vi)(II) of the Social Security Act (42 U.S.C. § 1395ww(d)(5)(vi)(ii), and 42 C.F.R. § 412.106(b)(4)(1), Medicaid eligible are to be included in the numerator of the Provider's Medicaid Fraction of the disproportionate patient percentage. The issue is whether the Medicare Contractor (MAC included in the Provider's Medicaid Fraction of the disproportionate patient percentage all Medicaid 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' 2020 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.[6]

In its Motion to Dismiss, the MAC asserts that the Provider was in violation of Board Rules 7 and 25.2.1 because it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its PPP and neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

With its PPP at Exhibit P-1, QRS filed a statement indicating that "[a] listing of the additional Medicaid Eligible days being claimed will be submitted directly to the MAC. A redacted version of the list will be uploaded thereafter to the portal." To date no such listing has been filed in the

[6] Provider's PPP at 7-8 (Oct. 1, 2025).

portal and according to the MAC's Motion to Dismiss, has not been filed with the MAC even though it has been ***more than 5 years after the fiscal year at issue closed***.

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

Based on the foregoing, the Board hereby DISMISSES the sole issue in this case – DSH Medicaid Eligible Days. Case No. 25-2509 is hereby closed and shall be removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/25/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Jessica Wray
Affirmation Home Health, LLC
10124 West Broad Street, Suite E
Glen Allen, VA 23060

RE: ***Notice of Dismissal***
Affirmation Home Health, LLC (Provider Number 49-7794)
FFY 2024
Case Number: 24-1711

Dear Ms. Wray:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Affirmation Home Health, LLC's ("Provider") Individual Appeal Request on **March 20, 2024**, appealing from a CMS Noncompliance Decision dated **January 1, 2024**. The appeal request contains one issue related to a payment reduction for federal fiscal year 2024 due to the Provider's failure to submit certain quality reporting data. The amount in controversy listed for this issue is estimated at $50,000.

The Board received the Provider's Preliminary Position Paper ("PPP") on **November 15, 2024**, and the Medicare Contractor's PPP on **March 14, 2025**. A notice of Hearing was issued on **February 4, 2025**, which set a hearing date for **December 2, 2025**. Neither party has designated any witnesses for the hearing, and the date for doing so has passed.

On **November 5, 2025**, the Board Advisor assigned to this case reached out to the parties to inquire whether the Provider was still pursuing this case. Neither party responded to the inquiry, and the Board Advisor sent a follow up on **November 10, 2025**. The Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), replied the next day indicating they had reached out to the Provider's representative, but received no response. To date, the Provider's designated representative has not replied to either e-mail from the Board Advisor.

On **November 17, 2025**, the Board issued a Notice of Potential Dismissal based on the failure of the Provider's Representative to respond to the Board's direct inquiries and the lack of any contact with the Board since filing its position paper in November, 2024. It specifically ordered the Provider's Representative to respond within five (5) days of the letter's signature date to advise whether the Provider is still pursuing this appeal and stated that failure of the Provider to respond by the filing deadline would result in the dismissal of this case. The Provider has not responded to the Board Advisor's e-mails or the Board's Notice of Potential Dismissal.

Board Rule 5.2 sets forth some of the responsibilities of a designated case representative:

> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (*see* Rule 1.1).
>
> Further, the case representative is responsible for:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - Responding timely to correspondence or request from the Board or the opposing party.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.

Board Rule 5.3 also explicitly notes that "[t]he Board's communications will be sent to the case representative via email to the case representative's email address on file with the Board (*see* Rule 5.2). The Board will address notices only to the official case representative."

Board Rule 41.2 (2023) permits dismissal or closure of a case on the Board's own motion:

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

Failure to comply with the Board's requirements or orders is addressed at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

Based on the failure of the Provider's Representative to respond to the Board's direct inquiries and the lack of any contact with the Board since filing its position paper in November, 2024, and the failure to respond to the Board's Notice of Potential Dismissal, the Board is exercising its discretion, pursuant to 42 C.F.R. § 405.1868(b)(1) to dismiss Case 24-1711 with prejudice and hereby removes it from its docket.

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

Board Members:

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

For the Board:

11/25/2025

X Kevin D. Smith, CPA

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

cc: Charles Moreland, Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
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RE: ***Expedited Judicial Review Determination***
Case Number: 25-1031GC - *Allina Health CY 2013 Post-Allina II DSH Part C Days (Pre-10/1/2013 Discharges) CIRP Group*

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petition for Expedited Judicial Review ("EJR") filed on **October 31, 2025** in the above-referenced 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 ("CIRP") group on **December 11, 2024** The Providers are all appealing from original or revised Notices of Program Reimbursement ("NPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ended ("FYE") December 31, 2013.

The issue in these appeals for which the Providers seek EJR 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] Statement of Group Issue at 1 (Dec. 11, 2024).
[3] *Id.* at 2-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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 required the parties to file supplemental briefs addressing whether vacatur of the June 9, 2023 Final Rule is the appropriate remedy.[50]

Providers' Position:

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

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

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

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

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[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] Appeal Request, Statement of Jurisdiction (citations omitted).
[52] Statement of Group Issue at 1.
[53] *Id.*
[54] *Id.* (citing to 139 S. Ct. at 1816).

vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[55]

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[56]

B. Providers' 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.[57] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[58] "The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the [NPRs] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[59] Since the Board is bound by this regulation,[60] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **November 7, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed a timely response to the Request for EJR which simply stated that "a jurisdictional challenge will be filed for provider 24-0038."[61] On **November 13, 2025**, the Board issued a Request for Information and Scheduling Order which stayed the 30-day period for responding to the EJR request.[62] The Order reiterated that, pursuant to Board Rule 44.6, any Jurisdictional Challenge from FSS must have been filed no later than **November 20, 2025**, which was twenty (20) days after the filing of the of the Request for EJR. The Order also set a deadline for the Provider to respond to the forthcoming challenge. On **November 17, 2025**, however, FSS filed an Amended Response to Provider's Request for EJR, simply advising that "the MAC will not be filing a jurisdictional challenge, the MAC will not be filing a substantive claim challenge and the MAC does not oppose Providers' request for EJR."[63]

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[55] *Id.*
[56] *Id.* (citing 4 U.S.C. § 706(2)).
[57] Providers' Petition for Expedited Judicial Review at 13 (Oct. 31, 2025).
[58] *Id.* at 16-17.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.
[61] Response to Provider's Request for Expedited Judicial Review at 1 (Nov. 7, 2025).
[62] *See* 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii).
[63] Amended Response to Provider's Request for Expedited Judicial Review at 1 (Nov. 17, 2025).

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; [64]
- 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 for a group of providers.[65]

For this CIRP group, the providers all appealed from original and revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the providers in this group were directly added to the group within 180 days of the issuance of their NPRs and RNPRs and the amount in controversy exceeds $50,000.

The Board finds that the Providers in Case 25-1031GC have all filed timely appeals from their original and revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs and RNPRs. The Board also finds that the amount in controversy 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:

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[64] 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).
[65] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

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 25-1031GC, 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 Case 25-1031GC the Board hereby closes the case and will remove it from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

11/25/2025

X Kevin D. Smith, CPA

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

Enclosure: Schedule of Providers

cc: Pamela VanArsdale, National Government Services, Inc. (J-6)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***EJR Determination and Notice of Dismissal***
Case Number: 25-3077GC *SSM Health FFY 2025 Reasonable Cost to IPPS Budget Neutrality Adjustment CIRP Group*

Dear Ms. Ellis:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request and Petition for Expedited Judicial Review ("EJR") filed by the Providers in the above-referenced Common Issue Related Party ("CIRP") group case.[1] The issue in this case relates to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1986 as it allegedly impacts their FFY 2025 IPPS rates. As set forth below, the Board Majority has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and, therefore, is dismissing the group case in its entirety. This decision is consistent with prior Board Majority decisions where the Board found it lacks *substantive* jurisdiction over the same issue.[2]

In summary, the Board Majority finds that it lacks substantive jurisdiction over the issue raised in this group appeal because the standardized amount used for IPPS rates for FFY 1986 is based on the rates from FFY 1985, which included the budget neutrality adjustment ("BNA"). The Board also finds that the *final* FFY 1985 standardized amount (on which the FFY 1986 standardized amount was based) is *inextricably intertwined* with the FFY 1985 BNA.[3] The Board Majority has also included at **Appendix A** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1985 BNA. These intervening adjustments for FFYs 1986 and 2018

[1] While the Petition for EJR was filed on **October 3, 2025**, the Office of Hearings was furloughed beginning on **October 1** and did not reopen until **October 27**. Pursuant to 42 C.F.R. § 405.1801(d)(2), "in calculating a designated period of time for an act by a reviewing entity, a day is not included where the reviewing entity is unable to conduct business in the usual manner due to extraordinary circumstances beyond its control such as . . . furlough. In that case, the designated time period resumes when the reviewing entity is again able to conduct business in the usual manner." Thus, as the request was filed during the furlough, the time period for the Board to evaluate whether it has jurisdiction and subsequently issue a decision on the Request for EJR did not begin until **October 27, 2025**.
[2] Case No. 25-1141GC.
[3] *See infra* note 68 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts.

Because the FFY 1985 budget-neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1985 BNA, the Board Majority finds that it may not review the standardized amount used for the FFY appealed as it relates to the common issue in this appeal. In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates (the final rates, after adjustment for the BNA). Accordingly, the Providers' assertion that the initial FFY 1985 standardized amount continues to serve as the base for all future calculations is incorrect as the causal link is broken.[4]

PROCEDURAL BACKGROUND:

A. Group Issue –Alleged Improper Carry-forward of FFY 1985 Adjustments

1. Initial Appeal and Issue Statement

The Board received a request, filed by the Providers' designated representative, Toyon Associates, Inc. ("Providers' Representative"), to establish this CIRP group appealing from the Federal Register published on **February 20, 2025**.

The Providers' appeal challenges their FY 2025 IPPS payments, arguing that CMS "unlawfully applied a pair of budget neutrality adjustments that by statute could only apply to IPPS rates ***for FY 1985***."[5] They note that 42 U.S.C. § 1395ww(d)(3)(C) directed CMS' predecessor, the Health Care Financing Administration ("HCFA"), "to adjust the 'average standardized amounts as may be required under [§] 1395ww(e)(1)(B) for that fiscal year.'"[6] The Providers argue that Section § 1395ww(e)(1)(B) requires, for discharges occurring in FY 1984 or 1985:

> . . . equal proportional adjustment in each of the average standardized amounts otherwise computed for that fiscal year as may be necessary to assure that -
>
> (i) The aggregate payment amounts provided under [IPPS] *for that fiscal year* for operating costs of inpatient services of hospitals,

[4] *See also* **Appendix A** outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.
[5] Issue Statement at 1 (Feb. 20, 2025).
[6] *Id.*

> Are not greater or less than –
>
> (ii) . . . the aggregate payment amounts which would have been payable for such services for those same hospitals *for that fiscal year* under this section under the law as in effect before April 20, 1983.[7]

Pursuant to his authority at 42 U.S.C. §§ 1395ww(d)(3)(C) and (e)(1)(B), the Secretary implemented two adjustments that resulted in a reduction of IPPS payments by 5.59% in FY 1985.[8] The Providers argue that these budget neutrality adjustments "were not to be applied in future years. . . . [and that the statute] includes instructions for calculating the standardized amount for FY 1986 and all years thereafter."[9] For FY 1986, the amount was to start with the "average standardized amount computed for the previous fiscal year under [§ 1395ww(d)(3)(A)]."[10] The Providers interpret the statute to require the standardized amount computed under this section be the amount *after* it was adjusted for inflation but before it was adjusted under §§ 1395(d)(3)(B) (for outliers), 1395(d)(3)(C) and (e)(1)(B) (for budget neutrality).[11]

The Providers continue by explaining that "for FY 1986, HCFA decided that the 'budget-neutrality adjusted rates for FY 1985 are…to be used as the basis for the determination of rates for later years.'"[12] They argue that calculating FY 1986 rates by preserving these ***FY 1985*** budget neutrality adjustments is unlawful and has been carried forward every year since, resulting in a present day IPPS payment understatement of 0.9441, "which could be corrected by an adjustment of 5.92% . . . ."[13] They "challenge the continued application of these budget neutrality adjustment because the statute says that they should have sunset at the end of FY 1985."[14]

2. Request for EJR

The Providers' **October 3, 2025** Request for EJR makes the same arguments found in their Issue Statement, with some elaboration. They discuss how the FY 1984 standardized amount was set using FY 1981 data. They also note that this amount was later adjusted pursuant to 42 U.S.C. § 1395ww(d)(2)(E) to account for outliers, and again pursuant to § 1395ww(d)(2)(F) to adjust the standardized amount "as may be required under subsection (e)(1)(B)."[15] This budget neutrality adjustment "adjusted the FY 1984 standardized amount by a factor of 0.97, which

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[7] *Id.* (citing 42 U.S.C. § 1395ww(e)(1)(B))
[8] *Id.* (citing 49 Fed. Reg. 34728, 34771 34796, (Aug. 31, 1984))
[9] *Id.* at 1-2.
[10] *Id.* at 2.
[11] *Id.*
[12] *Id.* (citing 50 Fed. Reg. 35646, 35695 (Sept. 3, 1985)).
[13] *Id.*
[14] *Id.*
[15] Petition for Expedited Judicial Review at 3-4 (Oct. 3, 2025).

translated to a 3 percent decrease."[16] The Request for EJR also describes a "second adjustment [which] required the Secretary to ensure that aggregate payments for FY 1984 did not exceed aggregate payments for services had he continued to make them under the prior reasonable cost payment system."[17]

The Providers then repeat the same arguments found in their Issue Statement with regard to the FY 1985 rate setting being unlawfully carried forward into FY 1986 and beyond.[18] The Request for EJR claims that "the FY 2025 rates continue to include the 0.954 adjustment to the standardized amount and the 1.05 percent adjustment to the DRG weights from FY 1985, effectively reducing those rates by a factor of 0.9441."[19]

The Providers request the Board grant EJR in this case, first noting the Board has jurisdiction over the appeal. They claim that each Provider is "dissatisfied with the Secretary's final payment determination in the FY 2025 IPPS final rule – specifically the Secretary's refusal to correct the rates to remove the budget neutrality adjustment he adopted in FY 1985."[20] They also argue that the challenge is not precluded from administrative and judicial review (specifically 42 U.S.C. § 1395ww(d)(7)(A), but acknowledge that the Board has previously found that it lacked subject matter jurisdiction over an appeal brought by a different group of providers challenging the same issue.[21] The Providers argue that "the Board interpreted § 1395ww(d)(7)(A) too broadly" because the action challenged is not the type of action shielded from review in that statue.[22] Section 1395ww(d)(7)(A) bars review of adjustments "effected pursuant to" 42 U.S.C. § 1395ww(e)(1), which does not encompass the Secretary's decision to base the 1986 standardized amounts based on the prior year's budget-neutralized rates.[23] They also discuss the Board's rationale that the decision to carry forward the FY 1985 budget neutrality adjustment to FY 1986 and onward was "inextricably intertwined" to the original calculation and application of that adjustment in FY 1985, but note that the court in *St. Mary's* rejected this proposition.[24] The Providers conclude that 42 U.S.C. § 1395ww(d)(7)(A) was intended to "preclude review of the Secretary's application of the budget neutrality adjustments in FYs 1984 and 1985 and nothing more."[25]

With regard to the Request for EJR, since the Board is bound to comply with all provisions of Title XVIII of the Social Security Act and regulations issued thereunder,[26] the Board is bound by the rates published in the FY 2025 IPPS final rule and cannot declare them unlawful. Thus, the

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[16] *Id.* at 4 (citing 49 Fed. Reg. 234, 334 (Jan 1. 1984)).
[17] *Id.* at 3.
[18] *Id.* at 4-8.
[19] *Id.* at 8.
[20] *Id.* at 14-15.
[21] *Id.* at 15-16 (quoting Case No. 25-1141GC, EJR Determination and Notice of Dismissal (Jan. 17, 2025) (copy at Ex. P-8)).
[22] *Id.* at 16 (citing *St. Mary's Regional Medical Center v. Becerra*, 2024 WL 5186641 (D.D.C. 2024) ("*St. Mary's*")).
[23] *Id.* at 16-17.
[24] *Id.* at 20-21.
[25] *Id.* at 17, n.6.
[26] 42 U.S.C. § 405.1867.

Providers argue that the Board does not have authority to resolve this dispute and EJR is appropriate.[27]

Finally, assuming the Board will once again find it lacks subject matter jurisdiction in this case, the Providers request the Board also make a finding with regard to whether it has the authority to grant the relief sought. They argue that this would serve the interest of judicial economy to avoid a remand for this limited purpose, and that the Board has done so in analogous cases in the past.[28]

The Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a Response to Provider's Request for Expedited Judicial Review on **October 14, 2025**. It reiterates its view that the Board lacks subject matter jurisdiction, as first argued in its Jurisdictional Challenge (which is detailed below).

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

The D.C. District Court's decision in *St. Mary's Regional Medical Center v. Becerra*,[29] involves a different substantive issue than the instant group appeals – namely whether the Secretary miscalculated the standardized amount in FY 1984 by including transfer cases in the denominator – but it does discuss as *dicta* whether section 1395ww(d)(7)(A) bars review of the Secretary's decision to apply the 1985 budget neutrality adjustment to the present-day rates.

In *St. Mary's*, a group of providers challenged their FY 2019 IPPS payments, alleging that when calculating "allowable operating costs per discharge" in calculating the IPPS, "the Secretary erroneously counted inter-hospital transfers as 'discharges,' . . . [which] depressed the inaugural standardized amounts and, . . . has perpetuated chronic underpayment up to the present day."[30] While there are time limits on when a provider can challenge their payment determinations, providers are generally permitted to challenge "predicate facts" – courts have permitted providers to modify "predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[31] Predicate fact challenges are permitted "no matter how long ago the facts were established, so long as the providers raise their challenge in a timely administrative appeal and seek damages only for underpayment during an open cost year."[32]

In April 2023, the Board dismissed the underlying providers' appeals in *St. Mary's* for lack of subject matter jurisdiction, finding the standardized amounts at issue were inextricably intertwined with the budget neutrality adjustments which were precluded from administrative review.[33] With regard to whether the providers had standing to bring their case, the court in *St.*

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[27] Petition for Expedited Judicial Review at 21-22.
[28] *Id.* at 2, 14, and 22.
[29] 2024 WL 5186641 (D.D.C. 2024).
[30] *St. Mary's.* at *4.
[31] *Id.* (citing *Kaiser Found. Hosps. v. Sebelius*, 708 F.3d 226, 232-233 (D.C. Cir. 2013)).
[32] *Id.* (citing *St. Francis Med. Ctr. v. Azar*, 894 F.3d 290, 294 (D.D.C. 2018)).
[33] Case No. 19-1723GC *et al.*

Mary's addressed the Board's arguments and rejected them all. The Board had noted that the original standardized amount calculations were actually inflated, rather than deflated, but this did not obviate "the independent, judicially cognizable injury which the plaintiffs now allege—to wit, that the Secretary's supposedly unlawful categorization of transfers as discharges exerted downward pressure on their compensation." This injury is not erased by "some unrelated benefit of equal or greater value" – which would be relevant to the issue of damages, but not jurisdiction.[34]

The court also rejected the notion that other adjustments to the standardized amount "between 1985 and 1997 may have broken the chain between the inaugural calculations and the allegedly depressed 2019 standardized amounts."[35] The court seemed skeptical,[36] and while it did not outright reject this argument, it was not sufficiently explored to defeat the Provider's jurisdictional claim of standing.[37]

While stated as *dicta* in the *St. Mary's* decision, but relevant to the instant cases, the court did explicitly state "no part of the IPPS statute, including the budget neutrality provisions, authorized the Secretary to carry forward the 1985 budget neutrality adjustment to the following year; in fact, the statute forbade him from doing so."[38]

The court then looked to whether the statutory preclusion provisions actually precluded review of the 1984 standardized amounts. It found that the statutes did not explicitly preclude review,[39] and also found that the calculation of the 1984 standardized amounts is not "inexplicably intertwined" with the budget neutrality adjustments, especially in light of the Administrative Procedure Act's strong presumption of judicial review.[40] The court ultimately remanded the case for further proceedings.[41] The Secretary then filed a motion for clarification or partial reconsideration of the Court's decision. On September 26, 2025, the Court issued a Memorandum & Order granting the Secretary's motion to confirm that the Court's holdings are limited to the Board's jurisdiction over the dispute, and denying the motion for partial reconsideration.[42] Thus, the decision is not yet final and the Secretary may still opt to appeal to the D.C. Circuit Court. The Board Majority notes that this District Court decision is not binding on the Board and, given the recent issue of the Order, is still subject to appeal. Based on the foregoing, the Board Majority declines to follow the holdings in *St. Mary's*.

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[34] *St. Mary's* at *7.
[35] *Id.*
[36] *Id.* ("[T]he Secretary himself reiterated that the current standardized amount is the result of adjusting and updating the original standardized amounts, necessarily—if implicitly—disclaiming the possibility that subsequent statutory or regulatory changes have washed away any trace of the inaugural calculations.") (citing 83 Fed. Reg. 41144, 41713 (Aug. 17, 2018)).
[37] *Id.*
[38] *Id.* at *9.
[39] *Id.* at *11-12.
[40] *Id.* at *13-17.
[41] *Id.* at *19.
[42] *St. Mary's Reg'l Med. Ctr. v. Kennedy*, No. 1:23-cv-01594-RCL (Sept. 26, 2025).

4. Substantive Claim Challenge

The Providers in this case certified, pursuant to Board Rule 20, that their case was fully formed and fully populated in OH CDMS on the same day their Request for EJR was filed on **October 3, 2025**. The Medicare Contractors' designated representative, Federal Specialized Services ("FSS"), then submitted a timely[43] Substantive Claim Challenge on **October 15, 2025**. On **October 30, 2025**, the Board issued a Scheduling Order for the Provider to respond to the Substantive Claim Challenge no later than November 13, 2025, and the Provider filed its Response on **November 10, 2025**.

The Providers do not generally dispute the allegations made in the Substantive Claim Challenge but argue that the regulations requiring them to make a Substantive Claim are unlawful.

BOARD DECISION:

As described more fully below, the Board Majority finds that it lacks substantive jurisdiction over these groups because: (1) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs;[44] and (2) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 BNAs.

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services

[43] 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 Request for EJR in these cases was filed on **October 3, 2025**, so any challenges (or certification that a challenge was forthcoming) would typically have been due no later than close of business **October 10, 2025**. FSS' initial response, filed on **October 14, 2025**, indicated that no substantive claim or jurisdictional challenges would be filed. A Substantive Claim Challenge, however, was filed on **October 15**, and an amended EJR Response was filed on **October 21** reflecting that filing. The Office of Hearings, however, was furloughed beginning on **October 1, 2025**, and did not reopen until **October 27**. Pursuant to 42 C.F.R. § 405.1801(d)(3), "[i]f the last day of the designated time period [by which a party must make a submission] is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the reviewing entity is unable to conduct business in the usual manner [due to extraordinary circumstances beyond its control such as . . . furlough], the deadline becomes the next day that is not one of the aforementioned days." Based on the foregoing, the Substantive Claim Challenge in this case was timely filed.

[44] *But see* **Appendix A**. The Board has not traced the standardized amount after FFY 1986 all the way up to the each of the years in question. **Appendix A** highlights how, in addition to the use of the FFY 1985 budget-neutrality-adjusted rates for FFY 1986 and forward, there could be other intervening statutory or regulatory events (whether discretionary or mandatory) that could break the Providers' alleged causal link between the alleged error in the initial FFY 1984 rates and the standardize amounts used in the years at issue.

under the IPPS.[45] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[46]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[47] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain base period cost data be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[48] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1981 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount and then *updated* by an inflationary factor to bring it forward to FFY 1984.[49] The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[50] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary (*see also* **Appendix A**). In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the BNA for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

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[45] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[46] *Id.*
[47] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[48] *Id.* (emphasis added).
[49] *Id*. at 39763-64.
[50] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> > (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[51]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 and 1985 rate years, respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality

[51] (Bold emphasis in original and italics and underline emphasis added.) The BNA at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).

> control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[52]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[53]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[54] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the BNA).

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[52] (Italics emphasis in original and bold and underline emphasis added.)
[53] (Italics emphasis in original and bold and underline emphasis added.)
[54] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board Majority's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1/2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other

---

and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.

Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 percentage point for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year ***1998***, 0 percent,

(XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

(XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

(XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,

(XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and

> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[55]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized

[55] (Emphasis added.)

> amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) for years after 1984, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 BNAs (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, **it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs**. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted

average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—

(A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and

(D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.

(ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—

(A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.

(3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal

> year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[56]

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

While the Providers in this case claim they are not specifically challenging the FY 1984 and 1985 standardized amounts, these amounts and their associated BNAs are implicated in their appealed issue and the preclusion on their review discussed below is still relevant.

The published standardized amount for the FFY in this appeal reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the BNAs for FFYs 1984 and 1985

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[56] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used for the very first year of IPPS and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[57] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, **the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs**.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***roughly 40 years*** to increase the FFY 1985 budget-neutrality adjusted rate to exclude the BNA and then use that increased rate to calculate the 1986 standardized amount. They would then simply carry or flow that *increase forward by the relevant 40 years*. However, in order to peel the amalgamated standardized amounts for the FFY at issue *as used in the IPPS rates for each FFY* back to the standardized amount***s*** (plural) used in FFY 1986, and then carry/flow any change forward *to the FFY at issue*, this necessarily implicates the FFY 1985 budget neutrality adjustment, as the providers are requiring that adjustment be excluded in the calculation of the 1986 rate.

However, they cannot do so because this BNA had the effect of ***fixing*** the pie for FFY 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[58] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 BNA and the IPPS rates paid for FFY 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1985.[59]

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[57] *See* **Appendix A.**

[58] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

[59] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the BNAs would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

Accordingly, the Board Majority finds that the Providers' challenge to the standardized amounts at issue are *inextricably* tied to the BNA made for FFY 1985.[6061]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1985 BNA. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and judicial review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[62]

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50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality*** *adjustment* (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[60] The Board Majority notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 BNAs given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[61] The Board majority also recognizes the recent D.C. District Court decision in *St. Mary's Reg'l Med. Ctr. v. Becerra*, 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024) ("*St. Mary's*") and the Providers' position that, while that case involves a different substantive issue - whether the Secretary miscalculated the standardized amount in FY 1984 by including transfer cases in the denominator –that it "held that section 1395ww(d)(7)(A) does not bar review of the Secretary's decision to apply the 1985 budget neutrality adjustment to the present-day rates." *See* Notice of Supplemental Authority (Dec. 31, 2024). The Board Majority notes that this District Court decision is not binding on the Board and, given its recent issuance, is still subject to appeal. Based on the foregoing, the Board declines to follow the holdings in *St. Mary's.*

[62] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1985 BNA is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the Board Majority finds that the FFY 1985 BNA effectively fixed the standardized amounts from that point forward for use in the IPPS system.[63]

1. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget-neutrality-adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and

[63] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[64]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[65] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix A**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification ***specified by Congress***:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[66]

The Board Majority has set forth in **Appendix B** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that:

- The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and
- The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

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[64] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").
[65] *Id.* (emphasis added).
[66] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

- Congress was both aware and involved in the final rates used in FFY 1986, and therefore, aware that those rates were based upon the FFY 1985 budget-neutrality adjusted rates.

Given the incorporation of the FFY 1985 budget-neutrality-adjusted rates into subsequent years, the Board Majority finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 BNA.

* * * * *

The Board Majority finds that it lacks substantive jurisdiction over the issue raised in this appeal because the ***prospectively-set*** standardized amount used for IPPS rates for FFY 1985 is based on the BNA made for that FFY.[67] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable BNAs.[68] Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1985 BNA and the resulting *final* standardized

[67] The Board Majority has included at **Appendix A** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1985 BNA. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts.

[68] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board Majority notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board Majority's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts (and, as discussed *supra*, any future FFY standardized amounts, since the incorporation of the FFY 1985 budget-neutrality-adjusted rates into subsequent years leaves them inextricably tied, at a minimum, to the FFY 1985 BNA) would be *inextricably* tied to the ensuing BNAs made for FFYs 1984 and 1985.

amounts for FFY 1985 was carried/flowed forward in the determination of the rates for FFY 1986 and succeeding FFYs, the Board Majority finds that it may not review the standardized amount used for the FFY being appealed as it relates to the common issue in this appeal.[69] In this regard, the Board Majority again notes that the rates for FFY 1986 and subsequent years are based on the FFY 1985 budget-neutrality-adjusted rates and the Providers may not simply pass through, or over, the BNA for FFY 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Further, a review of the Providers' calculations of the Amounts in Controversy filed with the original appeals, shows that these calculations are single-page summaries which identify IPPS payments and simply inflate them by 5.92%.[70] There is no evidence that the numerous adjustments made in the intervening years, some of which were required to be budget neutral, and some of which were discretionary, have been properly accounted for. As addressed above, the causal link between the 1986 rates and the 2025 rates is not clearly delineated, and cannot be verified. The effect of the intervening multiple changes noted in **Appendix A** have not been addressed in the calculations of the Amounts in Controversy.

Accordingly, the Board Majority finds that: (1) the appealed issue is *inextricably* tied with the FFY 1985 BNA to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[71]) prohibit administrative and judicial review of those BNAs. Based on these findings, the Board Majority concludes that it does not have substantive jurisdiction over the issue this group case, denies the Petition for EJR, and hereby closes the case and removes it from the Board's docket.

C. Finding re: Authority to Grant Relief Requested

Even if the Board finds that it lacks jurisdiction over the issue under appeal, for the sake of judicial economy the Providers have asked the Board to decide whether it has the authority to grant the relief requested.[72] If, on appeal to federal court, the Board is overruled on its substantive jurisdiction determination, this would eliminate the need for the cases to be remanded just for the Board to address this limited issue. The Providers argue that the Board has done this in the past for different issues where the Administrator disagreed with the Board's

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[69] *But see supra* note 44.
[70] *See, e.g.*, Monroe Clinic (Provider Number 52-0028).
[71] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).
[72] Petition for Expedited Judicial Review at 2, 14, 22.

findings on a particular issue. This request, however, is specifically prohibited by the regulation governing EJRs. 42 C.F.R. § 405.1842(b)(1) specifically states:

> ***Prerequisite of Board jurisdiction.*** The Board (or the Administrator) must find that the Board has jurisdiction over the specific matter at issue ***before***[73] the Board may determine its authority to decide the legal question.

Thus, the Board hereby ***denies*** the request to make such a finding in the event that a court, on appeal, finds it does have substantive jurisdiction over these appeals.

D. Substantive Claim Challenge

The Medicare Contractor has filed a Substantive Claim Challenge in this case, and while the Providers do not dispute the allegations therein, they argue the Substantive Claim regulations are unlawful.

Pursuant to 42 C.F.R. § 405.1873(e)(1), however, the Board is prohibited from including any findings of fact and conclusions of law when dismissing based on jurisdiction:

> (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.

Based on the Board Majority's finding that it lacks substantive jurisdiction in this case, the Board declines to make any specific findings of fact and conclusions of law with regard to the question of whether the providers' cost reports included an appropriate claim for the specific item in 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.

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[73] (Emphasis added).

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq. (dissenting)

For the Board:

11/25/2025

X Kevin D. Smith, CPA

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

Appendices A – Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1984 to the fiscal years at issue
B – Additional Excepts from FFY 1985 IPPS Final Rule Affirming Application of FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.
C – Pending appeals on Standardized Amount

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

Dissenting

The Board has seen numerous appeals regarding the standardized amount issue (see Appendix C) beginning with the "errors in the 1981 cost-reporting data that were used to calculate the standardized amounts in 1983 [and affecting] payment decisions ever since" (the "Transfer Policy" issue)[74] evolving to unlawful preservation of 1985 budget neutrality adjustments in establishing 1986 payment rates (the "Unlawful Application of Budget Neutrality Adjustments" issue) leading to understated IPPS payment rates.[75] In the FY 2025 IPPS final rule, commenters urged the Secretary to "remove those adjustments so that they do not continue to unlawfully reduce IPPS payments to hospitals in FY 2025 and onward."[76] Those comments were not addressed. The standardized amount issue will continue to evolve and be challenged until payment rates are updated, or a final determination is made in this chain of cases.[77]

The instant appeal concerns the issue Unlawful Application of Budget Neutrality Adjustments ("BNA").[78] The FY 1985 BNA included: a reduction to the FY 1985 standardized amount;[79] and an adjustment to the diagnosis related group ("DRG") weights[80] (these two adjustments being "the pair of budget neutrality adjustments" to which the Providers refer). As the FY 1986 IPPS payment rates form the basis for all subsequent years, the Providers believe that FY 2025 payments rates remain understated.[81] They request either the removal of the FY 1985 BNA from the FY 2025 standardized amounts or an adjustment to the DRG rates to remove the FY 1985 BNA.[82]

After filing their appeal, the Providers submitted a Petition for Expedited Judicial Review ("EJR") of this issue.[83] A provider may "seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter […] and the Board determines it lacks the authority to decide the legal question […]."[84] The Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met), if any, over the

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[74] *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 at 293 (D.C. Cir. 2018).
[75] *See* Notice of Dismissal for Case 25-1141GC (Univ. of KS Health Sys. FFY Reasonable Cost-to-IPPS BNA CIRP Group) (Jan. 17, 2025) (available on the Board's website, *see* footnote 1, *supra*.)
[76] Exhibit P-4 to Petition for Expedited Judicial Review (Oct. 3, 2025). On June 10, 2024, King & Spalding (a provider representative in many appeals of this ilk) submitted a comment to the FY 2025 IPPS Proposed Rule. That comment is substantively the same as the issue statement commencing the instant appeal. That comment and others are available at available at https://www.regulations.gov/document/CMS-2024-0131-0025/comment.
[77] *See e.g.*, *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018), which "opened the door to predicate fact challenges, no matter how long ago the facts were established, so long as the administrative appeal and seek damages only for underpayment during an open cost year." *St. Mary's* at *4. For a more fulsome discussion of the history of the standardized amount issues, *see St. Mary's* at *4-*5.
[78] *See* Issue Statement (Feb. 20, 2025).
[79] *See id.*, *citing* 49 Fed. Reg. 34728 at 34796 (Aug. 31, 1984).
[80] *See id.*, *citing* 49 Fed. Reg. 34728 at 34771 (Aug. 31, 1984).
[81] *See id.* at 2.
[82] *See id*.
[83] Petition for Expedited Judicial Review (Oct. 3, 2025).
[84] 42 C.F.R. § 405.1842(a).

matters at issue in the appeal *before* determining its authority to decide a legal question relevant to a matter at issue. [85]

Jurisdiction. To find that it has jurisdiction, the Board must find that a provider has met all claims-filing requirements and has a right to a hearing.

> (a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—
>
> (1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3).
>
> (2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
>
> (3) *The amount in controversy is, in the aggregate, $50,000 or more*, as determined in accordance with § 405.1839 of this subpart.[86]

The necessary requirements for a Board hearing under § 405.1835(a)[87] are:

> (a) Right to hearing on final contractor determination. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if—

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[85] 42 C.F.R. § 405.1840(a)(2). Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a)-(b). While 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction," 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*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[86] 42 C.F.R. § 405.1837(a) (emphasis added).

[87] 42 C.F.R. § 405.1835(c) relates to the right to a hearing when a final contractor determination is not issued within twelve months after the contractor receives the provider's perfected or amended cost report. As that is not an issue in the instant case, I will not address those factors.

> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. ***Exception***: If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) [omitted]
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[88]

The following facts related to fulfilling the requirements for a Board hearing are undisputed. The Providers are dissatisfied with the Secretary's determination of the FY 2025 Final Rule. The Providers filed their appeals within 180 days after the Secretary's determination (the August 28, 2024 publication of the Final Rule).[89] The matter at issue, Unlawful Application of Budget Neutrality Adjustments, is a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in this group.

Substantive Jurisdiction. Certain matters are not subject to administrative and judicial review under the prospective payment system. One of those matters is "[t]he determination of the requirement, or the proportional amount, of the *budget neutrality adjustment* in the prospective payment rates required under section 1886(e)(1) of the Social Security Act."[90] The Majority concludes that the final FFY 1985 standardized amount (on which the FFY 1986 standardized amount was based) is inextricably intertwined with the FFY 1985 budget neutrality adjustment for which administrative and judicial review is prohibited, thus precluding Board review of the appealed issue. The D.D.C. in *St. Mary's* summarizes "Preclusion Provisions" such as this one:

> Congress also made several of the Secretary's calculations unreviewable. 42 U.S.C. § 1395ww(d)(7) provides that "[t]here shall be no administrative or judicial review . . . of . . . any adjustment effected pursuant to subsection (e)(1) . . . ." Subsection (e)(1)(B), in turn, refers to and cross-references the budget neutrality adjustments described in step 6, above. Thus, the combined effect of § 1395ww(d)(7) and § 1395ww(e)(1)(B) is to immunize the Secretary's budget neutrality adjustments from judicial or administrative review. The non-reviewability of the budget

[88] 42 C.F.R. § 405.1835(a) (emphasis in original).
[89] *See* 89 Fed. Reg. 68986 at 69941-48, 69962-63 (Aug. 28, 2024).
[90] 42 C.F.R. § 405.1804(a) (emphasis added).

> neutrality adjustment is also enshrined in the organic statute of the Provider Reimbursement Review Board, the administrative body to which healthcare providers may appeal to challenge a reimbursement determination. That statute provides that "[t]he determinations and other decisions described in section 1395ww(d)(7) . . . shall not be reviewed by the Board or by any court . . . ." 42 U.S.C. § 1395oo(g)(2). Again, § 1395ww(d)(7) does not contain a cross-reference to any other statutory provision of relevance to this dispute; for purposes of the litigation, its sole referent is the budget neutrality adjustments. Finally, CMS's own regulations state that judicial and administrative review is unavailable for budget neutrality adjustments and the creation of DRGs, but do not identify any other aspects of the Secretary's calculations as non-reviewable. 42 CFR § 405.1804. These provisions barring review of the Secretary's budget neutrality adjustments are hereafter referred to as the "Preclusion Provisions."[91]

I respectfully ***dissent*** from the Majority opinion and instead agree with Provider's conclusion that "the agency action challenged in these appeals is not the same action that [42 U.S.C. § 1395ww(d)(7)(A)] shields from review."[92] Indeed, the court in *St. Mary's* echoes this reasoning:

> [T]he Preclusion Provisions bar review of "the requirement, or the proportional amount, of any adjustment *effected pursuant to subsection (e)(1)*," which refers to the budget neutrality adjustments. The plaintiffs are not challenging the "requirement" or "proportional amount" of the 1985 budget neutrality adjustment itself; rather, they are asserting that the outputs of this adjustment should not have been used as the basis of the subsequent year's standardized amount calculation. Under a plain textual reading of the statute, the Preclusion Provisions simply have no bearing on a challenge of that nature.[93]

The recent District Court decision in *St. Mary's* (albeit non-binding) is instructive in its methodology to determine whether one agency decision is inextricably intertwined with another.[94]

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[91] *St. Mary's* at *3.
[92] Petition for Expedited Judicial Review at 17. *See id.* at footnote 6, "The legislative history further confirms that Congress only intended section 1395ww(d)(7)(A) to preclude review of the Secretary's application of the budget neutrality adjustments in FYs 1984 and 1985 and nothing more."
[93] *St. Mary's* at *9 (internal citations omitted).
[94] "First, one agency decision is inextricably intertwined with another if the former is entirely subsumed within or practically indistinguishable from the latter, i.e. because the former constitutes the entire factual or methodological basis for the latter. Second, textual clues, such as whether the two agency processes appear in the same or different subsections of the controlling statute and the presence or absence of internal cross-references, may suggest whether the processes are inextricably intertwined. Third, agency actions are not inextricably intertwined if the means of implementing them are very different in practice, such as if they entail distinct rulemaking processes, impose different

Approaching the Unlawful Application of Budget Neutrality Adjustments issue in the same manner that the D.D.C. approached the Transfer Policy issue, I find that FFY 1986 IPPS Rates are not inextricably intertwined with the 1985 budget neutrality adjustment. First, the 1985 budget neutrality adjustment does not constitute the entire methodological basis for the FFY 1986 IPPS Rates. While, as highlighted by the Majority, the Secretary confirmed that the FFY 1985 budget-neutrality-adjusted federal rates would be the basis for determining the FFY 1986 federal rates, [95] it is also true that the Secretary "will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality"[96] and "the Secretary will consider the recommendations of the Prospective Payment Assessment Commission."[97] Continuing the analysis, the agency actions occur at different times (1985 versus 1986) and entail distinct rulemaking processes (each FFY has its own IPPS Final Rule). A challenge to one does not necessarily constitute a challenge to the other.

In conclusion, unlike my colleagues in the Board Majority, I find that the issues are not inextricably intertwined (i.e., review is not precluded), and that Providers have established their right to a Board hearing.[98]

11/25/2025

X Nicole E. Musgrave

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

obligations on private parties, or occur at different times. Fourth, lest a plaintiff circumvent Congress's intent to preclude review through artful pleading, agency decisions are inextricably intertwined if a challenge to one necessarily constitutes a challenge to the other." *St. Mary's* at *15.

[95] *See* 50 Fed. Reg. 35646 at 35697 (Sept. 3, 1985), which Provider cites in its Petition for Expedited Judicial Review at 7 to illustrate that the Secretary ignored the limits imposed by the statute.

[96] 42 C.F.R. § 405.473(c)(3) (1983).

[97] *Id*.

[98] In addition to challenging the FFY 2025 IPPS rates, the Providers argue that the regulations requiring them to make a Substantive Claim (42 C.F.R. § 413.24(j)) are unlawful. *See* Response to MAC's Substantive Claim Challenge (Nov. 10, 2025). These requests for EJR would need to be addressed if the Board had found jurisdiction.

APPENDIX A
Examples of other adjustments to the standardized amount that may potentially break the causal link from FFY 1985 to the fiscal years at issue

Set forth below are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments ("BNAs") and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). These other examples raise questions about the causal link between the standardized amount rates at issue and the standardized amounts set for FFY 1985.

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[99] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[100]

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[99] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[100] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

c. BNAs made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[101]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[102] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[103]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[104]

Id. at 35655-56.

[101] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[102] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A).

[103] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[104] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

g. The subsequent amendments that Congress made in 1994[105] and 1997[106] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[107]

To illustrate the complex nature of these issues, the Board Majority points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[108] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[109] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment*

[105] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."
[106] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).
[107] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").
[108] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).
[109] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

for inpatient hospital services furnished to beneficiaries. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport*

with the statutory requirement that the rates represent payment for efficiently delivered care.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[110]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates*. In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[110] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[111] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[112] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[113]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[114] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[115] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

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[111] *Id.* at 35703-04 (bold and underline emphasis added).
[112] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[113] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[114] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[115] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions.

APPENDIX B
Additional Excerpts from FFY 1985 IPPS Final Rule
Affirming Application of FFY 1985 budget-neutrality-adjusted rates to
FFY 1986 and subsequent years.

In its decision, the Board Majority has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to various IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 BNA*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue. Further, it is clear from the fact that the comments and responses quoted below from the various final rules directly address the use of the budget-neutrality-adjusted FFY 1985 rates in the development of future rates and that proper notice-and-comment rulemaking was followed in the development of these rates. The Providers were aware of the Secretary's handling, with no ambiguity, as early as 1986.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 BNA accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments

> to the Federal rates for this factor for either FY 1986 or FY 1987.[116]

2. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary addresses the issue of using the pre-BNA or post-BNA FFY 1985 rate for the development of the FFY 1986 rate:

> We have also considered the commenter's position that FY 1984 and FY 1985 standardized rates be recalculated to remove the entire effect of budget neutrality prior to developing the FY 1986 payment rates. We do not agree that the prior years' standardized rates before budget neutrality should serve as the basis for updating the FY 1986 rates. Since the budget-neutralized standardized amounts represent the actual payment rates used to pay hospitals in FY 1985, we believe the 'percentage change' for FY 1986 should be applied to these amounts. In addition, section 1886(d)(3)(A) and (C) of the Act does not explicitly require that the update factor apply to the FY 1985 payment rates prior to the adjustments for budget neutrality in FY 1985.[117]

3. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her BNAs for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section

---

[116] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). The Board Majority notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 BNA accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.
> For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

[117] 50 Fed. Reg. at 35697.

> 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**
>
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**[118]

4. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 BNA to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician

[118] 51 Fed. Reg. at 31505-31506.

> anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[119]

[119] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

Appendix C

Pending cases involving standardized amounts vis-à-vis and FFY 1985 budget-neutrality-adjusted rates to FFY 1986 and subsequent years.

St. Mary's Reg'l Med. Ctr. v. Becerra[120], 1:23-cv-1594-RCL, 2024 WL 5186641 (D.D.C. Dec. 20, 2024), *appealed from* Board dec. dated Apr. 6, 2023 (lead Case No. 19-1723GC);

Nea Baptist Mem'l Hosp. et al v. Becerra, 1:24-cv-00419 (D.D.C. filed Feb. 12, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Dec. 14, 2023 (lead Case No. 19-0520GC);

Baystate Franklin Med. Ctr. et al v. Becerra, 1:24-cv-00822 (D.D.C. filed Mar. 22, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC);

Acadia Gen. Hosp., Inc. et al v. Becerra, 1:24-cv-00936 (D.D.C. filed Apr. 1, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC);

Catholic Med. Ctr. et al v. Becerra, 1:24-cv-01231 (D.D.C. filed Apr. 26, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 28, 2024 (lead Case No. 19-0696GC);

Capital Health Med. Ctr. Hopewell et al v. Becerra, 1:24-cv-01240 (D.D.C. filed Apr. 26, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 28, 2024 (lead Case No. 19-0695GC);

Alameda Health Sys. et al v. Becerra, 1:24-cv-01259 (D.D.C. filed Apr. 29, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 28, 2024 (lead Case No. 19-0355GC);

Washington Hosp. Ctr. Corp. et al v. Becerra, 1:24-cv-01243 (D.D.C. filed Apr. 26, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 29, 2024 (lead Case No. 19-0456GC);

Albany Med. Ctr. et al v. Becerra, 1:24-cv-01258 (D.D.C. filed Apr. 29, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Feb. 29, 2024 (lead Case No. 19-0212G);

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[120] On Sept. 26, 2025, Judge Lamberth issued an order in *St. Mary's*, granting the Secretary's motion in part, confirming that the Court's holdings are limited to the Board's jurisdiction over the dispute, and denying the Secretary's motion in part, insofar as it seeks partial reconsideration of the Court's decision.

New York City Health and Hosp. Corp. et al v. Becerra, 1:24-cv-01302 (D.D.C. filed May 3, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Mar. 4, 2024 (lead Case No. 19-1643GC);

Northwestern Mem'l Hosp. et al v. Becerra, 1:24-cv-01309 (D.D.C. filed May 3, 2024) *stayed pending resolution of St. Mary's*, *appealed from* Board dec. dated Mar. 4, 2024 (lead Case No. 19-0295);

**Adena Reg'l Med. Ctr. et al v. Becerra*, 1:24-cv-03336 (D.D.C. filed Nov. 26, 2024) *appealed from* Board dec. dated Sept. 27, 2024 (lead Case No. 18-1646G);

**Christus St. Frances Cabrini Hosp. et al v. Becerra*, 1:24-cv-03355 (D.D.C. filed Nov. 27, 2024) *related case St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 20-2104GC);

**Armstrong County Mem'l Hosp. et al v. Becerra*, 1:24-cv-03359 (D.D.C. filed Nov. 27, 2024) *related case, St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 24-1601G);

**Alameda Health Sys. et al v. Becerra*, 1:24-cv-03357 (D.D.C. filed Nov. 27, 2024) *related case St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 19-0354GC); and

St. Barnabas Med. Ctr. et al v. Becerra, 1:24-cv-03363 (D.D.C. filed Nov. 29, 2024) *related case St. Mary's*, *appealed from* Board dec. dated Sept. 30, 2024 (lead Case No. 19-1143GC).

*Univ. of Kansas Hosp. Auth. et al v. Kennedy, 1:25-cv-00603 (D.D.C. filed Feb. 28, 2025) *related case St. Mary's*, *appealed from* Board dec. dated Jan. 17, 2025 (lead Case No. 25-1141GC).

* Capital Health System, Inc. et al v. Kennedy, Jr., 1:25-cv-03073 (D.D.C. filed Sept. 8, 2025) *related case, University of Kansas Health Sys.*, *appealed from* Board dec. dated July 10, 2025 (lead Case No. 25-1403GC).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Decision***
25-0865GC: *Penn State Health CY 2022 Capital DSH CIRP Group*
25-0362GC: *HonorHealth CY 2021 Capital DSH CIRP Group*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the **November 5, 2025** consolidated request for expedited judicial review[1] ("EJR") for the above-referenced common issue related party ("CIRP") group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

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

Background:

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

[1] Providers' Petition for Expedited Judicial Review (Nov. 5, 2025) ("Request for EJR").
[2] The Request for EJR encompasses four (4) group cases. On **November 12, 2025**, pursuant to Board Rule 44.6 (2023), the Medicare Contractor's representative made a filing which indicated it would be submitting Substantive Claim Challenges in the instant cases, Case Nos. 24-2564GC and 25-0191GC, which will be addressed by the Board under separate cover.
[3] Request for EJR at 1.

create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

1. Geographic Reclassification

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

2. Operating DSH Adjustment Under Operating IPPS

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

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

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

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

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

3. Capital DSH Adjustment Under Capital IPPS

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

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

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

> as of September 30, 1987, and does not include a return on equity capital.[14]

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

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

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

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

[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 Nov. 20, 2025).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).

> reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

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

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

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

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH 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

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

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

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

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1,1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l)(ii) of the regulations.[20]

[19] *Id.* at 43409-10 (bold and underline emphasis added).
[20] *Id.* at 43377.

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

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

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

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

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

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

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

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

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

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

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

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

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

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

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

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

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

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the 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

[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.)

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) The term *urban area* means—

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

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

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

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

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

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

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

> of redesignation of an MSA by the Executive Office of Management and Budget.[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:
>
> (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

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

> discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[39]

[39] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).

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

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

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

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

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

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

> reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[43]

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

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

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

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

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

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[43] 71 Fed. Reg. 47870, 48104 (Aug. 18, 2006).
[44] *Id.* at 48105.
[45] (Bold emphasis added.)
[46] 621 F.Supp.3d *13 (D.D.C. 2021).

> 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 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:

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

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

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

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

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

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

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

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

Providers' Request for EJR

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

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[55] *Id.* at *29.
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.*
[60] *Id.* at *30.
[61] *Id.*
[62] Request for EJR at 7.

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The Providers note that "[t]he capital PPS provisions are located in an entirely different section of the statute, in 452 U.S.C. § 1395ww(g), and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes."[63]

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

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

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

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[63] *Id.* at 1, 7.
[64] *See id.* at 7-8.
[65] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[66] *Id.*
[67] *Id.* at 8-9.
[68] *Id.* at 9-10.
[69] *Id.* at 10 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023).
[70] *Id*.

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

Medicare Contractor's Response:

Following receipt of the Consolidated Request for EJR on **November 5, 2025**, the Medicare Contractor's representative, Federal Specialized Services ("FSS") filed notices on **November 12, 2025** certifying that that it would be filing Substantive Claim Challenges in Cases 24-2564GC and 25-0191GC. FSS, however, failed to certify that it would file challenges in Cases 25-0865GC and 25-0362GC within the time required by the Board's Rules.[73]

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; [74]

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[71] *See* 42 C.F.R. § 405.1867.
[72] Request for EJR at 10-12.
[73] Board Rule 44.5.2 (2023) typically requires a party questioning whether a participant included an appropriate claim on the cost report at issue to file its Substantive Claim Challenge within 60 days of the group filing its Final Schedule of Providers ("SOP"). When an EJR Request is filed within 60 days of the Final SOP, the moving party must certify that it will be filing a challenge within five business days and then must file the actual challenge within 20 days following the filing of the EJR Request. The Consolidated EJR Request in the case was filed on November 5, 2025. On November 12, 2025 (five business days after the EJR Request), FSS certified that it would be filing substantive claim challenges in Cases 24-2564GC and 25-0191GC only.
[74] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986). Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the

- 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.[75]

The Providers have appealed from original NPRs or the failure of the Medicare Contractor to issue a timely NPR.

Based on its review of the record, the Board finds that each of the participants in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations or failure to issue a determination[76] as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals' and that the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[77] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[78] 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

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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) . . .

[75] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

[76] The regulation at 42 C.F.R. § 405.1835(c) permits a provider to file an appeal with the Board where:

(1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
(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) . . .

[77] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

[78] *Id.* at 70555.

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 six cases have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement for the Board's ***jurisdiction*** is not applicable.

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

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

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

> in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

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

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

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[79] 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.[80] In these two cases, the Medicare Contractor failed to certify that it would be filing a Substantive Claim Challenge[81] within the time frame specified by Board Rule 44.6 (2023) for any of the Providers with FYEs December 31, 2016 or later.

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[79] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[80] *See* 42 C.F.R. § 405.1873(a).
[81] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[82] 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).

4. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in Cases 25-0865GC and 25-0362GC are entitled to a hearing before the Board;

2) Board review of whether the Providers' cost reports included an appropriate claim for a specific item as required by 42 C.F.R. § 405.1873(a) has not been triggered;

3) 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;

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Cases 25-0865GC and 25-0362GC. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the cases and will remove them from its docket.

[82] 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."

Board Members Participating:

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

FOR THE BOARD:

11/25/2025

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
Dean Wolfe, Noridian Healthcare Solutions (J-F)
Scott Berends, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
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RE: ***Expedited Judicial Review Determination***
Case Numbers: 26-0289GC *et al.* (12 Cases – *See* **Appendix A**)

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **November 5, 2025** in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

The Board received the individual appeal requests or requests to establish optional or Common Issue Related Party ("CIRP") groups for these twelve (12) cases between **March, 2025** and **November, 2025**. The Providers are all appealing from original or revised Notices of Program Reimbursement ("NPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Year Ends ("FYE") spanning from 2005 to 2013.

The issue in these appeals is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[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] *See, e.g.,* Case No. 26-0289GC, Statement of Group Issue at 1 (Oct. 31, 2025).
[3] *Id.* at 2-3.

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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

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

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

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

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

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

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

In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

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

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in

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[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[31] *Id.* at 2011.
[32] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[33] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[34] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board,* ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[35] 139 S.Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S.Ct. at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

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

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

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

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

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

*fractions for **each** applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[43]

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

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

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[46]

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

The Board also notes that, on September 30, 2025, the District Court for the District of Columbia issued a decision holding Part C enrollees are "entitled to [Part A] benefits" within the context of 42 U.S.C.§ 1395ww(d)(5)(F)(vi), even when they elect to receive Part C benefits.[47] It ruled,

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[43] 88 Fed. Reg. at 37774-75 (emphasis added).
[44] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[45] *Id.* at 37788 (emphasis added).
[46] *Id.* (emphasis added).
[47] *Montefiore Med. Ctr. v. Kennedy*, 2025 WL 2801237, *7-12 (D.D.C. 2025).

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

Providers' Position:

A. Providers' Appeal Requests

The Providers' appeal requests include a "Statement of Jurisdiction" asserting that the Providers have met the applicable statutory conditions for appeal because they are dissatisfied with their original or revised NPRs which apply the June 9, 2023 retroactive final rule related to Part C days. They cite language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[51]

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

The Providers characterized the relevant background facts as follows:

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

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

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2014 was procedurally invalid because 42 U.S.C. § 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted standard was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the standard could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[54]

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[48] *Id.* at *12-19.
[49] *Id.* at *19-22.
[50] *Id.* at *23.
[51] *E.g.,* Case No. 26-0289GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[52] *E,g,,* Case No. 26-0289GC, Appeal Request, Statement of Group Issue at 1. The Board notes that the Statement of Issue included with each individual appeal is materially identical to the Statement of Group Issue included with each optional and CIRP group appeal.
[53] *Id.*
[54] *Id.* (citing to 139 S. Ct. at 1816).

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.[55]

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[56]

B. Providers' Petitions for EJR

The Providers have requested EJR over the "post-*Allina* retroactive Part C policy issue" because they believe they have met the requirements for a hearing before the Board, but the Board lacks the authority to decide the substantive and procedural validity of CMS' final rule published in the Federal Register on June 9, 2023.[57] They seek a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[58] "The Providers contend that the new, post-*Allina* retroactive part C days rule, applied in the NPR[s] appealed here, is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[59] Since the Board is bound by this regulation,[60] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **November 12, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all twelve (12) cases. It simply advised that, in each case, "no substantive claim challenge has been filed, no jurisdictional challenge has been filed and the MAC does not oppose the request for EJR."[61]

Decision of the Board:

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

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[55] *Id.*
[56] *Id.* (citing 4 U.S.C. § 706(2)).
[57] *E.g.*, Case No. 26-0289GC, Providers' Petition for Expedited Judicial Review at 13 (Nov. 5, 2025).
[58] *Id.* at 16-17.
[59] *Id.* at 1-2.
[60] 42 C.F.R. § 405.1867.
[61] *E.g.,* Case No. 26-0289GC, Response to Provider's Request for Expedited Judicial Review at 1 (Nov. 12, 2025).

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [62]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[63]

For these twelve (12) appeals, the providers all appealed from original and/or revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All the Providers in the individual appeals listed in **Appendix A** filed their appeals within 180 days of the issuance of their NPRs and/or RNPRs and the amount in controversy exceeds $10,000. Likewise, all the providers in the group appeals listed in **Appendix A** appealed the Part C Days issue in an individual appeal (and subsequently transferred the issue to their group appeal) or were directly added to the group within 180 days of the issuance of their NPRs and/or RNPRs and the amount in controversy exceeds $50,000.

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

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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

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

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

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in all twelve (12) Cases listed in **Appendix A**, the Board hereby closes these twelve (12) cases and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

11/25/2025

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)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Scott Berends, Federal Specialized Services

Appendix A

PRRB Case Number	PRRB Case: Case Name
26-0289GC	*Methodist Health System CY 2007 Post-Allina II DSH Part C Days CIRP Group*
25-3583G	*Ropes & Gray CY 2008 Post-Allina II DSH Part C Days (Allina Plaintiffs) Group*
25-3607G	*Ropes & Gray CY 2010 Post-Allina II DSH Part C Days (Allina Plaintiffs) Group*
25-3611G	*Ropes & Gray CY 2011 Post-Allina II DSH Part C Days (Allina Plaintiffs) Group*
25-3673G	*Ropes & Gray CY 2012 Post-Allina II DSH Part C Days (Allina Plaintiffs) Group*
25-5621G	*Ropes & Gray CY 2007 Post-Allina II DSH Part C Days (Allina Plaintiffs) Group*
26-0252	*Maimonides Medical Center (33-0194), FYE 12/31/2005*
26-0253	*Maimonides Medical Center (33-0194), FYE 12/31/2006*
26-0254	*Maimonides Medical Center (33-0194), FYE 12/31/2008*
25-5822G	*Ropes & Gray CY 2007 Post-Allina II DSH Part C Days Group*
25-3672G	*Ropes & Gray CY 2013 Post-Allina II DSH Part C Days (Allina Plaintiffs) Group*
26-0306	*Tampa General Hospital (10-0128), FYE 09/30/2005*

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ken Janowski
Strategic Reimbursement Group, LLC
16408 E. Jacklin Dr.
Fountain Hills, AZ 85268

RE: ***Notice of Dismissal***
SRI Adventist 2011 DSH Medicaid Ratio Eligible Days CIRP Group
Case No. 16-0406GC

Dear Mr. Janowski:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 16-0406GC. Set forth below is the decision of the Board to dismiss the appeal challenging the Provider's Unmatched/Unpaid Medicaid Eligible Days.

Background

On **December 4, 2015**, Strategic Reimbursement Group, LLC ("SRG") filed a request for a Group Appeal on behalf of Adventist Health, the parent organization for the providers in this appeal. The common issue for the participants in this appeal is Unmatched or Unpaid Medicaid Eligible Days. The group issue statement reads:

> Whether the Intermediary's adjustment to the computation of disproportionate share that excludes certain Medicaid eligible patient days in the numerator of the Medicaid patient utilization percentage used to complete the patient Disproportionate Share reimbursement percentage in the disproportionate share settlement, is consistent with 42 CFR Regulation §412.320, 42 U.S.C. Section 1886(d)(5)(f) and Provider Reimbursement Manual Instructions.

On **August 30, 2023**, SRG notified the Board that the Group was Fully Formed.

On **September 1, 2023**, the Board issued the CIRP Group Fully Formed 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 Group Representative regarding the content of its preliminary position paper:

> Group's Preliminary Position Paper – 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 11, 2023**, SRG timely filed the Group's preliminary position paper. The Group suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that:

> In accordance with the PRRB's Alert 10 issued on May 23rd, 2014, documentation has been or is being prepared to address each of the PRRB's bulleted requests:
>
> - "A detailed description of the process that the provider used to identify and accumulate the actual Medicaid paid and unpaid eligible days that were reported and filed on the Medicare cost report as issue."
> - "The number of additional Medicaid paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation."
> - "A detailed explanation why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed. If there is more than one explanation/reason, identify how many of these days are associated with each explanation/reason."[2]

On **February 5, 2024**, the Medicare Administrative Contractor ("MAC") filed its preliminary position paper. The MAC's position paper noted that to date, the Provider Group "have not submitted listings of acute care hospital days the Providers may claim are additional Medicaid eligible days that were not included in the final settlement."[3]

On **May 5, 2025**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Group regarding the content of its final position paper:

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[1] (Emphasis added.)
[2] Provider Group's Preliminary Position Paper at 6 (Oct. 11, 2023).
[3] MAC's Preliminary Position Paper at 4 (Feb. 5, 2024).

> Group's Final Position Paper – The final position paper filing should reflect the *refinement* of the issue from the preliminary position paper or proposed joint scheduling order.
>
> ***
>
> 1. For appeals filed *on or after* August 29, 2018, the final position paper is an *optional* filing, intended to hone/refine the group issue, if necessary, but is not required. *See* 42 C.F.R. § 405.1853(b)(2)-(3) and **Board Rule 27** for more specific content and exhibit requirements. If the Group opts not to file a final position paper, then the arguments and exhibits related to the issue under appeal may be limited to those set forth in the preliminary position paper. *See* **Board Rules 27.4** and **35.3**.*For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[4]

On **August 27, 2025**, the Provider filed its final position paper. The final position paper is substantively identical to the preliminary position paper.

On **October 13, 2025**, the MAC filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Group has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or described why such documentation was and continues to be unavailable; (2) the Providers' failure to furnish such documentation (or describe why such documentation remains unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2; and (3) the Providers have effectively abandoned their claim for Unmatched Medicaid Days. The MAC points out that "[t]he Providers submitted their PPP on October 11, 2023, and their FPP on August 27, 2025. More than 14 years have passed since the end of the 2011 fiscal year at issue, and at no time were listings of the "understated" days submitted for the MAC's review."[5] The MAC argues the Group has abandoned its claim and therefore, the case should be dismissed.[6]

On **October 15, 2025**, the MAC filed its final position paper. In it, the MAC states, "There is no evidence of a submission of a listing or any other detail of the disputed days for each of the cost

[4] (Emphasis included.)
[5] Motion to Dismiss at 2 (Oct. 13, 2025).
[6] *Id*. at 4.

reports under appeal. The MAC contends that the Providers have had enough time to obtain the Medicaid eligibility verification results from the State of California."[7]

Decision of the Board

Pursuant to Board Rule 44.3, "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." Accordingly, the Group's response to the MAC's Motion to Dismiss filed on October 13, 2025, was due on November 12, 2025. However, the Provider ***failed*** timely respond and this matter is now ripe for ruling.

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

According to its Appeal Request, the Group asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Group states the issue being appealed as:

> Whether the Intermediary's adjustment to the computation of disproportionate share that excludes certain Medicaid eligible patient days in the numerator of the Medicaid patient utilization percentage used to complete the patient Disproportionate Share reimbursement percentage in the disproportionate share settlement, is consistent with 42 CFR Regulation §412.320, 42 U.S.C. Section 1886(d)(5)(f) and Provider Reimbursement Manual Instructions.

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

[7] MAC's Final Position Paper at 4 (Oct. 15, 2025).

> data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[8]

Similarly, with regard to position papers,[9] Board Rule 25.2.1 (Nov. 2021) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[10] 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.[11]

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; or upon

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

failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868).

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

This appeal was initiated on December 4, 2015 (nearly 10 years ago), and at that time, the Providers did not include a list of additional Medicaid eligible days they assert should be included in their Medicaid percentage and DSH computations with their appeal request. ***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.[12] 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 hereby DISMISSES the group appeal. Accordingly, Case No. 16-0406GC is closed and shall be removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/25/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Barnes Jewish Hospital (Provider No. 26-0032)
FYE 12/31/2017
Case No. 22-0578

Dear Mr. Kramer and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 22-0578*

On **August 24, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

On **January 27, 2022**, the Board received 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

On **January 28, 2022**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

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

On **September 22, 2022**, the Provider timely filed its preliminary position paper.

On **November 14, 2022**, the Medicare Administrative Contractor ("MAC") requested from the Provider all documentation necessary to resolve Issue 2 (DSH Payment – Medicaid Eligible Days).

On **December 28, 2022**, the MAC filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 2. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **December 30, 2022**, the MAC timely filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-0143GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider 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.[2]

The group issue statement in Case No. 21-0143GC, BJC Healthcare CY 2017 DSH SSI Percentage CIRP Group, to which the Provider is a participant, reads in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include

[1] (Emphasis added).
[2] Issue Statement at 1 (Jan. 27, 2022).

> paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[3]

The amount in controversy listed for both Issue 1 in the Provider's individual appeal request and the Provider as a participant in Case No. 21-0143GC is $408,850.

On September 22, 2022, the Provider filed its preliminary position paper. The following is the entirety of Provider's position on Issue 1 as set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI

[3] Group Issue Statement, Case No. 21-0143GC.

> entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[4]

C. Description of Issue 2 in the Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 8,27,29,30,s-d
>
> Estimated Reimbursement Amount: $1,635,315[5]

[4] Provider's Preliminary Position Paper at 8-9 (Sept. 22, 2022).
[5] Appeal Request at Issue 2.

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

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues the realignment sub-issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[8]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[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 regarding the merits of its claim in its Preliminary Position Paper."[11]

Issue 2 – DSH Payment – Medicaid Eligible Days

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[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's Preliminary Position Paper at 7-8.
[8] Jurisdictional Challenge at 5-6 (Dec. 28, 2022).
[9] *Id*. at 4-5.
[10] *Id*. at 6.
[11] *Id*. at 7.

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats their appeal request.[12]

Provider's Jurisdictional Response

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

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 1 and 2.

A. DSH Payment/SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH

[12] *Id*. at 10.

percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 21-0143GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[13] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the MAC "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] The Provider argues that "its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [MAC]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-0143GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to a single provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-0143GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal.

In accordance with 42 C.F.R. § 405.1853(b), the Commentary to Rule 23.3, explains that preliminary position papers must "be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." The commentary to Rule 25 also explicitly states, "[T]he Board requires preliminary position papers to present the ***fully***-developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline."

Moreover, Board Rule 25.2.2 specifies:

[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[16]

In its PPP, the Provider only cites to the 2000 Federal Register as the source for the MEDPAR data it claims it has yet to receive. But additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have since occurred. For example, as noted in the FY 2006 IPPS Final Rule:

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

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

[16] (Emphasis added).

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[17]

This CMS webpage describes access to DSH data ***from 1998 to 2023*** and instructs providers to send a request via email to access their DSH data."[18] The Provider's appeal is relative to FYE 2017.

Based on the foregoing, the Board finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rules 23 and 25 (November 1, 2021) governing the content of position papers. The Board also finds that the Provider's *Preliminary Position Paper* failed to comply with Board Rule 25.2.2 by not addressing why the MEDPAR data for FYE 2017 was allegedly unavailable. Thus, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in the group case and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-0143GC.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-0143GC are the same issue.[19] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request[.]" In this case, there is nothing in the record indicating that a proper written realignment request was made by the Provider and that the MAC made a final determination regarding DSH SSI Percentage realignment from which the Provider can appeal. Moreover, an appeal before the Board may not be used as a conduit for the MAC (the intermediary) nor for CMS. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

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[17] Last accessed August 14, 2024.
[18] Emphasis added.
[19] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a BJC Healthcare CIRP group per 42 C.F.R. § 405.1837(b)(1).

B. DSH Payment – Medicaid Eligible Days

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

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

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

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

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) states:

> 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.

[20] Individual Appeal Request, Issue 2.

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

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

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[21]

Similarly, with regard to position papers,[22] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[23] 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:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;

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

> 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.[24]

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 January 27, 2022 (over 3 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[25] ***To-date, no listing has been provided—even after the MAC requested the listing***. Accordingly, the Provider has abandoned the issue by failing to properly develop its arguments and provide supporting documents, and by failing to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[26] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

****

In summary, the Board hereby DISMISSES the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-0143GC and because the

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[24] (Emphasis added).
[25] Provider's Preliminary Position Paper at 8.
[26] *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.

purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0578 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:

11/25/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Randall Gienko
Strategic Reimbursement Group, LLC
360 W. Butterfield Road, Suite 310
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RE: ***Notice of Dismissal***
Tower Health CY 2018 Unmatched Medicaid Days CIRP Group
Case No. 22-1507GC

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1507GC. Set forth below is the decision of the Board to dismiss the appeal challenging the Provider's Unmatched Medicaid Eligible Days.

Background

On **September 28, 2022**, Strategic Reimbursement Group, LLC ("SRG") filed a request for a Group Appeal on behalf of Tower Health, the parent organization for the providers in this appeal. The common issue for the participants in this appeal is Unmatched Medicaid Eligible Days. The group issue statement reads:

> **1. Unmatched Medicaid Days (Unpaid Medicaid Eligible Days)**
>
> The provider contends that the Medicaid fraction of its Operating Disproportionate Share Hospital and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations") has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 CFR 412.106.
>
> The provider requests that patient days pertaining to additional patient stays that were not paid by Medicaid but related to patients who were eligible for medical assistance under a Medicaid-approved state plan during their stay ("Medicaid Eligible Days") be included in the Medicaid fraction of the Calculations. Based on prior experience with the Medicaid eligibility data compiled by state Medicaid agencies, the provider believes that the number of Medicaid Eligible Days in its Calculations may be materially understated. Among other causes, delays or errors in initial applications for Medicaid recipients can cause the eligibility data

> utilized in the Calculations to be inaccurate at the time the cost report is filed. The provider seeks to ensure a more accurate count of Medicaid Eligible Days is used to determine the proper amount of DSH reimbursement due to the provider. Based on historical industry experience the provider has estimated the amount of appealed reimbursement to be 2% of eligible DSH days, the reimbursement impact is detailed in the attached calculations.

On **September 28, 2023**, SRG notified the Board that the Group was Fully Formed.

On **October 5, 2023**, the Board issued the CIRP Group Fully Formed 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 Group Representative regarding the content of its preliminary position paper:

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

On **November 27, 2023**, SRG timely filed the Group's preliminary position paper. The Group suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that:

> In accordance with the PRRB's Alert 10 issued on May 23rd, 2014, documentation has been or is being prepared to address each of the PRRB's bulleted requests:
>
> - "A detailed description of the process that the provider used to identify and accumulate the actual Medicaid paid and unpaid eligible days that were reported and filed on the Medicare cost report as issue."
> - "The number of additional Medicaid paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation."

[1] (Emphasis added.)

> - "A detailed explanation why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed. If there is more than one explanation/reason, identify how many of these days are associated with each explanation/reason."[2]

On **March 27, 2024**, the Medicare Administrative Contractor ("MAC") filed its preliminary position paper. The MAC's position paper noted that to date, the Provider Group had "advised that they would follow up as to when DSH listings will be available."[3]

On **May 5, 2025**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Group regarding the content of its final position paper:

> Group's Final Position Paper – The final position paper filing should reflect the *refinement* of the issue from the preliminary position paper or proposed joint scheduling order.
>
> ***
>
> 2. For appeals filed *on or after* August 29, 2018, the final position paper is an *optional* filing, intended to hone/refine the group issue, if necessary, but is not required. *See* 42 C.F.R. § 405.1853(b)(2)-(3) and **Board Rule 27** for more specific content and exhibit requirements. If the Group opts not to file a final position paper, then the arguments and exhibits related to the issue under appeal may be limited to those set forth in the preliminary position paper. *See* **Board Rules 27.4** and **35.3**.*For each remaining issue*, the position paper ***must*** *state the material facts* that support the appealed claim, identify the controlling authority (e.g., statutes, regulations, policy, or case law), ***and*** *provide arguments* ***applying the material facts*** to the controlling authorities. This filing ***must*** *also include* ***any exhibits*** *the Provider will use to support its position*. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[4]

On **August 14, 2025**, the Provider filed its final position paper. The final position paper is substantively identical to the preliminary position paper.

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[2] Provider Group's Preliminary Position Paper at 6 (Nov. 27, 2023).
[3] MAC's Preliminary Position Paper at 11 (Mar. 27, 2024).
[4] (Emphasis included.)

On **October 10, 2025**, the MAC filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Group has failed to develop its case as required by the regulations and the PRRB Rules; (2) That the Group has failed to develop facts and arguments regarding its dispute in its Preliminary and Final Position Papers; (3) That the Group have had adequate time to develop the merits of their appeal and prepare their argument; (4) That each Provider has essentially abandoned its appeal by filing a perfunctory Preliminary and Final Position Paper; [5] (5) That the Group violated PRRB Rules 25 and 27.1, and 42 C.F.R. § 405.1853(b)(2) because its Preliminary and Final Position Paper did not set forth the relevant facts and arguments regarding the merits of the Group's claims; and (5) That the Board dismiss the Group appeal. [6]

On **November 7, 2025**, the MAC filed its final position paper. In it, the MAC states that the Provider failed to identify or support any Medicaid Eligible days that it claims are at issue.[7]

Decision of the Board

Pursuant to Board Rule 44.3, "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." Accordingly, the Group's response to the MAC's Motion to Dismiss filed on October 10, 2025, was due on November 9, 2025. However, the Provider ***failed*** timely respond and this matter is now ripe for ruling.

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

According to its Appeal Request, the Group asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Group states the issue being appealed as:

> **1. Unmatched Medicaid Days (Unpaid Medicaid Eligible Days)**
>
> The provider contends that the Medicaid fraction of its Operating Disproportionate Share Hospital and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations") has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 CFR 412.106.
>
> The provider requests that patient days pertaining to additional patient stays that were not paid by Medicaid but related to patients who were eligible for medical assistance under a Medicaid-

[5] MAC Motion to Dismiss at 5 (Oct. 10, 2025).
[6] *Id*.
[7] MAC's Final Position Paper at 12 (Nov. 7, 2025).

> approved state plan during their stay ("Medicaid Eligible Days") be included in the Medicaid fraction of the Calculations. Based on prior experience with the Medicaid eligibility data compiled by state Medicaid agencies, the provider believes that the number of Medicaid Eligible Days in its Calculations may be materially understated. Among other causes, delays or errors in initial applications for Medicaid recipients can cause the eligibility data utilized in the Calculations to be inaccurate at the time the cost report is filed. The provider seeks to ensure a more accurate count of Medicaid Eligible Days is used to determine the proper amount of DSH reimbursement due to the provider. Based on historical industry experience the provider has estimated the amount of appealed reimbursement to be 2% of eligible DSH days, the reimbursement impact is detailed in the attached calculations.

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.

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

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

> *provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[8]

Similarly, with regard to position papers,[9] Board Rule 25.2.1 (Nov. 2021) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[10] 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.[11]

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

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

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

This appeal was initiated on September 28, 2022 (over 3 years ago), and at that time, the Providers did not include a list of additional Medicaid eligible days they assert should be included in their

---

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

Medicaid percentage and DSH computations with their appeal request. ***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.[12] 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 hereby DISMISSES the group appeal. Accordingly, Case No. 22-1507GC is closed and shall be removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/25/2025

X Shakeba DuBose

Shakeba DuBose, Esq.
Board Member
Signed by: PIV

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

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