DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Woodland Heights Medical Center (Prov. No. 45-0484), FYE 12/31/2016
Case No. 20-0433

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0433. 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. 20-0433***

On **May 14, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On **November 8, 2019**, the Board received the Provider's individual appeal request. The appeal was filed by the parent organization Community Health Systems, Inc. ("CHS") and included five (5) issues:

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

On **December 3, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

[1] On June 18, 2020, this issue was transferred to Case No. 19-1409GC.
[2] This issue was withdrawn in the Preliminary Position Paper Cover letter.
[3] On June 18, 2020, this issue was transferred to Case No. 19-1410GC.

> 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 **June 18, 2020,** CHS transferred Issues 2 and 5 to CIRP groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there are two (2) remaining issues in this appeal: Issue 1: SSI (Provider Specific) and Issue 3: Medicaid Eligible Days.

On **June 29, 2020**, CHS timely filed the Provider's preliminary position paper (*hereafter, PPP*). Iin the cover letter to the PPP, CHS withdrew the Uncompensated Care Distribution Pool Issue (#4).[5]

On **September 29, 2020**, the Medicare Contractor ("MAC") filed a Jurisdictional Challenge over the SSI Percentage (Provider Specific) issue. The MAC contends that there are three sub-issues to Issue 1. Two of the sub-issues are duplicative of the issue that was transferred to Group Case No. 19-1409GC and the portion related to SSI realignment is premature as there was no final determination and the Provider has not exhausted all available remedies.

On **October 30, 2020**, the MAC filed its PPP. The MAC reiterated its jurisdictional challenge over the SSI Percentage (Provider Specific) issue. With regard to Issue 3, the MAC noted that it had not yet received the eligibility listing even though CHS had indicated one would be sent under separate cover in its PPP. In addition, the MAC indicated it had sent a previous request to the Provider for a listing of days on **December 18, 2019**, but one had not been submitted.

On **November 14, 2022**, the MAC filed a global Jurisdictional Challenge over CHS' appeals in which it challenged jurisdiction over the Medicaid eligible days issue.

On **December 14, 2022,** CHS filed its response to the MAC's Jurisdiction Challenge.

On December 15, 2022, CHS requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS"). The Board effectuated the change to QRS the following day.

On **December 28, 2022**, the MAC responded to CHS' responsive jurisdictional brief. The MAC argues that the Nov 2021 version of the Rules in place when the appeal was filed required the

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[4] (Emphasis added).
[5] The Board acknowledged the withdrawal of the issue on May 4, 2021, but used the date of the cover letter, June 20, 2021 as the withdrawal request date. The withdrawal was effectuated in the Office of Hearings Case & Document Management System ("OH CDMS") on June 29, 2020.

filing of complete PPPs with exhibits and made final position papers filings optional. In addition, the MAC clarified that it wasn't requesting the Board deny jurisdiction due to the Providers' failure to claim the Medicaid days at issue. Rather, the MAC was requesting dismissal of the issue due to the Provider's failure to file a complete PPP in accordance with Board Rules, and effectively abandoning the issue.

On **January 20, 2023**, CHS uploaded a copy of an "Administrative Resolution Package" it sent to the MAC into OH CDMS. Although the copy didn't include the exhibits, it indicates that one of the exhibits forwarded to the MAC was a listing of Medicaid DSH days showing 4,784 days with a reimbursement impact of $4,800.

On **July 11, 2025**, the case was scheduled for a hearing date on January 22, 2026.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 19-1409GC

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.
>
> 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.
>
> 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] Issue Statement at 1 (Nov. 8, 2019).

The Group issue Statement in Case No. 19-1409GC, to which the Provider transferred Issue 2 (the SSI Percentage), reads in part:

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

In the Provider's June 29, 2020 PPP in Case No. 20-0433, 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 (December 31).

[7] Group Issue Statement, Case No. 19-1409GC.

> 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).[8]

The amount in controversy listed on the calculation support for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $30,290.[9]

C. Description of Issue 3 in the Individual Appeal Request

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

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

[8] Provider's PPP at 8-9 (June 29, 2020).
[9] The Provider rounded the reimbursement impact for Issues 1 and 2 to $30,000 in OH CDMS.

> of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 7, 8, 10, S-D
>
> Estimated Reimbursement Amount: $56,000 *(rounded from $56,131 per calculation support)*[10]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[11] 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.[12]

MAC's Contentions: Issue 1 – DSH SSI Provider Specific

In its September 29, 2020 Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider's PPP, this issue has three components: 1) SSI data accuracy; 2) SSI realignment and 3) Individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the two components related to SSI data accuracy should be dismissed because they are duplicative of the DSH SSI Percentage issue transferred to Case No. 19-1409GC. Additionally, the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[13]

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

In a subsequent November 14, 2022 Jurisdictional Challenge, the MAC argued that the Provider failed to include a list of additional Medicaid eligible days it expected to be included (even though the Provider's PPP included a statement indicating a listing of additional Medicaid eligible days would be sent under separate cover.)[14] In addition, the MAC contends that the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2. and 25.3.[15] Therefore, since the issue was not properly developed, the Provider did not

[10] Appeal Request at Issue 3.
[11] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[12] Provider's PPP at 7 (June 29, 2020).
[13] MAC's Jurisdictional Challenge at 2.
[14] MAC's jurisdictional challenge at 4 and Exhibit C-1. (Nov. 14, 2022).
[15] *Id*. at 4.

provide a list of additional Medicaid days, nor did it explain why it could not produce the documentation, the MAC contends the Provider has abandoned the issue.[16]

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.[17] The Provider did not file a response to the Jurisdictional Challenge over the SSI Provider Specific issue and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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

The Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[18] The Provider goes on to argue that:

> The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.
> . . .
> These impediments are related to the State eligibility matching being unavailable at this time due to a change in the State's matching vendor changes. Concurrent with this letter to the Board the Providers are sending to the MAC the listing of additional Medicaid eligible days for providers not impacted by practical impediment.[19]

The Provider contends that they "have cured the sole defect on which the MAC relies, and the Board should deny the MAC's motion to dismiss."[20]

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.

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[16] *Id* at 6.
[17] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[18] Provider's Jurisdictional Response at 1 (Dec. 14, 2022).
[19] *Id*. at 2.
[20] *Id*.

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

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 19-1409GC.

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."[21] 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)."[22] 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."[23]

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case No. 19-1409GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Percentage (Provider Specific) issue in Case No. 20-0433 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[24], 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.[25] Accordingly, the Provider's reference

[21] Issue Statement at 1.
[22] *Id.*
[23] *Id.*
[24] PRRB Rules v. 2.0 (Aug. 2018).
[25] 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 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. 19-1409GC.

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. 19-1409GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[26]

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*

[26] (Italics and underline emphasis added.)

> *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.[27]

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."[28]

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case No. 19-1409GC are the same issue.[29] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

B. DSH Payment – Medicaid Eligible Days

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

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[27] Last accessed August 26, 2025.
[28] Emphasis added.
[29] 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).

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

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

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

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

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

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

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

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

> *timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[30]

Similarly, with regard to position papers,[31] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[32] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

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

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

This appeal was initiated on November 8, 2019 (more than 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.[33] ***To date, there is no evidence that the listing has been provided—even after the MAC requested the listing on 2 separate occasions***.[34] 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.[35] 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.

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[30] (Emphasis added).
[31] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[32] (Emphasis added).
[33] Provider's PPP at 8.
[34] MAC PPP at 11-12 and Nov. 14, 2022 Jurisdictional Challenge at 2 and Exhibit C-1.
[35] *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.

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Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: SSI Percentage (Provider Specific) -Issue 1 and Medicaid Eligible Days - Issue 3. As no issues remain, the Board hereby closes Case No. 20-0433 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:

9/2/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center Hillcrest, Prov. No. 45-0101, FYE 08/31/2017
PRRB Case No. 21-0312

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-0312. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 21-0312*

On **June 1, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2017.

On **October 29, 2020**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained eight (8) issues:

1. SSI Percentage (Provider Specific)
2. SSI Percentage
3. SSI Fr. Medicare Managed Care Part C Days
4. SSI Fraction Dual Eligible Days
5. Medicaid Eligible Days
6. Medicaid Fr. Managed Care Part C Days
7. Medicaid Fraction Dual Eligible Days
8. Standardized Payment Amount

The Provider is commonly owned/controlled by Baylor Scott & White Health (hereinafter "BS&W") and, thereby, is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 24, 2021**, the Provider transferred issues 2, 3, 4, 6, 7 and 8 to BS&W CIRP Groups.

On **December 2, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **June 25, 2021**, the Provider timely filed its preliminary position paper (*hereafter "PPP"*). The Provider briefed the two remaining issues: SSI Provider Specific and Medicaid Eligible Days, however the SSI Provider Specific issue was subsequently withdrawn. With respect to Issue No. 5, the Provider indicated that an Eligibility Listing was being sent under separate cover. It included the original calculation support filed with the appeal in which it is seeking reimbursement for an additional 150 Medicaid eligible days with a reimbursement impact of $72,268.

On **September 28, 2021**, the Medicare Contractor ("MAC") filed its PPP.

On **May 9, 2023,** BS&W requested a change of representative to Quality Reimbursement Services, Inc. ("QRS"). On **May 10, 2023**, QRS was made the representative.

On **January 31, 2025**, the Board issued a Notice of Hearing scheduling the case for a hearing on **September 16, 2025** and requiring final position papers be filed by the Parties.

On **June 17, 2025,** QRS timely filed its final position paper, which included a statement that "A listing of the additional Medicaid Eligible days being claimed will be submitted directly to the MAC. A redacted version of the list will be uploaded to the portal thereafter."

On **July 10, 2025**, the MAC filed a jurisdiction challenge over the SSI Provider Specific issue and Medicaid eligible days issues. Since the SSI Provider Specific issue was subsequently withdrawn, that portion of the challenge is moot. With regard to the Medicaid eligible days issue, the MAC contends the Provider failed to file complete PPP & final PPs including all support per 42 CFR 405.1853(b)(2) and Rules 25 & 27. In addition, the MAC indicated the Provider failed to provide an auditable listing of days or an explanation as to why it cannot produce the documents. Finally, the MAC argued the Provider is untimely and improperly attempting to add the 1115 waiver days issue to the appeal via its final position paper filing.

[1] (Emphasis added.)

On **July 11, 2025**, the MAC timely filed a final position paper and reiterated the arguments in its challenge.

On **August 11, 2025**, QRS uploaded a "Redacted Medicaid Eligible Days Listing." The 26-page listing shows 5,851 days and was titled "Additional ME & 1115 Waiver Days." On the same day, QRS filed its response to the MAC's jurisdiction challenge. QRS addressed only the 1115 waiver days issue and claimed that 1115 waiver days are part of the eligible days issue that was included in the initial appeal. With regard to MAC's claim that the Provider abandoned the issue, QRS cited to the litigation in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, which it contends "require the inclusion of section 1115 waiver days in the providers' Medicaid Fractions." QRS also advised that an unredacted listing to the MAC (purportedly on the same date it filed the redacted listing as a supplement to its (*final*) position paper).

On **August 12, 2025**, QRS withdrew the SSI Provider Specific issue.

On **August 19, 2025**, QRS requested a 60-day postponement awaiting the Board's jurisdictional decision.

MAC's Contentions re: Issue 5 – DSH Payment – Medicaid Eligible Days[2]

The MAC argues that the Provider abandoned the Medicaid eligible days issue when it failed to file complete preliminary and final position papers, including all supporting exhibits, to document the merits of its argument and failed to properly develop its argument within its position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27. Alternatively, the Provider failed to state its efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Section 1115 Waiver Days

Additionally, the MAC contends the Provider is attempting to untimely add the section 1115 waiver days issue as a sub-issue via its final position paper filed on June 17, 2025. The Provider originally characterized the Medicaid eligible days issue in its initial appeal request using the following language:

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

Neither the appeal request, nor the PPP, identified or mentioned the section 1115 waiver days issue. It was not until the final position paper submission that the Provider raised the issue – which was more than four years after the regulatory deadline to add a new issue to the case. Therefore, the MAC contends that the section 1115 waiver days, which a separate issue from the

[2] Since the SSI Provider Specific issue was withdrawn, only the Medicaid Eligible Days issue will be addressed.

Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.[3]

Provider's Jurisdictional Response

In its jurisdictional response, the Provider responds only to the MAC's challenge over the section 1115 waiver days issue. The Provider argues that the phrasing of its issue statement with respect to the Medicaid eligible days issue makes clear that the Provider appealed all Medicaid eligible days, including section 1115 waiver days. Whereas the MAC states that the section 1115 waiver days issue is one component of the DSH issue, the regulations at 42 C.F.R. § 405.1835 contain requirements for appealing an "issue" and a time limit on adding an "issue" – not on clarifying "sub-issues" or "components" of an issue. The Provider references both a June 25, 2004 proposed rule (69 *Fed. Reg.* 35716) and a May 23, 2008 final rule (73 *Fed. Reg.* 30190) which indicate that an "issue" is encapsulated by a specific cost report adjustment. "They do not slice and dice an "issue" into component parts, including the specific reason why Medicaid eligible days were not counted in the numerator of the Medicaid Fraction of the Disproportionate Payment Percentage." The Provider asserts "[t]here is no dispute that the same cost report adjustment that affects other types of Medicaid eligible days also affects section 1115 waiver days." [4]

The Provider goes on to claim that the version of Board Rule 8 (July 1, 2015) that was effective when the Provider filed its appeal, makes no mention of "section 115 waiver days" nor even "Medicaid eligible days." Thus, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be a denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days. [5]

Finally, with regard to the MAC's challenge that the section 1115 waiver days issue was abandoned because it was not briefed in the PPP, the Provider argues that, prior to its final position paper,

> . . . the Fifth Circuit ruled that the statute and CMS's own regulations require that CMS regard inpatient days attributable to an uncompensated care pool population as Medicaid eligible days. *Forrest General Hospital v. Azar*, 926 F.3d 221 (5th Cir. 2019)." The Medicare Contractor is required by specific command of CMS to accept and audit the Provider's section 1115 waiver days in providers' Medicaid Fractions. Following a string of litigation defeats, including those in *Forrest General Hospital* and *Bethesda Health, Inc. v. Azar*, 980 F.3d 121 (D.C. Cir.2020), CMS issued Change Request 12669, Transmittal No. 11912 (March 16, 2023).

[3] Jurisdictional Challenge at 15 (July 10, 2025).
[4] Provider's jurisdictional response at 2 (Aug. 11, 2025).
[5] Id at 3.

The Provider asserts that under this Transmittal, the MAC is required to accept and audit the Provider's listing of section 1115 days. The Provider states that it submitted an unredacted listing to the MAC as a supplement to its final position paper on August 11, 2025.[6]

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

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

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

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

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

[6] Jurisdictional Responsive Brief at 4 (Aug. 11, 2025).

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[7]

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

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

Rule 25 Preliminary Position Papers[8]

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

25.1 Content of Position Paper Narrative

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

25.1.1 The Provider's Position Paper

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

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

25.2 Position Paper Exhibits

25.2.1 General

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

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The December 2, 2020 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being

claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[9]

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

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

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

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

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

On June 25, 2021, 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.[10] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $71,268 based on an estimated 150 days). The Provider's complete briefing of this issue in its position paper is as follows:

[9] (Emphasis added.)
[10] Provider's PPP at 8 (June 25, 2021).

Calculation of Medicaid Eligible Days

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

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

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

Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2017 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its July 10, 2025 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those

documents, as required by the Board Rules.[11] In addition, the MAC argued the Provider was attempting to untimely and improperly add the section 1115 waiver days issue by including it in its final position paper submission.

On August 11, 2025 (4 years after the PPP deadline), QRS uploaded a Redacted Medicaid Eligible Days Listing in the Office of Hearings Case and Document Management System ("OH CDMS").[12] The 26-page listing did not include the sum, but when extracted and totaled, it shows 5,851 Medicaid eligible and 1115 waiver days. The Listing does not explain why the number of days included was over the initial 150 days the Provider claimed in its appeal, nor did it explain why it was being submitted at this late date. Regardless, the filing ***was more than 4 years past the deadline for including it with the Provider's PPP*** for which the deadline was June 26, 2021.

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

The Board rejects the Provider's attempts to include the eligible days listing uploaded to OH CDMS on August 11, 2025 (*purportedly, as a supplement to its June 21, 2025 final position paper*) because:

1. The upload was filed ***4 years*** *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); and (b) *why* the listing of the roughly 5,851 days were not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until nearly 5 years after this appeal was filed and almost 8 years after the fiscal year at issue had closed).

[11] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[12] The listing was titled "Additional ME & 1115 Waiver Days."

3. Neither the Board Rules, nor the December 2, 2020 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload to the final position paper, that they do).

4. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP, nor the subsequent listing QRS uploaded 2 months after it filed the final position paper, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP (indeed the *tentative* 5,851 days listed in the late exhibit is, without explanation, *significantly* larger than the original estimated 150 days included with the appeal request).[13]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[14] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

The Board finds that the section 1115 waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 waiver days.

The appeal was filed with the Board in October of 2020 and the regulations required the following:

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

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

> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[15]

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

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

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[16]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[17]

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

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

[15] 42 C.F.R. § 405.1835(b).
[16] (Bold and italic emphasis added).
[17] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

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

In this regard, the Board notes that section 1115 waiver days are not traditional Medicaid eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[18] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[18] 65 FR 47054, 47087 (Aug. 1, 2000).

> paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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

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

Finally, even in the Provider's final position paper, the Provider fails to identify what section 1115 waiver program(s) are involved and whether or not the section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory in that it only makes cursory conclusions.[19] Again, the Provider failed to so develop its position paper notwithstanding 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[20] In that case, the

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

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

provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[21] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[22] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[23] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 5). As no issues remain, the Board hereby closes Case No. 21-0312 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
Nicole E. Musgrave, Esq.
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For the Board:

9/2/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Michael Redmond, Novitas Solutions c/o GuideWell Source (J-H)
Wilson Leong, FSS

[21] *Id*. at *11.
[22] *Id.*
[23] *Id.*

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
Elmhurst, IL 60126

RE: ***Notice of Dismissal***
TowerHealth CY 2020 Unmatched Medicaid Days CIRP Group
Case No. 24-1889GC

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-1889GC. Set forth below is the decision of the Board to dismiss the appeal challenging the Providers' Unmatched Medicaid Eligible Days.

Background

On **June 5, 2024**, Strategic Reimbursement Group, LLC ("Strategic") filed 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 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 ["DSH"] and Capital [DSH] 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 **April 7, 2025**, Strategic notified the Board that the Group was fully formed with three participants.

On **April 11, 2025**, the Board issued the Group Completion Notice 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 the same date, the MAC filed its Rule 22 Jurisdictional Comments. The MAC advised the Board that the issue is not suitable for the group format as the facts regarding Medicaid eligibility data are different for each provider and that the group, therefore, does not involve a single question of fact.

On **May 13, 2025**, Strategic timely filed the Group's PPP. The PPP did not include listings of Medicaid eligible days for any of the group participants, nor did it explain why the listings were not included with the PPP filing. Indeed, the PPP filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue for each Provider.

On **June 2, 2025**, the MAC filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

On **August 20, 2025**, the MAC filed its PPP. The MAC's PPP noted that "[t]he Group is not challenging the MAC's computations but merely requesting the inclusion of additional days in these computations. However, as of this writing, the Group has not produced any evidentiary documentation to support the additional days."[2]

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[1] (Emphasis added.)
[2] MAC's PPP at 7 (Aug. 20, 2025).

MAC's Contentions

The MAC contends that the Providers failed to comply with Board procedures or filing deadlines under the authority of 42 C.F.R. § 405.1868(b) and Board Rules 25 and 25.2.2.
The Providers failed to furnish documentation in support of their claims for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The MAC alleges:

- On June 6, 2024, the MAC requested a DSH package for all group participants to which the Representative did not respond;
- The MAC contacted the Representative in an effort to confer via email on May 15, 2025, asking it to confirm that the Group had failed to identify or support any days without a response;
- The Group has failed to meet the requirements of 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 regarding the requirements of position papers, as well as Board Rule 25.2.2 regarding Unavailable and Omitted Documents; and
- The Providers have effectively abandoned their claims for additional Medicaid Eligible Days by filing a perfunctory PPP.

To that end, the Group Representative has not responded to the MAC's June 6, 2024 request for DSH packages for the providers in the Group.[3] Therefore, the MAC argues the Group has abandoned its claim and, therefore, the case should be dismissed.[4]

Provider's Jurisdictional Response

Pursuant to Board Rule 44.3, the Group's response to the Motion to Dismiss was due within 30 days but the Group Representative failed to timely file a response. "Unless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Decision of the Board

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

According to its Appeal Request, the Providers in this group assert that all Medicaid eligible days were not included in the calculations of the DSH calculation.

[3] MAC's Motion to Dismiss at 2 (June 2, 2025).
[4] MAC's Motion to Dismiss at 5 (June 2, 2025).

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*.[5]

Similarly, with regard to position papers,[6] Board Rule 25.2.1 (Nov. 2021) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[7] 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*

[5] (Emphasis added).
[6] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[7] (Emphasis added).

> *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.[8]

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 June 5, 2024 (over 1 year ago), and at that time, the Providers 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 Group's PPP was filed, and again provided no listing of eligible days. In fact, according to the MAC's PPP filed on August 20, 2025, the Group had not yet submitted a listing***—even after the MAC requested it on June 6, 2024***. 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.[9] 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.

---

[8] (Emphasis added).

[9] *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.

* * * * *

Based on the foregoing, the Board dismisses the group appeal. Case No. 24-1889GC is hereby closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

9/10/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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RE: ***Board Decision*** **– DSH Payment/SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Novant Health UVA Prince William Medical Center (Provider No. 49-0045)
FYE 12/31/2017
Case No. 22-0300

Dear Mr. Ravindran and Ms. Johnson,

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

Background:

A. ***Procedural History for Case No. 22-0300***

On **June 25, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

On **December 21, 2021**, 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 **December 22, 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 **August 17, 2022**, the Provider timely filed its preliminary position paper.

On **November 9, 2022**, the Medicare Contractor 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 **November 23, 2022**, the Medicare Contractor timely filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-0301GC

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. 22-0301GC, Novant Health CY 2017 DSH SSI Percentage CIRP Group, to which the Provider was directly added, 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?

[1] (Emphasis added).
[2] Issue Statement at 1 (Dec. 21, 2021).

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 instant appeal and for the Provider in the CIRP Group is $31,297.

On August 17, 2022, the Provider filed its preliminary position paper. 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 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 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

[3] Group Issue Statement, Case No. 22-0301GC.

> 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): 3,18,24, S-D
>
> Estimated Reimbursement Amount: $124,995[5]

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

[4] Provider's Preliminary Position Paper at 8-9 (Aug. 17, 2022).
[5] Appeal Request at Issue 2.
[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).

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 (42 C.F.R. § 412.106(b)(3)). Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The MAC had not made a determination on the realignment of the SSI percentage to the hospital fiscal year end, as the Provider has not yet requested realignment. Since the Provider did not request SSI realignment, as required by 42 C.F.R. § 412.106(b)(3), the MAC could not have made a final determination of this issue. The Provider's appeal is premature. The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this subsidiary realignment 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 being appealed in Case No. 22-0301GC 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 and 27.1."[10] The MAC posits that the Provider "failed to submit a complete Preliminary Position Paper with all exhibits as required by the Board Rules."[11] Specifically the MAC avers:

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[7] Provider's Preliminary Position Paper at 7.
[8] Jurisdictional Challenge at 5-6 (Nov. 9, 2022).
[9] *Id*. at 3-5.
[10] *Id*. at 6.
[11] *Id*. at 9.

> In its Preliminary Position Paper for the instant appeal, the Provider's sole argument consists of the identical, generic passage previously deemed insufficient by the Board in *City Hospital, Inc*. Here, the Provider only offered a single exhibit reflecting its estimated impact to be a 25% increase to the SSI percentage in its appeal request. In its Preliminary Position Paper, it only offered the total amount in controversy and not the actual calculation. Like *City Hospital, Inc.*, the Provider had access to its MEDPAR data prior to filing its position paper of this issue, yet failed to supply any documentation utilizing that data to support the alleged inaccuracy of its published SSI percentage, or explain why the documents remain unavailable, describe efforts to obtain any additional documents or advise when the documents will become available. Accordingly, the MAC contends that the sole relevant exhibit lacks the requisite narrative description to provide a thorough understanding of the parties' positions or basis for this estimate. Like the provider in *City Hospital, Inc.*, the Board should find that the Provider in the instant case has failed to submit a complete Preliminary Position Paper with all exhibits as required by the Board Rules. Therefore, the MAC respectfully requests that the issue be dismissed.[12]

Issue 2 – DSH Payment – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its 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.[13]

[12] *Id*. at 9 (Citations omitted).
[13] *Id*. at 11.

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." The 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.[14] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed.

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue Nos. 1 and 2.

A. Issue No. 1: 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 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.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 22-0301GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[15] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly

[14] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[15] Issue Statement at 1.
[16] *Id.*

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.”[17]

The Provider’s DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-0301GC 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 this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 22-0301GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[18], 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.[19] Accordingly, Provider’s reference to Issue 1 as “Provider Specific” and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged “provider specific” errors averred in Issue 1 are distinguished from the alleged “systemic” issues argued in Case No. 22-0301GC, and why those alleged “provider specific” errors should not be subsumed into the “systemic errors” issue appealed in Case No. 22-0301GC.

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. 22-0301GC, 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 Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) 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 of its issue and explain the nature of the any alleged “errors” in its Preliminary Position Paper 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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[17] *Id.*
[18] PRRB Rules v. 3.1 (Nov. 2021).
[19] 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**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[20]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such 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.[21]

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

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[20] (Emphasis added).
[21] 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005).

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[22]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[23]

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 22-0301GC are the same issue.[24] 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.

B. Issue 2: DSH Payment – Medicaid Eligible Days

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

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

[22] Last accessed August 14, 2024.
[23] Emphasis added.
[24] 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 Novant Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

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.[25]

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

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

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

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

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

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.

[25] Individual Appeal Request, Issue 3.

> 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*.[26]

Similarly, with regard to position papers,[27] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[28] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides 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.[29]

[26] (Emphasis added).
[27] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[28] (Emphasis added).
[29] (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 December 21, 2021 (nearly 4 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expect to be included in their 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.[30] ***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.[31] 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. 22-0301GC and because the purported realignment portion of the issue is premature in absence of a properly submitted written realignment request subject to a final determination from which the Provider can appeal. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for submitting fully developed and complete position papers in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0300 and removes it from the Board's docket.

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

[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 merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

Review of this determination 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:

9/12/2025

X Nicole E. Musgrave

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services, Inc.
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RE: ***Notice of Dismissal***
Barnes Jewish Hospital (Prov. No. 26-0032), FYE 012/31/2016, Case No. 20-0449

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0449. 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. 20-0449***

On **July 23, 2019**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016. The Provider is commonly owned by BJC Healthcare ("BJC").

On **December 5, 2019**, Quality Reimbursement Services, Inc. ("QRS") filed an appeal on behalf of the Provider. The Individual Appeal Request included two (2) issues:

1. DSH SSI Provider Specific
2. DSH Medicaid Eligible Days

On **December 16, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

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

On **July 28, 2020**, the Provider timely filed its preliminary position paper (hereinafter "PPP").

On **October 22, 2020**, the Medicare Contractor ("MAC") filed a jurisdictional challenge over the DSH SSI Provider Specific issue 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. However, the Provider ***failed*** to file any response.

On **November 19, 2020**, the MAC timely filed its PPP. The MAC indicated that it had not yet received a listing of the additional Medicaid Eligible Days although the Provider's PPP indicated the listing was being submitted under separate cover. The MAC requested listings from the Provider on December 13, 2019 and June 19, 2020 but received no response.[2]

On **January 10, 2023**, the MAC filed a copy of its Final Request for Medicaid Eligible Days Support.

On **June 23, 2025**, the MAC filed a Motion to Dismiss the Medicaid Eligible Days issue. 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. The Provider again failed to respond.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 19-0737GC

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.
>
> 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

[1] (Emphasis added).
[2] MAC PPP at 6 and Exhibit C-2.

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i)[3]

The Group issue Statement in Case No. 19-0737GC, the SSI Percentage CIRP group to which the Provider was directly added as 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 paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[4]

On July 28, 2020, the Board received the Provider's PPP in Case No. 20-0449. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[3] Issue Statement at 1 (Dec. 15, 2019).
[4] Group Issue Statement, Case No. 19-0737GC.

> **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 (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 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).[5]

The amount in controversy listed for both SSI Provider Specific issue in the individual appeal and for the SSI Percentage issue in the group is $398,649.

C. Description of Issue 2 in the Individual Appeal Request

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

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

[5] Provider's PPP at 8-9 (July 28, 2020).

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, 8, 22, S-D

Estimated Reimbursement Amount: $1,594,438 (rounded to $30,000 in OH CDMS)

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

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider's appeal request, Issue 1 has two components: SSI data accuracy and SSI realignment. The MAC contends that the portion related to SSI data accuracy should be dismissed because it is duplicative of the SSI Percentage issue that was directly added to group Case No. 19-0737GC. The remaining component which is 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.[8]

Issue 2 – DSH Payment – Medicaid Eligible Days

In a separate Motion to Dismiss, the MAC contends that the Provider abandoned the Medicaid Eligible Days issue when it failed to properly develop its arguments within the preliminary

[6] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[7] Provider's PPP at 7 (July 28, 2020).
[8] MAC's Jurisdictional Challenge at 1 (Oct. 22, 2020).

position paper in accordance with Board Rule 25. Additionally, the Provider has failed to provide a list of additional Medicaid eligible days or any other supporting documents and did not provide an explanation for why it cannot produce those documents.[9]

Provider's Jurisdictional Response

Issue 1- DSH SSI (Provider Specific)

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] The Provider did not file a response to the Jurisdictional Challenge over the SSI Provider Specific issue and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Issue 2 – Medicaid Eligible Days

The Board Rules require that Provider Responses to the MAC's Motion to Dismiss must be filed within thirty (30) days.[11] The Provider did not file a response to the Motion to Dismiss the Eligible Days issue and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Unless 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."

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 2.

A. DSH 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.

[9] MAC's Motion to Dismiss at 5 (June 23, 2025).
[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[11] Board Rule 44.3, v. 2.0 (Aug. 2018).

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 in the group, Case No. 19-0737GC, in which the Provider is a participant.[12]

The DSH/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."[13] Per the appeal request, the Provider's legal basis for its DSH/SSI (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 [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."[15]

The Provider's DSH/SSI Percentage (*Systemic Errors*) issue in group Case No. 19-0737GC 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). Thus, the Board finds that the DSH SSI Provider Specific issue in Case No. 20-0449 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 19-0737GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], the Board dismisses this aspect of the DSH 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.[17] 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. 19-0737GC.

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[12] Barnes Jewish Hospital was directly added to the group on December 5, 2019.
[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*
[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] 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 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. 19-0737GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[18]

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."

[18] (Italics and underline emphasis added.)

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.[19]

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."[20]

Accordingly, *based on the record before it*, the Board finds that DSH SSI Provider Specific issue in the instant appeal and the group issue in Case No. 19-0737GC are the same issue.[21] 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 SSI Provider Specific issue.

2. Second Aspect of Issue 1

The second aspect of the DSH - SSI 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.

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's issue statement for Issue 2 is stated, *supra*.

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

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[19] Last accessed September 12, 2025.
[20] Emphasis added.
[21] 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).

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

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

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

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

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

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[22]

[22] (Emphasis added).

Similarly, with regard to position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

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

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

This appeal was initiated on December 5, 2019 (more than 5.5 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.[25] ***To date, there is no evidence that the listing has been provided—even after the MAC requested the listing on 4 separate occasions***.[26] 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.[27] 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.

****

[23] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[24] (Emphasis added).
[25] Provider's PPP at 8.
[26] MAC Motion to Dismiss at 2 and Exhibit C-2 through C-4 and MAC Request dated Jan. 10, 2023.
[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.

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 2). As no issues remain, the Board hereby closes Case No. 20-0449 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:

9/16/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Lake Norman Regional Medical Center (Prov. No. 34-0129), FYE 09/30/2017,
Case No. 20-0534

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0534. 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") SSI Percentage (Provider Specific) and Medicaid Eligible Days issues.

Background:

A. ***Procedural History for Case No. 20-0534***

On **July 1, 2019**, 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").

On **December 9, 2019**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request included nine (9) issues:

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

On **December 20, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **July 20, 2020**, the parent organization, CHS is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). Therefore, CHS transferred issues 2, 3, 4, 6, 7 and 9 to CIRP Groups.

On **July 29, 2020**, the Provider timely filed its preliminary position paper (*hereafter "PPP).* In the cover letter to the PPP (which was dated July 14, 2020) CHS withdrew the UCC Distribution Pool issue (No. 8), leaving only two issues remaining: SSI Percentage (Provider Specific) and Medicaid Eligible Days. With respect to Issue No. 5, the Provider indicated that an Eligibility Listing was being sent under separate cover.

On **October 30, 2020**, the Medicare Contractor ("MAC") filed a jurisdiction challenge over the SSI Percentage (Provider Specific) issue. The MAC argues that the issue involved 3 components, 2 of which were duplicative of the issue under appeal in CIRP Group 20-1332GC and the 3rd which was premature.

On **November 23, 2020**, the MAC filed its PPP. The MAC requested dismissal of the Medicaid Eligible Days issue because the Provider had failed to provide the listings necessary to resolve the issue. In addition, the MAC contends that the Provider failed to file a fully developed position paper in accordance with Rule 23.3. With regard to the SSI Percentage (Provider Specific) issue, the MAC reiterated its arguments addressed in the earlier jurisdiction challenge.

On **August 4, 2023**, the MAC filed a Motion to Dismiss the Medicaid Eligible Days issue.

On **August 7, 2023,** CHS requested a change of representative to Quality Reimbursement Services, Inc. ("QRS"). On **August 8, 2023**, QRS was made the representative.

On **November 24, 2023**, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission." The 4-page listing shows 473 days.

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[1] (Emphasis added.)

On **July 11, 2025**, the Board issued a Notice of Hearing scheduling the case for a hearing on **February 12, 2026** and requiring final position papers be filed by the Parties.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 20-1332GC

In its Individual Appeal Request, the Provider summarizes the 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 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.[2]

The Group issue Statement in Case No. 20-1332GC, to which the Provider transferred Issue 2 (the SSI Percentage), reads in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively,

[2] Issue Statement at 1 (Dec. 9, 2019).

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.[3]

In the Provider's July 29, 2020 PPP in Case No. 20-0534, 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 North Carolina and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of North Carolina 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.

[3] Group Issue Statement, Case No. 20-1332GC.

> 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.[4]

The amount in controversy listed for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $29,000.[5]

C. Description of Issue 5 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 5 as:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> 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.[6]

[4] Provider's PPP at 8-9 (July 29, 2020).
[5] Based on the calculation support filed with these issues, the Provider rounded the reimbursement impact down from $29,412.
[6] Appeal Request at Issue 5 (Dec. 9, 2019).

Audit Adjustment Number(s): 4,13,14,15, S-D

Estimated Reimbursement Amount: $72,000[7]

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[8] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[9]

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

In the Jurisdictional Challenge filed on October 30, 2020, the MAC argues that the Board lacks jurisdiction over the SSI Percentage (Provider Specific) issue. According to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) Individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the two portions related to SSI data accuracy should be dismissed because they are duplicative of the SSI Percentage issue 2 - that was transferred to group Case No. 20-1332GC. The remaining component which is related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. In addition, the MAC points out that the Provider's fiscal year end ("FYE") of September 30th is the same as the Federal FYE ("FFY"). Therefore, the computation based on the Provider's FYE would be the same as that based on the FFY.[10]

MAC's Contentions Issue 5 – Medicaid Eligible Days

In a separate Motion to Dismiss filed on August 4, 2023, the MAC argued that the Provider abandoned the Medicaid eligible days issue when it failed to properly develop its arguments within the preliminary position paper in accordance with Board Rule 25. Additionally, at the time, the Provider had failed to provide a list of additional Medicaid eligible days or any other supporting documents (even after the MAC made multiple requests on January 23, 2020, June 19, 2020 and January 4, 2023), nor did it provide an explanation for why it could not produce those documents.[11]

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

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.[12] Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's

[7] Based on the calculation support filed with this issue, the Provider rounded the reimbursement impact down from $72,501.
[8] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[9] Provider's PPP at 7 (July 29, 2020).
[10] MAC's Jurisdictional Challenge at 2 (Oct. 30, 2020).
[11] MAC's Motion to Dismiss at 2 & 5 (Aug. 4, 2023).
[12] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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 failed to file a response to the MAC's challenge.

Provider's Jurisdictional Response Issue 5 – Medicaid Eligible Days

Similarly, the Provider's response to the Motion to Dismiss was due within 30 days and again the Provider failed to timely file a response. Board Rule 44.3 specifies that with respect to motions, "[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." Although the Provider filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days," purportedly in response to the motion -it was filed 2 months after the deadline to respond.

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 5.

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 DSH/SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 20-1332GC.

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."[13] Per the appeal request, the Provider's legal basis for its SSI Percentage (Provider Specific) issue asserts

[13] Issue Statement at 1.

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 [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."[15]

The Provider's DSH/SSI Percentage (*Systemic Errors*) issue in group Case No. 20-1332GC 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). Thus, the Board finds that the SSI Percentage (Provider Specific) issue in Case No. 20-0534 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 20-1332GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6[16], 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.[17] 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. 20-1332GC.

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. 20-1332GC 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.

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[14] *Id.*
[15] *Id.*
[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] 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).

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.[18]

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.[19]

[18] (Italics and underline emphasis added.)
[19] Last accessed September 15, 2025.

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."[20]

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case No. 20-1332GC are the same issue.[21] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

Finally, the Board notes that the Provider's FYE is September 30, which is the same as the FFY. Even if a realignment had been requested, there would be no change in the computation, making this aspect of the appeal moot.

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 5 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.

[20] Emphasis added.
[21] 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).

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

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

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

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*.[22]

[22] (Emphasis added).

Similarly, with regard to position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

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

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

This appeal was initiated on December 9, 2019 (more than 5.5 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.[25]

Notably, the MAC sent three requests for the Provider's list of Medicaid eligible days. The first notice was sent on January 23, 2020; the second request was sent on June 19, 2020; and the third, final, request was sent on January 4, 2023, more than five years after the end of the Provider's cost reporting period. The MAC also informed the Provider in its final request for information that the deadline to respond was February 3, 2023.

Due to the non-responsiveness of the Provider, on August 4, 2023, the MAC filed a Motion to Dismiss, requesting dismissal of the Medicaid eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its PPP in violation of Board Rules 25.2.1 and 25.2.2 (or when requested by the MAC 3 separate times after that). The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide

[23] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[24] (Emphasis added).
[25] Provider's PPP at 8 (July 29, 2020).

supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules.[26]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider failed to respond to the Motion by the September 3, 2023 filing deadline (i.e., 30 days after August 4, 2023). Two months after the deadline, on November 24, 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 4 pages with roughly 473 Medicaid eligible days. QRS' filing did not explain why the listing, which included substantially more than the 100 days noted in the initial appeal, was being submitted at this late date or why it was not final despite having been submitted almost 6 years after the fiscal year at issue had closed.

Regardless, this filing was 2 months past the deadline for responding to the Motion to Dismiss and, more importantly, was more than 3 years past the deadline for including it with its PPP since the position paper deadline was August 5, 2020.

The Board concurs with the MAC, that the Provider is required to identify the material facts (i.e., the number of days at issue) and provide relevant supporting documentation to identify and prove the specific additional Medicaid eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(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 3 months after the Provider requested the change of its designated representative to QRS does not excuse the Provider for its failure to include the information with its PPP or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 24, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed more than 3 years after the deadline for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed

[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.

to timely reply to the MAC's Motion to Dismiss Issue 5 and the alleged "Supplement" was filed more than 2 months after the deadline for filing a response to the Motion to Dismiss Issue 5.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.,* upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 473 days was not previously available, in whole or in part (*i.e.,* it is not clear why the Provider failed to identify a single day at issue until almost 4 years after this appeal was filed and almost 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 December 20, 2019 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* 473 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[27]

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"[28] 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,

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

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.[29]

****

Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: SSI Percentage (Provider Specific) -Issue 1 and Medicaid Eligible Days - Issue 5. As no issues remain, the Board hereby closes Case No. 20-0534 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:

9/16/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Bayfront Health Brooksville (Prov. No. 10-0071), FYE 09/30/2018
Case No. 22-1131

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-1131. Set forth below is the decision of the Board to dismiss the remaining 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. 22-1131***

On **January 24, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2018.

On **June 22, 2022**, the Board received the Provider's individual appeal request. The appeal was filed by the parent organization Community Health Systems, Inc. ("CHS") and included five (5) issues:

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

On **June 24, 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 **January 6, 2023,** CHS transferred Issues 2, 4 and 5 to CHS common issue related party ("CIRP") groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there are two remaining issues in this appeal: Issue 1: "DSH Pymt/SSI % (Provider Specific)" and Issue 3: "DSH Pymt - Medicaid Eligible Days."

On **February 13, 2023**, CHS timely filed the Provider's preliminary position paper (*hereinafter, "PPP"*).

On **April 10, 2023**, the Medicare Contractor ("MAC") filed a Jurisdictional Challenge over the "DSH Pymt/SSI % (Provider Specific)" and "DSH Pymt - Medicaid Eligible Days" issues.

The MAC contends that there are three sub-issues to Issue 1. Two of the sub-issues are duplicative of the issue that was transferred to Group Case No. 21-1206GC and the portion related to SSI realignment is premature as there was no final determination and the Provider has not exhausted all available remedies.

With regard to the Medicaid Eligible Days issue – the MAC contends the Provider abandoned the issue by not filing a complete PPP per Rule 25.3.

On **April 11, 2023**, CHS requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS"). The Board effectuated the change to QRS the following day.

On **April 25, 2023**, the MAC filed its PPP. The MAC reiterated its jurisdictional challenge over the two issues. With regard to Issue 3, the MAC noted that it had not yet received the eligibility listing even though in its PPP CHS had indicated one would be sent under separate cover. In addition, the MAC indicated it had previously requested a listing of days on **February 23, 2023**, but one had not been submitted.

On **May 10, 2023, QRS** filed its response to the MAC's Jurisdiction Challenge. With regard to the SSI Provider Specific issue, QRS indicates that it relied on Board Rule 8.1 regarding issues with multiple components. The SSI Provider Specific and Systemic issues represent different aspects of the SSI issue. QRS claims that the Provider is not addressing the errors which result from CMS' improper data matching process, rather it is addressing various errors of omission and commission that do not fit into the "systemic errors" category.

With regard to the Eligible Days issue, QRS points to the Rules in effect in 2018 when the appeal was filed. Under version 2, a final position paper is required for cases filed prior to the effective date. Based on that rule, it was the Provider's understanding that the listing of additional Medicaid eligible days would be due at the time the final position paper was due.

[1] (Emphasis added).

QRS also explains that the Provider's operations were disrupted by COVID. Therefore, the Provider did not abandon the Medicaid Eligible Days issue.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 21-1206GC

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

> The Provider contends that 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.
>
> 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.
>
> 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.[2]

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue 2 (the SSI Percentage), reads in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include

[2] Issue Statement at 1 (June 22, 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]

On February 13, 2023, the Board received the Provider's PPP in Case No. 22-1131. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

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

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate*

[3] Group Issue Statement, Case No. 21-1206GC.

> *Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[4]

The amount in controversy listed on the calculation support for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $33,804.

C. Description of Issue 3 in the Individual Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
> Audit Adjustment Number(s): 7, 8, 18, S-D
>
> Estimated Reimbursement Amount: $35,059

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[5] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[6]

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[4] Provider's PPP at 9-10 (Feb. 13, 2023).
[5] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[6] Provider's PPP at 8 (Feb. 13, 2023).

MAC's Contentions: Issue 1 – DSH SSI Provider Specific

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI (Provider Specific) issue. According to the Provider's PPP, this issue has three components: 1) SSI data accuracy; 2) SSI realignment and 3) Individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the two components related to SSI data accuracy should be dismissed because they are duplicative of the DSH SSI Percentage issue transferred to Case No. 21-1206GC. Additionally, the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.[7]

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

With regard to Medicaid Eligible Days, the MAC argued that the Provider failed to include a list of additional Medicaid eligible days it expected to be included (even though the Provider's PPP included a statement indicating a listing of additional Medicaid eligible days would be sent under separate cover.)[8] In addition, the MAC contends that the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2. and 25.3.[9] Therefore, since the issue was not properly developed, the Provider did not provide a list of additional Medicaid days, nor did it explain why it could not produce the documentation, the MAC contends the Provider has abandoned the issue.[10]

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

The Provider contends that the SSI (Provider Specific) and SSI Percentage issues are separate and distinct issues. The Systemic issue addresses various errors as discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). Instead, the SSI (Provider Specific) issue covers various errors of omission and commission that do not fit into the "systemic errors" category, like patients believed entitled to both Part A and SSI who were not included in the SSI percentage due to errors that are or may be specific to the provider -but are not the systemic errors in the *Baystate* litigation.

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

The Provider's position is that, based on the Rules in effect at the time the appeal was filed, the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[11] QRS also suggested that the Provider's operations were disrupted by COVID.[12]

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[7] MAC's Jurisdictional Challenge at 2 (April 10, 2023).
[8] MAC's jurisdictional challenge at 10-11 (April 10, 2023).
[9] *Id*. at 14.
[10] *Id* at 6.
[11] Provider's Jurisdictional Response at 3 (May 10, 2023).
[12] *Id*.

Board Analysis and Decision:

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

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

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 21-1206GC.

The SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[13] 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)."[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 [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."[15]

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case No. 21-1206GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Percentage (Provider Specific) issue in Case No. 22-1131 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], the Board dismisses this aspect of the SSI Percentage (Provider Specific) issue.

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[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*
[16] PRRB Rules v. 2.0 (Aug. 2018).

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.[17] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[18]

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,

[17] 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).
[18] (Italics and underline emphasis added.)

> 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.[19]

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."[20]

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case No. 21-1206GC are the same issue.[21] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

Under 42 C.F.R. § 412.106(b)(3), the applicable regulation for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Moreover, without this written request, the MAC cannot issue a final determination with which the Provider

[19] Last accessed August 26, 2025.
[20] Emphasis added.
[21] 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).

can be dissatisfied for Board appeal purposes. There is nothing in the record to indicate the MAC has made a final determination regarding DSH SSI Percentage realignment. Therefore, in accordance with 42 C.F.R. § 405.1835(a)(1), the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

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

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

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

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

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

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

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

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in

> § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[22]

Similarly, with regard to position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

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

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

This appeal was initiated on June 22, 2022 (more than 3 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[25] ***To date, there is no evidence that the listing has been provided—even after the MAC requested the listing***.[26] 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.[27] Specifically, the Board

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[22] (Emphasis added).
[23] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[24] (Emphasis added).
[25] Provider's PPP at 9.
[26] MAC PPP at 12-13 (Apr. 25, 2023) & MAC Jurisdictional Challenge at 10-11 & Exhibit C-1 (Apr. 10, 2023).
[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

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

****

Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: "DSH Pymt SSI % (Provider Specific)" - Issue 1 and "DSH Pymt - Medicaid Eligible Days" - Issue 3. As no issues remain, the Board hereby closes Case No. 22-1131 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:

9/17/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Stephanie Webster, Esq.
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RE: ***Expedited Judicial Review Determination***
25-0488GC *Univ of Rochester CY 2010 Post-Allina II DSH Part C Days CIRP Group*

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed on **August 22, 2025** in the above-referenced appeal. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

On **October 29, 2024**, the Board received a request to establish a group appeal. The two Providers in the group are appealing from original or revised Notices of Program Reimbursement ("NPRs") dated **May 22, 2024** and **February 25, 2025**, 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 Ending ("FYE") 12/31/2010.

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* litigation. The Providers contend that part C days must be excluded in their entirety from the SSI fraction and those 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 (Oct. 29, 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 IPPS 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. § 412.106(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 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]

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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).

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' group appeal request includes, for each provider, a "Statement of Jurisdiction" asserting that the Provider has met the applicable statutory conditions for appeal because it is dissatisfied with its NPR which applies the June 9, 2023 retroactive final rule related to Part C days. It cites language from that final rule which outlined Providers' ability to challenge this final rule once they were issued NPRs implementing the rule.[47]

The "Statement of Group Issue" included with the appeal request states that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for 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."[48] 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.[49]

The Provider characterized the relevant background facts as follows:

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

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

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

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

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[47] Appeal Request, Statement of Jurisdiction (citations omitted).
[48] Appeal Request, Statement of Group Issue at 1.
[49] *Id.*
[50] *Id.* (citing to 139 S. Ct. at 1816).

Based on the above, the Providers maintain that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, exceeds the agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[51]

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.[52] 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.[53] The request states, "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."[54] Since the Board is bound by this regulation,[55] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On August 29, 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."[56]

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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[51] *Id.* (citing 5 U.S.C. § 706(2)).
[52] Providers' Petition for Expedited Judicial Review at 13 (Aug. 22, 2025).
[53] *Id.* at 17.
[54] *Id.* at 1-2.
[55] 42 C.F.R. § 405.1867.
[56] Response to Provider's request for expedited judicial review at 1 (Aug. 29, 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; [57]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[58]

Both Providers in this group appeal appealed from original or revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. The Providers appealed within 180 days of the issuance of their NPRs/RNPRs and the amount in controversy exceeds $50,000.

The Board finds that the Providers have filed timely appeals from their original or revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs/RNPRs. The Board also finds that the amount in controversy in the group case exceeds $50,000 as required by 42 C.F.R. § 405.1839(b)(1). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

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

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

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

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[57] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[58] 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' request for EJR for the issue and the subject year.

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

Board Members Participating:

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

FOR THE BOARD:

9/17/2025

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Santa Rosa Medical Center, Prov. No. 10-0124, FYE 05/31/2018
Case No. 22-0395

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0395. Set forth below is the decision of the Board to dismiss the 2 remaining issues in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific) and Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 22-0395*

On **July 29, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2018. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **January 11, 2022**, CHS filed the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)[3]
5. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days) – (SSI Fraction & Medicaid Fraction)[4]

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 15, 2022**, the Provider transferred Issues 2, 4, and 5 to CHS CIRP groups.

[1] On August 15, 2022, this issue was transferred to Case No. 21-1206GC.
[2] On December 12, 2022, the Medicare Contractor filed a jurisdictional challenge over Issues 1 and 3.
[3] On August 15, 2022, this issue was transferred to Case No. 20-2149GC.
[4] On August 15, 2022, this issue was transferred to Case No. 21-0066GC.

As a result of the case transfers, there are two (2) remaining issues in this appeal: Issue 1 (the DSH – SSI Percentage Provider Specific) and Issue 3 (the DSH – Medicaid Eligible Days).

On **January 12, 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.[5]

On **August 24, 2022**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions." As a result, the Provider included, as an Exhibit, the original appeal request showing an amount in controversy for this issue of $48,203.

On **November 23, 2022**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had failed to include a Medicaid eligible days listing with its position paper notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **December 12, 2022**, the Medicare Contractor timely filed a Jurisdictional Challenge[6] with the Board over Issues 1 and 3 requesting that the Board dismiss these issues. Pursuant to Board

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[5] (Emphasis added.)

[6] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of

Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. The Provider filed a response to the Jurisdictional Challenge on July 22, 2024, over 18 months after the deadline to submit a response.

On **November 2, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

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."[7] The Listing was 8 pages with roughly 1,152 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 1,152 days) was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 1,152 included in this belated listing is *exponentially* larger than the original *estimated* impact of 100 days included with the appeal request.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 21-1206GC - CHS CY 2018 DSH SSI Percentage CIRP Group

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

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395(d)(5)(F)(i).[8]

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue No. 2, reads, in part:

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).

[7] (Emphasis added.)

[8] Issue Statement at 1 (Jan. 11, 2022).

Statement of the Issue:

Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

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

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[9]

On August 24, 2022, the Board received the Provider's preliminary position paper in 22-0395. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (May 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.

[9] Group Appeal Issue Statement in Case No. 21-1206GC.

> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from [s]tate records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[10]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $19,816.

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of Issue 2. The portion 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.[11]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC contends that the Provider failed to properly develop its arguments within its preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC argues the Provider has not submitted a Medicaid eligible days listing and therefore, requests the Board dismiss the issue.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider failed to file a response to the Jurisdictional Challenge until July 22, 2024, more than 18 months after the

[10] Provider's Preliminary Position Paper at 8-9 (Aug. 24, 2022).
[11] Medicare Contractor's Jurisdictional Challenge at 6-7 (Dec. 12, 2022).
[12] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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."

Decision of the Board

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

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in Case No. 21-1206GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[13] 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)."[14] The Provider argues in its issue statement, which was included in the appeal request, that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that

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

the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 22-0395 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, 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.[16] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question consistent with its obligations under Board Rule 25.2.[17] Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with 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 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**
>
> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:

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

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.[18]

The Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") as explained on the following webpage:

https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[19]

This CMS webpage describes access to DSH data ***from 1998 to 2022*** and instructs providers to send a request via email to access their DSH data."[20]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 21-1206GC.

Accordingly, *based on the record before it*,[21] the Board finds that the SSI Provider Specific issue in Case No. 22-0395 and the group issue from the CHS CIRP group under Case No. 21-1206GC

[18] (Italics and underline emphasis added.)
[19] Last accessed Oct. 15, 2024.
[20] (Emphasis added).
[21] Again, the Board notes that the Provider failed to timely respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

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.

B. DSH Payment – Medicaid Eligible Days

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

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

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

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

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

> **timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[22]

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

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

> **Rule 25 Preliminary Position Papers**[23]
>
> **COMMENTARY**:
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be addressed in the Board's notice, the provider may file an *optional* response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully***-developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the applicable sub-section.
>
> **25.1.1 Provider's Position Paper**
>
> The provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
> B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:

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

- States the material facts that support the provider's claim
- Identifies the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

. . .

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, 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. . .

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

The Board requires the parties file a ***complete*** preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), 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. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

COMMENTARY:
Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking 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 January 12, 2022, included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

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

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[24]

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:

[24] (Emphasis added.)

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

On August 24, 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.[25] 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 an amount in controversy included with its appeal request (i.e., the amount in controversy of $48,203 based on an estimated 100 days). The Provider's complete briefing of this issue in its position paper is as follows:

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

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

> whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

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 8 pages with roughly 1,152 Medicaid eligible days. QRS' filing did not explain why the listing of so many days (again around 1,152 days) was being submitted at this late date or why it was not final (*i.e*., why it was "pending finalization") at this late date, ***more than 5 years after the fiscal year at issue had closed***. NOTE—the roughly 1,152 days included in this belated listing is *exponentially* larger than the original estimate of 100 days included with the appeal request. Regardless, this filing ***was over a year past the deadline for including it with its preliminary position paper*** since the position paper deadline was September 8, 2022.

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

The fact that the Listing was filed merely 5 days after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the 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 ***more than a year*** *after the deadline* for that exhibit to be included with its preliminary position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Jurisdictional Challenge to Issue 3 and the alleged "Supplement" was filed ***nearly 10 months*** *after the deadline* for filing a response to the Jurisdictional Challenge.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 1,152 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until nearly 2 years after this appeal was filed and more than 5 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the January 12, 2022 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper (indeed the *tentative* 1,152 days listed in the alleged "Supplement" is, without explanation, *exponentially* larger than the original estimated 100 days included with the appeal request).[26]

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

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures 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 describe why said evidence is unavailable, which the Provider has failed to do.[28]

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[26] *See, e.g.,* Board Rule 27.3 (Nov. 2021) stating: "A party may also file a revised or supplemental position paper; however, this filing should not present new positions, arguments or evidence except on written agreement between the parties."

[27] (Emphasis added.)

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

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a

* * * * *

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. 22-0395 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:

9/17/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

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

RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Randall Gienko
Strategic Reimbursement Group, LLC
360 W. Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Notice of Dismissal***
Renown Health CY 2018 & 2019 Unmatched Medicaid Days CIRP Group
Case No. 24-0033GC

Dear Mr. Gienko:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 24-0033GC. Set forth below is the decision of the Board to dismiss the appeal challenging the Providers' Unmatched Medicaid Eligible Days.

Background

On **October 9, 2023**, Strategic Reimbursement Group, LLC ("Strategic") filed request for a Group Appeal on behalf of Renown Health, the parent organization for the providers in this appeal. The common issue for the participants in this appeal is Unmatched Medicaid 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 ["DSH"] and Capital [DSH] 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 **October 27, 2023**, the Board issued a notification in which it agreed to expand the CY 2019 CIRP group to include calendar year ("CY") 2018. The expansion of the CIRP group allowed a related provider, Renown Regional Medical Center (Prov. No. 29-0001), to transfer its issue for CY 2018 to the CY 2019 CIRP group since the only other provider in the chain was not able to secure its rights to pursue the issue for that year.

On **October 4, 2024**, Strategic notified the Board that the Group was fully formed with three participants.

On **October 7, 2024**, the Board issued the Group Completion Notice and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers (hereinafter "PPP"). This Notice also gave the following instructions to the Group Representative regarding the content of its PPP:

> 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 18, 2024**, Strategic timely filed the Group's PPP. The PPP did not include listings of Medicaid eligible days for any of the group participants, nor did it explain why the listings were not included with the PPP filing. Indeed, the PPP filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue for each Provider.

On **January 31, 2025**, the Medicare Contractor ("MAC") filed its Rule 22 Jurisdictional Comments. The MAC advised the Board that the Unmatched Medicaid Days issue is not suitable for the group format since the facts regarding Medicaid eligibility data are different for each provider. Therefore, the group does not involve a single question of fact. In addition, the MAC noted that the Group had not filed its Rule 20 Certification indicating whether the group was fully populated in the Office of Hearings Case & Document Management System ("OH CDMS").

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[1] (Emphasis added.)

On the same date, but two months after it was due, Strategic filed its Rule 20 Certification, indicating the group was fully populated in OH CDMS.

On **February 20, 2025**, the MAC filed its PPP. The MAC's PPP noted that "there is no evidence of a submission of a listing or any other detail of the disputed days. The MAC contends the Provider has had enough time to obtain the Medicaid eligibility verification results from the State of California."[2] In addition, the Medicaid Eligible Days issue is not appropriate for a group appeal as the issue is a multiple component issue which required documentation specific to each provider in the group.

On **March 17, 2025**, the MAC filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days for various reasons.

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

MAC's Contentions

The MAC contends that:

- More than five years have passed since the end of the two CYs under appeal in the group and none of the Providers in the group have provided listings of "understated" days for the MAC's review;
- The Providers have not provided any rationale for why the listings are unavailable as required per Board Rule 7;
- The Group has failed to meet the requirements of Board Rules 25.2.1 and 25.2.2 regarding the exchange of documentation or detailing the unavailability of documents;
- The Providers have not furnished adequate data to prove eligibility for each Medicaid patient day claimed, as well as State verification that a patient was eligible for Medicaid during the hospital day as required by 42 C.F.R. § 4012.0106(b)(4)(iii);
- The Providers violated Rule 20 by failing to file a certification regarding the population of the case in OH CDMS by the deadline; and
- The Providers have effectively abandoned their claims for Unmatched Medicaid Days.

Therefore, the MAC requests that the Board dismiss the Group appeal.[3]

Provider's Jurisdictional Response

Pursuant to Board Rule 44.3, the Group's response to the Motion to Dismiss was due within 30 days but the Group Representative failed to timely file a response. "Unless 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."

[2] MAC PPP at 4 (Jan. 31, 2025).
[3] MAC's Motion to Dismiss at 6 (March 17, 2025).

Decision of the Board

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

According to its Appeal Request, the Providers in this group assert that all Medicaid eligible days were not included in the calculations of the DSH calculation as discussed *supra*.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days that affect the percentage), 42 C.F.R. § 412.106(b)(4)(iv), 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*.[4]

Similarly, with regard to position papers,[5] Board Rule 25.2.1 (Nov. 2021) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[6] 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.[7]

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 October 9, 2023 (almost two years ago) and at that time, the Providers 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

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[4] (Emphasis added).
[5] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[6] (Emphasis added).
[7] (Emphasis added).

Group's PPP was filed and, again, provided no listing of eligible days. In fact, according to the MAC's February 20, 2025 PPP and the March 17, 2025 Motion to Dismiss, none of the Providers had submitted a listing of the understated days for the MAC's review.

Accordingly, the Board finds that the Providers have abandoned the issue by failing to properly develop their 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.[8] Specifically, the Board finds that the Providers have 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 dismisses the group appeal. Case No. 24-0033GC is hereby closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

9/18/2025

X Nicole E. Musgrave

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

[8] *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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Via Electronic Delivery

Nathan Summar, Vice President, Revenue Management
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RE: ***Notice of Dismissal***
AllianceHealth Deaconess (Prov. No. 37-0032), FYE 10/31/2017
Case No. 21-1557

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1557. 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 Percentage (Provider Specific) and Medicaid Eligible Days issues.

Background:

A. *Procedural History for Case No. 21-1557*

On **March 1, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end October 31, 2017.

On **August 10, 2021**, the Board received the Provider's individual appeal request. The Appeal Request was filed by the parent organization, Community Health Systems, Inc. (hereinafter "CHS") and included three (3) issues:

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

On **August 13, 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 March 9, 2022, CHS transferred the SSI Percentage issue to a common issue related party ("CIRP") group, Case No. 20-0997GC in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there are two (2) remaining issues in this appeal: Issue 1: SSI Percentage (Provider Specific) and Issue 3: Medicaid Eligible Days.

On **March 30, 2022**, CHS filed the Provider's preliminary position paper (*hereafter, PPP*).

On **July 20, 2022**, the MAC filed a Jurisdictional Challenge over the SSI Percentage (Provider Specific) and Medicaid Eligible Days issues. To date, the Provider has not replied.

On **July 20, 2022**, the MAC filed its PPP.

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 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 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

[1] (Emphasis added.)

> individuals that were "eligible" for SSI but did not receive an SSI payment.[2]

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

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

On March 30, 2022, the Board received the Provider's PPP in Case No. 21-1557. 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

[2] Issue Statement at 1 (Aug. 10, 2021).
[3] Group Issue Statement, Case No. 20-0997GC.

> 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 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]

The amount in controversy listed on the calculation support for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $33,000.

C. Description of Issue 3 in the Individual Appeal Request

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

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

[4] Provider's PPP at 8-9 (March 30, 2022).

> of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 16, 17, 30, S-D
>
> Estimated Reimbursement Amount: $31,000

In its PPP, the Provider argues that pursuant to the *Jewish Hospital* case[5] and HCFA Ruling 97-2, "all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage" of the DSH payment adjustment.[6]

MAC's Contentions: Issue 1 – DSH SSI Provider Specific

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider's PPP, this issue has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) Individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the two components related to SSI data accuracy should be dismissed because they are duplicative of the DSH SSI Percentage issue transferred to Case No. 20-0997GC. Additionally, the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. In addition, the MAC argues that the issue should be dismissed because the Provider failed to file a complete position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[7]

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

The MAC also argued that the Provider failed to include a list of additional Medicaid eligible days it expected to be included, even though the Provider's PPP indicated a listing would be sent under separate cover. In addition, in its PPP, the MAC indicates it requested the Provider submit a listing of days to which the Provider did not respond.[8] Again, the MAC contends that the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.3. Therefore, since the issue was not properly developed, the Provider did not provide a list of additional Medicaid days, nor did it explain why it could not produce the documentation, the MAC contends the Provider has abandoned the issue.[9]

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[5] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[6] Provider's PPP at 7 (March 30, 2022).
[7] MAC's Jurisdictional Challenge at 2 (July 20, 2022).
[8] MAC's PPP at 14. (July 29, 2022).
[9] MAC's Jurisdictional Challenge at 10 (July 20, 2022).

Provider's Jurisdictional Response: Issue 1 and 3- SSI Percentage (Provider Specific) & Medicaid Eligible Days

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

Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[10]

The Provider did not file a response to the Jurisdictional Challenge over the SSI Provider Specific and Medicaid Eligible Days issues and the time for doing so has elapsed.

Board Analysis and Decision:

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

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

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 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."[11] 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)."[12] The Provider argues that "its'[sic] SSI

[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).
[11] Issue Statement at 1.
[12] *Id.*

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.”[13]

The Provider’s SSI Percentage (*Systemic Errors*) issue in group Case No. 20-0997GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Percentage (Provider Specific) issue in Case No. 21-1557 is duplicative of the DSH/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[14], 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.[15] 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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[13] *Id.*

[14] PRRB Rules v. 2.0 (Aug. 2018).

[15] 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.[16]

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.[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]

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[16] (Italics and underline emphasis added.)
[17] Last accessed September 15, 2025.
[18] Emphasis added.

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case No. 20-0997GC are the same issue.[19] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

B. Medicaid Eligible Days

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

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

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

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

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

[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 CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

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

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

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[20]

Similarly, with regard to position papers,[21] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

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

[20] (Emphasis added).
[21] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[22] (Emphasis added).

- upon failure to appear for a scheduled hearing.

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

This appeal was initiated on August 10, 2021 (over 4 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[23] ***To date, there is no evidence that the listing has been provided—even after the MAC allegedly requested the listing***.[24] 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.[25] Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.

****

Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: SSI Percentage (Provider Specific) - Issue 1 and Medicaid Eligible Days - Issue 3. As no issues remain, the Board hereby closes Case No. 21-1557 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:

9/22/2025

X Nicole E. Musgrave

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

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

[23] Provider's PPP at 8 (March 30, 2022).
[24] MAC PPP at 14 (July 29, 2022).
[25] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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***
Reynolds Memorial Hospital (Prov. No. 51-0013), FYE 12/31/2016
Case No. 22-0049

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 22-0049. 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. 22-0049*

On **April 22, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On **October 12, 2021**, the Board received the Provider's individual appeal request. The Appeal Request was filed by the parent organization, West Virginia University Health System (hereinafter "WVU") and included six (6) issues:

1. DSH Supplemental Security Income (SSI Provider Specific)
2. DSH Supplemental Security Income (SSI)
3. DSH Medicaid Eligible Days
4. DSH Managed Care Part C Days (SSI & Medicaid Fraction)
5. DSH Dual Eligible Days (SSI & Medicaid Fraction)
6. Standardized Payment Amount

On **October 19, 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 May 6, 2022, WVU requested the representative be changed to Quality Reimbursement Services, Inc. ("QRS"). The Board effectuated the change to QRS on the same day.

On **May 9, 2022,** QRS transferred Issues 2, 4, 5 and 6 to WVU common issue related party "CIRP" groups in accordance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, there are two (2) remaining issues in this appeal: Issue 1: DSH SSI Percentage (Provider Specific) and Issue 3: DSH Medicaid Eligible Days.

On **June 9, 2022**, QRS filed the Provider's preliminary position paper (*hereafter, PPP*).

On **September 22, 2022**, the Medicare Contractor ("MAC") filed a Substantive Claim Challenge for both the SSI Provider Specific and Eligible Days issues.

On **September 27, 2022,** the MAC filed its PPP.

On **October 11, 2022**, the MAC filed a Jurisdictional Challenge over the DSH SSI Percentage (Provider Specific) and DSH Medicaid Eligible Days issues.

The MAC contends that there are three sub-issues related to Issue 1. Two of the sub-issues are duplicative of the issue that was transferred to Group Case No. 21-1434GC and the portion related to SSI realignment is premature as there was no final determination and the Provider has not exhausted all available remedies.

With regard to the Medicaid Eligible Days issue – the MAC contends the Provider abandoned the issue by not filing a complete PPP per Rule 25.3. In addition, the Provider failed to submit a list of additional days or any other support explaining why it could not produce those documents.

Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. The Provider's response to the jurisdictional challenge was due to the Board by November 10, 2022 but to date has not been filed.

[1] (Emphasis added.)

B. Description of Issue 1 in the Individual Appeal Request (Case No. 22-0049) and the Provider's Participation in Case No. 21-1434GC

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.
>
> 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.[2]

The Group issue Statement in Case No. 21-1434GC, to which the Provider transferred Issue 2 (the SSI Percentage), reads in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[2] Issue Statement at 1 (Oct. 12, 2021).

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]

In the Provider's June 9, 2022 PPP in Case No. 22-0049, 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 (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 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.

[3] Group Issue Statement, Case No. 21-1434GC.

> 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]

The amount in controversy listed on the calculation support for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $1,669.

C. Description of Issue 3 in the Individual Appeal Request

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

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 12, 13, S-D
>
> Estimated Reimbursement Amount: $18,982[5]

[4] Provider's PPP at 8-9 (June 9, 2022).
[5] Appeal Request at Issue 3.

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

MAC's Contentions: Issue 1 – DSH SSI Provider Specific

In its Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Provider Specific issue. According to the Provider's PPP, this issue has three components: 1) SSI data accuracy; 2) SSI realignment and 3) Individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the two components related to SSI data accuracy should be dismissed because they are duplicative of the DSH SSI Percentage issue transferred to Case No. 21-1434GC. Additionally, the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies. Finally, the MAC argues that the issue should be dismissed because the Provider failed to file a complete position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[8]

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

The MAC also argues that the Provider failed to include a list of additional Medicaid eligible days it expected to be included, even though the Provider's PPP indicated a listing would be sent under separate cover. In addition, the MAC requested a listing on two separate occasions to which the Provider did not respond.[9] Again with this issue, the MAC contends that the Provider did not file a complete PPP in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2. and 25.3.[10] Therefore, since the issue was not properly developed, the Provider did not provide a list of additional Medicaid days, nor did it explain why it could not produce the documentation, the MAC contends the Provider has abandoned the issue.[11]

Provider's Jurisdictional Response

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

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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 PPP at 7 (June 9, 2022).
[8] MAC's Jurisdictional Challenge at 2 (Oct. 11, 2022).
[9] MAC's jurisdictional challenge at 11 and Exhibit C-1. (Oct. 11, 2022).
[10] *Id*. at 11.
[11] *Id* at 14.
[12] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

Board Analysis and Decision:

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

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

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 21-1434GC.

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."[13] 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)."[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 [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."[15]

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case No. 21-1434GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Percentage (Provider Specific) issue in Case No. 22-0049 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 21-1434GC. Because the issue is duplicative, and

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

duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], 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.[17] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1434GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1434GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[18]

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:

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[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] 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).
[18] (Italics and underline emphasis added.)

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

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

> https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[19]

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."[20]

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case No. 21-1434GC are the same issue.[21] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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[19] Last accessed September 15, 2025.
[20] Emphasis added.
[21] 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 WVU CIRP group per 42 C.F.R. § 405.1837(b)(1).

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.

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's issue statement for Issue 3 is stated, *supra*.

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

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

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

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

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

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

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[22]

Similarly, with regard to position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). Also consistent with that regulation, Board Rule 25.2.2 provides instruction on the content of position papers as it relates to unavailable documentation/exhibits, as discussed *supra*.

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

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

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

This appeal was initiated on October 12, 2021 (almost 4 years ago), and at that time, the Provider did not include a list of additional Medicaid eligible days they expected to be included in their Medicaid percentage and DSH computations with their appeal request. Subsequently, the

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[22] (Emphasis added).
[23] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for PPPs. *See* Board Rule 27.2.
[24] (Emphasis added).

Provider's PPP indicated that it would be sending the eligibility listing under separate cover.[25] ***To date, there is no evidence that the listing has been provided—even after the MAC requested the listing on two separate occasions***.[26] 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.[27] 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.

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Based on the foregoing, the Board is dismissing the two (2) remaining issues in this case: SSI Percentage (Provider Specific) - Issue 1 and Medicaid Eligible Days - Issue 3. As no issues remain, the Board hereby closes Case No. 22-0049 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
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Nicole E. Musgrave, Esq.
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For the Board:

9/22/2025

X Nicole E. Musgrave

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

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

[25] Provider's PPP at 8 (June 9, 2022).
[26] MAC PPP at 21.
[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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Decision***
24-1768GC *UHHS CY 2021 Capital DSH CIRP Group*
24-2452G *Bass, Berry & Sims, PLC CY 2021 Capital DSH Group*
24-1919G *Bass, Berry & Sims, PLC CYs 2017 & 2018 Capital DSH Group*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the July 19, 2025 consolidated request for expedited judicial review[1] ("EJR") for the above-referenced optional and common issue related party ("CIRP") group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

> [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 create incentives for hospitals to operate efficiently, while providing adequate compensation to

[1] Providers' Petition for Expedited Judicial Review (July 19, 2025) ("Request for EJR").
[2] The Request for EJR also encompassed Case Nos. 25-4953GC, 25-4547GC, 25-3356GC, 24-2203G, 24-2032GC, and 25-0971GC, which were adjudicated on August 13, 2025 under separate cover.
[3] Request for EJR at 1 (Jul. 19, 2025).

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 Sept. 24, 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 an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).
[14] (Underline and italics emphasis added.)

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]

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

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

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more

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[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 Sept. 24, 2025).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).
[17] *Id.* at 43369-70 (emphasis added).

than 100 beds. The proposal was described as follows:

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

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

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

[18] *Id* at 43377.

> disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

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

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1,1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l){ii) of the regulations.[20]

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, 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

[19] *Id.* at 43409-10 (bold and underline emphasis added).
[20] *Id.* at 43377.

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

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

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

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

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

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

> *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.

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

> *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]

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

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if

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

an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

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

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

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

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

[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.)

treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

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

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

****

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification

> by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

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

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

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[28] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).
[29] 65 Fed. Reg. 47026, 47048. (Aug. 1, 2000).

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

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

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

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

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

[30] 56 Fed. Reg. at 43452.
[31] (Bold and underline emphasis added.)
[32] Pub. L. 108–173.
[33] 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).

CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[34]

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

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—
>
> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security 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

[34] *Id.*
[35] *Id.*

> 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:

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

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

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

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

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

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

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

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

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

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

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

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[39] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[40] of the Department of Health and Human Services.
[41] 71 Fed. Reg. 23996, 24122 (Apr. 25, 2006).
[42] *Id.*

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

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

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

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the

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

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

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

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

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

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

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

412.320 for large urban hospitals (the capital DSH payment).[51] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[52]

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

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

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

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

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

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

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

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

> that Congress directed it to review. *State Farm*, 63 U.S. at 43. 103 S.Ct. 2856. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[59]

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

Providers' Request for EJR

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

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The Providers note that "[t]he capital DSH provisions are located in an entirely different section of the statute, in 42 U.S.C. § 1395ww(g), and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes."[63]

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

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[59] *Id*.
[60] *Id.* at *30.
[61] *Id.*
[62] Request for EJR at 7.
[63] *Id.*
[64] *See id.* at 7-8.
[65] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[66] *Id.*

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

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

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

Board Decision

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

[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*.
[71] *See* 42 C.F.R. § 405.1867.
[72] Request for EJR at 10-12.

their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [73]

- 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.[74]

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

The Board lacks the authority to decide the legal question presented here because it is a challenge to the validity of a regulation, namely 42 C.F.R. § 412.320(a)(1)(iii).[75] All of the providers in these three (3) groups, however, are subject to the substantive claim regulations at 42 C.F.R. §§ 413.24 and 405.1873.

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

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[76] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[77] The Secretary revised the Medicare cost reporting regulations in

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[73] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986). Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected or amended cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

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

[74] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[75] 42 C.F.R. § 405.1842(f)(1)(ii).
[76] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[77] *Id.* at 70555.

42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in these three 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 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"[78] 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.[79]

4. Substantive Claim Challenges

In all of these group cases, the Providers' Rule 20 certification was filed on **July 18, 2025**, the day before the Request for EJR was filed. Thus, pursuant to Board Rule 44.6, the Medicare

[78] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[79] *See* 42 C.F.R. § 405.1873(a).

Contractor had five business days (*i.e.,* until **July 25, 2025**) to either file any Substantive Claim Challenges or certify that it would be filing a challenge. On **July 24, 2025**, the Medicare Contractor's designated representative, Federal Specialized Services ("FSS") filed a Response to Providers' EJR Request, noting that substantive claim challenges would be filed in Cases 24-1768GC, 24-2452G and 24-1919G.

Based on this timely certification, the deadline for any Substantive Claim Challenges in these cases was **Friday, August 8, 2025**. The Board notes that FSS filed timely Substantive Claim Challenges in in the three (3) group cases noted in this Request for Information.

Based on the foregoing, and pursuant to Board Rule 44.6, the Board issued a Scheduling Order to set a deadline (Friday, **August 29, 2025**) for the Providers' responses to the three (3) Substantive Claim Challenges filed in cases 24-1768GC, 24-2452G and 24-1919G. The Board notes that the Providers filed timely responses in each case on **August 25, 2025**.

A. Medicare Contractor's Challenges

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

i. Case 24-1768GC

FSS asserts the following two (2) Providers did not make an appropriate claim for the Rural Capital DSH issue on their cost reports:

- UH St. John Medical Center (Provider No. 36-0123, FYE 12/31/2021)
- UH Cleveland Medical Center (Provider No. 36-0137, FYE 12/31/2021)[80]

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

ii. Case 24-2452G

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

- Baptist Hospital (Provider No. 10-0093, FYE 09/30/2021)
- Novant Health New Hanover Regional Medical Center (Provider No. 34-0141, FYE 12/31/2021)

[80] Medicare Administrative Contractor Substantive Claim Challenge (Case No. 24-1768GC) at 2 (Jul. 31, 2025).
[81] *Id.* at 5-6.

- St. Luke's Hospital Bethlehem (Provider No. 39-0049, FYE 06/30/2021)[82]

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

iii. Case 24-1919G

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

- Tuscon Medical Center (Provider No. 03-0006, FYE 12/31/2018)
- Naples Community Hospital (Provider No. 10-0018, FYE 09/30/2018)
- Camden Clark Memorial Center (Provider No. 51-0058, FYE 12/31/2017)
- Spartanburg Medical Center (Provider No. 42-0007, FYE 09/30/2018)[84]

FSS argues that each Provider filed its relevant cost report identifying a specific amount in Part A Protested Amounts, as well as a Summary of Protested Amounts. These documents, however, did not establish a self-disallowed item for the Rural Capital DSH in its cost report, and therefore each provider failed to include an appropriate claim for the specific item sought as prescribed in 42 C.F.R. § 413.24(j).[85]

iv. "Non-Challenged Participants"

For all remaining participants in these three (3) group cases (collectively "the Non-Challenged Participants"), since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[86] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for the Non-Challenged Participants.

[82] Medicare Administrative Contractor Substantive Claim Challenge (Case No. 24-2452G) at 2 (Aug. 7, 2025).
[83] *Id.* at 4-5.
[84] Medicare Administrative Contractor Substantive Claim Challenge (Case No. 24-1919G) at 2 (Jul. 31, 2025).
[85] *Id.* at 3-4.
[86] The Board notes that Board Rule 10.2 (2023) 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."

B. Providers' Responses

The Providers filed a consolidated response to the Substantive Claim Challenges.[87] For the Challenged Participants, the Providers argue that, while they did not claim Capital DSH as an allowable cost or protested amount for the year at issue, they did self-disallow the issue based on the Medicare Contractor being bound by 42 C.F.R. § 412.320(a)(1)(iii).[88] They also argue that the substantive claim requirements found in 42 C.F.R. §§ 413.320(j) and 405.1873 are unlawful and seek to challenge their validity.[89] They claim that these regulatory provisions "contravene the Board's authority as set forth in 42 U.S.C. § 1395oo."[90] They cite *Bethesda Hosp. Ass'n v. Bowen*[91] and *Banner Heart Hospital v. Burwell*[92] in support of their position that these regulations are unlawful.[93]

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

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

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[95] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

For the Non-Challenged Participants, the Board need not make any findings of fact or conclusions of law with regard to whether an appropriate cost report claim was made since no party has raised the question.

The Challenged Participants generally do not dispute that they did not claim Capital DSH as an allowable cost or protested amount for the year at issue. They note that they did self-disallow the issue based on the Medicare Contractor being bound by 42 C.F.R. § 412.320(a)(1)(iii),[96] but they

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[87] Providers' Response to FSS's Substantive Claim Challenges and Petition for Expedited Judicial Review of the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (Aug. 25, 2025) ("Response to Substantive Claim Challenges").
[88] *E.g.*, *id.* at 3.
[89] *Id.* at 1, 8.
[90] *Id.* at 8.
[91] 485 U.S. 399 (1988).
[92] 201 F.Supp.3d 131 (D.D.C. 2016)
[93] Response to Substantive Claim Challenges at 8-12.
[94] Response to Substantive Claim Challenges at 8.
[95] (Emphasis added.)
[96] *E.g.*, Response to Substantive Claim Challenges at 3.

do not dispute FSS' assertion that there is insufficient support for the allegedly protested items. There were no worksheets describing how the providers calculated the estimated reimbursement for this specific item accompanying the cost report as required by 42 C.F.R. § 413.24(j)(2)(ii). Based on the foregoing, the Board finds no appropriate claim was made when granting EJR for these participants.

5. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that all of the participants in Cases 24-1768GC, 24-2452G, and 24-1919G are entitled to a hearing before the Board;

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

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

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

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

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

    a. Whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid; and
    b. For the Challenged Participants, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.[97]

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Cases 24-1768GC, 24-2452G, 24-1919G. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Challenged Providers' requests for EJR for the issue and the subject years.

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

Board Members Participating:

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

FOR THE BOARD:

9/24/2025

X Kevin D. Smith, CPA

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

Enclosure: Schedules of Providers

cc: Judith Cummings, CGS Administrators (J-15)
Geoff Pike, First Coast Service Options, Inc. c/o GuideWell Source (J-N)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Scott Berends, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
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Via Electronic Delivery

Fallon Deffes, Administrator
Sunplex Subacute Center
6520 Suncope Drive
Ocean Springs, MS 39564

RE: ***Board Determination on Request for Reconsideration of Dismissal***
Sunplex Subacute Center (Provider Number 25-5244)
Case Number: 25-0921
Period Ended: 12/31/2024

Dear Ms. Deffes:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned appeal in response to September 5, 2025 correspondence from Sunplex Subacute Center ("Sunplex"/"Provider") in which it requests that the Board reconsider the July 28, 2025 "Dismissal for Untimely Filing." The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

On **November 26, 2024,** Sunplex filed its individual appeal, based on the October 4, 2024 "Notice of Quality Reporting Program Noncompliance Decision Upheld" for its fiscal year ("FY") 2025 Annual Payment Update ("APU") under Case No. 25-0921.

On **December 2, 2024,** the Board issued a "Case Acknowledgement and Critical Due Dates Notice" ("ACCD") setting the Provider's preliminary position paper deadline for July 24, 2025 and the Medicare Contractor's preliminary position paper deadline for November 21, 2025.[1]

On **July 28, 2025**, following the expiration of the preliminary position paper deadline, the Board dismissed Case No. 25-0921 because the Provider failed to timely file the preliminary position paper.

On **September 5, 2025**, Sunplex filed a reconsideration requesting that the Board reinstate its case and set deadlines for the continuation of its appeal. Sunplex explained that it had gone through changes in its administration over the last eight months. Because of the changes, Sunplex was unaware that it had a deadline, until it received the Board's dismissal letter.

[1] The ACDD also set due dates for the submission of a Representative letter and a more comprehensive Issue Statement. Both documents were timely filed on December 10, 2024.

Board Determination:

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

Sunplex has filed a motion requesting that the Board reinstate the case. 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. If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .
>
> ****

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*. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[2]

Board Rule 47.1 states that the Board will not reinstate if the provider was at fault and Board Rule 47.3 further clarifies that, when the dismissal is based on the failure to comply with Board Procedures (such a filing a required position paper), the Board may reinstate for good cause which does ***not*** include administrative oversight. Here, the Board finds that the Provider was at fault since it failed to meet the preliminary position paper deadline due to its own admitted

[2] (Emphasis added.)

oversight. Further, contrary to Board Rule 44 governing motions, Sunplex's motion for reconsideration is deficient because: (1) it failed to include a statement confirming it had contacted the Medicare Contractor prior to filing the motion to see if the Medicare Contractor would concur or oppose the motion; and (2) did not include supporting documentation (i.e., the missing position paper). This requirement is reiterated on Board Rule 47.3 which states that "[i]f the dismissal was for failure to file with the Board a required position paper, . . . then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion."[3]

In denying the request, the Board notes that the ACDD Notice clearly stated that Provider had to file the Preliminary Position Paper and that failure to do so would result in dismissal. Specifically, it stated that "[t]he parties must meet the . . . due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests" and that "[i]f the provider misses any of its due dates, the Board will dismiss the appeal." Similarly, Board Rule 23.4 states: "The provider's preliminary position paper due date will be set on the same day as the PJSO due date. Accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by the filing due date, *the Board will dismiss the case*."[4]

The Board requirements are consistent with 42 C.F.R. § 405.1853(b). The Provider failed to follow the process set forth in the ACDD and Board Rules. The representative is charged with being familiar with Board Rules and deadlines and failure of the representative to carry out his/her responsibilities as a representative is not considered good cause for failing to meet filing deadlines, as noted in Board Rule 5.2:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board*:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/prrb-rules-and-board-orders (*see* Rule 1.1).
>
> *Further, the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - *Meeting the Board's deadlines*; and
> - *Responding timely to correspondence or requests from the Board* or the opposing party.

[3] Emphasis in original.
[4] Emphasis added.

> *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.[5]

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board denies Sunplex's request for reinstatement of Case No. 25-0921. The Board finds that the Provider was at fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted fault and failed to provide: 1) the missing document (i.e., the preliminary position paper) and 2) the required Medicare Contractor's concurrence required by Board Rules 47.1 and 44. Therefore, the Board declines to exercise its discretion to reinstate Case No. 25-0921 and it thereby remains closed. The Board denial is consistent with numerous cases in which federal courts have upheld the Board's authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.[6]

Board Members:

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

For the Board:

9/24/2025

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
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-H)

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

[6] *Kaiser Found. Hosps. v. Sebelius*, 649 F.3d 1153 (9th Cir. 2011) (upholding dismissal for failure to file preliminary position paper); *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226 (2009) (upholding dismissal for failure to file preliminary position paper); *High Country Home Health Inc. v. Thompson*, 359 F.3d 1307 (10th Cir. 2004); *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 351 (4th Cir. 2001) (upholding dismissal for failure to file preliminary or final position papers and stating "The Hospital argues that the Board irrationally concluded that administrative oversight is not a valid excuse. We disagree. Because the Hospital's failure to file timely position papers was due to circumstances entirely within its own control, the Board had a rational basis for its decision."); *UHI, Inc. v. Thompson*, 250 F.3d (6th Cir. 2001); *Lutheran Med. Ctr. v. Burwell*, No. 14-VC-731, 2016 WL 3882896 (E.D. N.Y. July 13, 2016); *Rapid City Reg. Hosp. v. Sebelius*, 681 F. Supp. 2d 56 (D.D.C. 2010) (upholding dismissal for failure to file preliminary position paper and citing to "the general proposition that legitimate procedural rules can be relied upon to control the Board's docket by dismissing appeals that are not timely filed" (citations omitted) and upholding Board denial based on the); *S.C. San Antonio Inc. v. Leavitt*, No. SA-07-CA-527-OG, 2008 WL 4816611(W.D. Tex. Sept. 30, 2008); *Lutheran Med. Ctr. v. Thompson*, No. 02-CV- 6144, 2006 WL 2853870 (E.D.N.Y. Oct. 2, 2006); *Novacare, Inc. v. Thompson*, 357 F. Supp. 2d 268, 272-273 (D.D.C. 2005) (upholding denial of reinstatement where the Board explained that "failure to communicate clearly with its counsel was insufficient basis to justify reinstatement"); *Saint Joseph Hosp. v. Shalala*, No. 99-C7775, 2000 WL 1847976 (N.D. Ill. Dec. 15, 2000).

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

RE: ***Notice of Dismissal***
Tennova Healthcare, Prov. No. 44-0120, FYE 09/30/2015, PRRB Case No. 21-1258

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1258. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 21-1258*

On **November 3, 2020**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On **April 22, 2021**, the Board received the Provider's individual appeal request. The initial appeal request included seven (7) issues:

1. DSH - SSI Percentage (Provider Specific)
2. DSH - SSI Percentage (Systemic Errors)
3. DSH -SSI Fraction/Medicare Managed Care Part C Days
4. DSH - SSI Fraction/Dual Eligible Days
5. DSH - Medicaid Eligible Days
6. DSH - Medicaid Fraction/Managed Care Part C Days
7. DSH - Medicaid Fraction/Dual Eligible Days

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory common issue related party "CIRP" group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **November 18, 2021**, the Provider transferred issues 2, 4, and 7 to CHS CIRP Groups, and on **November 19, 2021**, it transferred issues 3 and 6 to CIRP groups.

On **April 28, 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 **December 1, 2021**, the Provider timely filed its preliminary position paper (*hereafter "PPP).* The Provider briefed the two remaining issues: SSI Provider Specific and Medicaid Eligible Days.[2] With respect to Issue No. 5, the Provider indicated that an Eligibility Listing was being sent under separate cover.

On **March 30, 2022**, the Medicare Contractor ("MAC") filed its PPP.

On **April 1, 2022**, the MAC filed a jurisdiction challenge over the SSI Provider Specific issue which, as noted, was subsequently dismissed on **July 18, 2024**.

On **September 8, 2023**, the Board issued a Notice of Hearing scheduling the case for a hearing on **June 7, 2024** and requiring final position papers be filed by the Parties. The hearing date was subsequently rescheduled three times and is currently scheduled for **October 10, 2025**.

On **March 8, 2024**, CHS filed its final position paper, and for the first time noted the inclusion of section 1115 waiver days. CHS included a redacted copy of a listing, titled "1115 Waiver and Additional ME Days Consolidated" and again, advised that the unredacted listing would be sent under separate cover. The 5- page listing included as an exhibit showed 751 days and included a caveat that the "Listing [was] pending finalization upon receipt of State eligibility data."

On **April 3, 2024**, the MAC timely filed a final position paper. The MAC indicated that it had not yet received an auditable listing of additional Medicaid eligible days.[3]

On **May 15, 2024,** CHS requested a change of representative to Quality Reimbursement Services, Inc. ("QRS"), which was effectuated on the same date.

On **May 23, 2024**, QRS uploaded a 32-page "Redacted Medicaid Eligible Days Listing Submission" showing 4132 days to OH CDMS.

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[1] (Emphasis added.)
[2] The SSI Provider Specific issue was subsequently dismissed by the Board in a jurisdictional determination dated July 18, 2024.
[3] MAC Final PP at 17 (Apr. 3, 2024).

On **July 18, 2024**, the Board dismissed the SSI Provider Specific issue.

On **November 18, 2024**, the MAC filed a Jurisdictional Challenge over the Medicaid eligible days issue. The MAC claims the Provider abandoned the issue when it failed to properly develop its arguments in its PPP and final position paper and asserts that the Provider failed to submit an unredacted, auditable listing of days. In addition, the MAC maintains that the Provider untimely and improperly added the 1115 waiver days issue via its final position paper.

On **April 21, 2025**, 4 months after the deadline, QRS responded to the jurisdictional challenge.

MAC's Contentions re: Issue 5 – DSH Payment – Medicaid Eligible Days

The MAC argues that the Provider abandoned the Medicaid eligible days issue when it failed to file complete preliminary and final position papers, including all supporting exhibits, to document the merits of its argument and failed to properly develop its argument within its position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27. The Provider failed to timely submit a finalized, unredacted, auditable listing of additional Medicaid eligible days. Alternatively, the Provider failed to state its efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Section 1115 Waiver Days

Additionally, the MAC contends the Provider is attempting to untimely and improperly add the section 1115 waiver days issue as a sub-issue via its final position paper filed on March 8, 2024. The Provider originally characterized the Medicaid eligible days issue in its initial appeal request using the following language:

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

Neither the appeal request, nor the PPP, identified or mentioned the section 1115 waiver days issue. It was not until the final position paper submission that the Provider raised the issue – (*which was more than 2.5 years after the regulatory deadline to add a new issue to the case*.) Therefore, the MAC contends that the section 1115 waiver days, which is a separate issue from the Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.[4]

[4] Jurisdictional Challenge at 10 (Apr. 21, 2025).

Provider's Jurisdictional Response

The Provider's response to the Jurisdictional Challenge was due within 30 days or by December 18, 2024. The Provider did not file its response until April 21, 2025, which was more than 4 months beyond the deadline. Board Rule 44.4.3 specifies that with respect to challenges, "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

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

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

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

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

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[5]

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

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

Rule 25 Preliminary Position Papers[6]

> **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.

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

D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The April 28, 2021 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[7]

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 December 1, 2021, 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.[8] 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 $21,044 based on an estimated 50 days). The Provider's complete briefing of this issue in its position paper is as follows:

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[7] (Emphasis added.)
[8] Provider's PPP at 8 (Dec. 1, 2021).

Calculation of Medicaid Eligible Days

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

The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F. 3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth, and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala,* 101 F. 3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala,* 83 F. 3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala,* 97 F. 3d 1261 (9th Cir. 1996).

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

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

Based on the listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2015 cost report does not reflect an accurate number of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its November 18, 2024 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to

produce those documents, as required by the Board Rules.[9] In addition, the MAC argued the Provider was attempting to untimely and improperly add the section 1115 waiver days issue by including it in its final position paper submission.

On May 23, 2024 (almost 2.5 years after the PPP deadline), QRS uploaded a Redacted Medicaid Eligible Days Listing in the Office of Hearings Case and Document Management System ("OH CDMS").[10] The 32-page listing did not include the sum, but when extracted and totaled, it shows 4,132 "ME and 1115 Waiver Days." The Listing does not explain why the number of days included was over the initial 50 days the Provider claimed in its appeal, nor did it explain why it was being submitted at this late date. Regardless, the filing ***was almost 2.5 years past the deadline for including it with the Provider's PPP*** for which the deadline was December 18, 2021.

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

The Board rejects the Provider's attempts to include the eligible days listing uploaded to OH CDMS on May 23, 2024 (*purportedly, as a supplement to its March 8, 2024 final position paper*) because:

1. The upload was filed ***almost 2.5 years*** *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); and (b) *why* the listing of the roughly 4,132 days were not previously available, *in whole or in part* (*i.e.*, it is not clear why the Provider failed to identify a single day at issue until nearly 3 years after this appeal was filed and more than 8.5 years after the fiscal year at issue had closed).

[9] *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.
[10] The listing was titled "Additional ME & 1115 Waiver Days."

3. Neither the Board Rules, nor the April 28, 2021 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload that they do).

4. Given that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP, nor the subsequent listing QRS uploaded almost 2 months after the final position paper was filed, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the PPP since no specific days or listing were included with the PPP (indeed the *tentative* 4,132 days listed in the late exhibit is, without explanation, *significantly* larger than the original estimated 50 days included with the appeal request).[11]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[12] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

The Board finds that the section 1115 waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 waiver days.

The appeal was filed with the Board in April of 2021 and the regulations required the following:

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

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

> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[13]

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

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

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[14]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[15]

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

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

[13] 42 C.F.R. § 405.1835(b).
[14] (Bold and italic emphasis added).
[15] *See* 73 Fed. Reg. 30190 (May 23, 2008).

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

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

In this regard, the Board notes that section 1115 waiver days are not traditional Medicaid eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[16] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

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

> paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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

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

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

The Board's finding that neither the appeal request nor the final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[18] In that case, the

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

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

provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[19] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[20] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[21] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 5). As no issues remain, the Board hereby closes Case No. 21-1258 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:

9/25/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

[19] *Id*. at *11.
[20] *Id.*
[21] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Tennova Healthcare, Prov. No. 44-0120, FYE 09/30/2016, PRRB Case No. 21-1428

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1428. Set forth below is the decision of the Board to dismiss the remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") Medicaid Eligible Days.

Background

A. *Procedural History for Case No. 21-1428*

On **January 4, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On **June 16, 2021**, the Board received the Provider's individual appeal request which included seven (7) issues:

1. SSI Percentage (Provider Specific)
2. SSI Percentage (Systemic Errors)
3. SSI Fraction/Medicare Managed Care Part C Days
4. SSI Fraction/Dual Eligible Days
5. Medicaid Eligible Days
6. Medicaid Fraction/Managed Care Part C Days
7. Medicaid Fraction/Dual Eligible Days

The Provider is commonly owned/controlled by Community Health Systems, Inc. (hereinafter "CHS") and, thereby, is subject to the mandatory common issue related party "CIRP" group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **January 7, 2022**, CHS transferred issues 2, 3, 4, 6 and 7 to CHS CIRP Groups.

On **July 9, 2021**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers.

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

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

On **February 8, 2022**, the Provider timely filed its preliminary position paper (*hereafter "PPP).* With respect to Issue No. 5, the Provider indicated that an Eligibility Listing was being sent under separate cover.

On **May 13, 2022**, the Medicare Contractor ("MAC") filed its PPP.

On **May 17, 2022**, the MAC filed a jurisdiction challenge over the SSI Provider Specific issue which was subsequently withdrawn.

On **March 21, 2025**, the Board issued a Notice of Hearing scheduling the case for a hearing on **November 17, 2025** and requiring final position papers be filed by the Parties.

On **August 15, 2025**, CHS withdrew the SSI Provider Specific issue.

On **August 18, 2025**, CHS filed its final position paper, and for the first time noted the inclusion of section 1115 waiver days. Again, CHS noted that the listing of Medicaid eligible days would be sent under separate cover.

On **September 9, 2023,** CHS requested a change of representative to Quality Reimbursement Services, Inc. ("QRS"). On **September 10, 2023**, QRS was made the representative.

On **September 11, 2025**, QRS filed a 32-page "Redacted Medicaid Eligible Days Listing Submission" showing 5,868 days.

On **September 12, 2025**, the MAC timely filed a final position paper. The MAC indicated that it had not yet received a complete, auditable listing of additional Medicaid eligible days.[2] In addition, the MAC notes the Provider is improperly trying to add the section 1115 waiver days issue to the appeal via its final position paper filing.

On **September 16, 2025**, the MAC filed a formal jurisdictional challenge over the Medicaid eligible and 1115 waiver days issue.

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[1] (Emphasis added.)
[2] MAC Final PP at 11 (Sept. 12, 2025).

On **September 20, 2025**, QRS filed its response to the jurisdictional challenge. QRS addressed only the 1115 waiver days issue and claimed that 1115 waiver days are part of the eligible days issue that was included in the initial appeal.

MAC's Contentions re: Issue 5 – DSH Payment – Medicaid Eligible Days

In its September 16, 2025 jurisdictional challenge, the MAC contends that the Provider abandoned the Medicaid eligible days issue when it failed to file complete preliminary and final position papers, including all supporting exhibits, to document the merits of its argument and failed to properly develop its argument within its position papers in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 and 27. The MAC also notes that the Provider failed to timely submit a finalized, unredacted, auditable listing of additional Medicaid eligible days. Alternatively, the Provider failed to state its efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Section 1115 Waiver Days

Finally, the MAC argues that the Provider is attempting to untimely and improperly add the section 1115 waiver days issue as a sub-issue via its final position paper filed on March 8, 2024. The Provider originally characterized the Medicaid eligible days issue in its initial appeal request using the following language:

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

Neither the appeal request, nor the PPP, identified or mentioned the section 1115 waiver days issue. It was not until the final position paper submission that the Provider raised the issue – (*which was more than 2.5 years after the regulatory deadline to add a new issue to the case*.) Therefore, the MAC contends that the section 1115 waiver days, which is a separate issue from the Medicaid eligible days issue, should be dismissed on the grounds that it was untimely and improperly added to the case.

Provider's Jurisdictional Response

QRS filed a responsive jurisdictional brief which responded to the MAC's challenge over the section 1115 waiver days sub-issue. QRS argued that:

1. Based on the phrasing of the issue statement, the Provider timely appealed the Medicaid Eligible Days issue. The statement included the following language:

   > The MAC, contrary to the regulation, failed to include all Medicaid eligible days, *including but not limited to* Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff

> date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation. (Emphasis added.)

According to QRS, "[b]y definition, section 1115 waiver days are Medicaid eligible days. See 42 C.F.R. § 412.106(b)(4)(i) and (ii)."[3]

2. Regarding the MAC's argument that the Provider abandoned the issue, QRS contends the MAC is required to accept and audit the Provider's section 1115 waiver days per CMS instruction. QRS asserts that it submitted a redacted listing of section 1115 waiver days on September 11, 2025 (via upload in OH CDMS) and submitted an unredacted version to the MAC.[4]

Decision of the Board

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

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

A. DSH Payment – Medicaid Eligible Days

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

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the

[3] Jurisdictional Response at 1 (Sept. 20, 2025).
[4] Jurisdictional Response at 3-4 (Sept. 20, 2025).

> 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.[5]

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

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

Rule 25 Preliminary Position Papers[6]

> **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.)

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

and require no further documentation to be submitted.

B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The July 9, 2021 Notice of Case Acknowledgement and Critical Due Dates issued to the Provider included instructions on the content of the Provider's PPP consistent with the above-Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 5, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for ***each*** Medicaid patient *day claimed* under this paragraph, ***and*** of *verifying with the State* that a patient was eligible for Medicaid during each claimed patient hospital day.[7]

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

[7] (Emphasis added.)

- upon failure to appear for a scheduled hearing.

On February 8, 2022, the Provider filed its PPP in which it indicated that the eligibility listing was imminent by promising that the listing was being sent under separate cover.[8] Significantly, the PPP did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the estimated impact of $20,440 based on an estimated 50 days). The Provider's complete briefing of this issue in its PPP is as follows:

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

[8] Provider's PPP at 8 (Feb. 8, 2022).

> of Medicaid eligible days, as requested by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its September 16, 2025 Jurisdictional Challenge, the MAC requested dismissal of the Medicaid eligible days issue because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish an unredacted, auditable list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the Board Rules.[9] In addition, the MAC argued the Provider was attempting to untimely and improperly add the section 1115 waiver days issue by including it in its final position paper submission.

On September 11, 2025, QRS uploaded a Redacted Medicaid Eligible Days Listing in the Office of Hearings Case and Document Management System ("OH CDMS"). The 32-page listing did not include the sum, but when extracted and totaled, it shows 5,868 "Additional ME & 1115 Waiver Days." The Listing does not explain why the number of days included was over the initial 50 days the Provider claimed in its appeal, nor did it explain why it was being submitted at this late date. Regardless, the filing ***was 3.5 years past the deadline for including it with the Provider's PPP*** for which the deadline was February 11, 2022.

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

The Board rejects the Provider's attempts to include the eligible days listing uploaded to OH CDMS on September 11, 2025 (*purportedly, as a supplement to its August 18, 2025 final position paper*) because:

1. The upload was filed 3***.5 years*** *after the deadline* for the exhibits to be included with the PPP filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

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[9] *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.

2. The uploaded exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); and (b) *why* the listing of the roughly 5,868 days were not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until nearly 4 years after this appeal was filed and almost 9 years after the fiscal year at issue had closed).

3. Neither the Board Rules, nor the July 9, 2021 Case Acknowledgment and Critical Due Dates notice, permit the Provider to file a "Supplement" to its PPP (nor did the Provider allege in the upload that they do).

4. Given that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the PPP filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its PPP or a supplement of documents that were identified in the PPP as being unavailable consistent with Board Rule 25.2.2. However, neither the PPP, nor the subsequent listing QRS uploaded 3 weeks after the final position paper was filed, identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the uploaded listing cannot be considered a refinement of the position paper since no specific days or listing were included with the PPP (indeed the *tentative* 5,868 days listed in the late exhibit is, without explanation, *significantly* larger than the original estimated 50 days included with the appeal request).[10]

5. Finally, pursuant to 42 C.F.R. § 412.106(b)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[11] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(4)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

B. Section 1115 Waiver Days

The Board finds that the section 1115 waiver days issue is not a part of this appeal as it was not properly or timely added. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the section 1115 waiver days.

The appeal was filed with the Board in June of 2021 and the regulations required the following:

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

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing…must be submitted in writing to the Board, and the request must include…
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[12]

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

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

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

> Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> Common examples include: . . . ***Section 1115 waiver days (program/waiver specific). . .***[13]

Effective August 21, 2008, following the appropriate notice and comment period, new Board

[12] 42 C.F.R. § 405.1835(b).
[13] (Bold and italic emphasis added).

regulations went into effect that limited the addition of issues to appeals.[14]

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

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

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

In this regard, the Board notes that section 1115 waiver days are not traditional Medicaid eligible days and, indeed, were only incorporated into the DSH calculation effective January 20, 2000.[15] Rather, these days relate to Medicaid expansion programs and are only includable in the DSH adjustment calculation if they meet the requirements in 42 C.F.R. § 412.106(b)(4) relating to section 1115 waiver days. Indeed, not every state Medicaid program has a qualifying section 1115 expansion program and not every inpatient day associated with a beneficiary enrolled in a section 1115 waiver program qualifies to be included in the Medicaid fraction. In contrast, every state has a Medicaid state plan, and every state Medicaid plan includes inpatient hospital benefits.

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

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

[14] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[15] 65 FR 47054, 47087 (Aug. 1, 2000).

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

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

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

Finally, even in the Provider's final position paper, the Provider fails to identify what section 1115 waiver program(s) are involved and whether or not the section 1115 waiver days at issue would qualify under 42 C.F.R. § 412.106(b)(i)-(ii) as "days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act" and the patients underlying those days are "deemed eligible for Medicaid" based on "the patient [being] eligible for inpatient hospital services . . . under a waiver authorized under Section 1115(a)(2) . . . on that day, regardless of whether particular items or services were covered." Rather, the final position paper is perfunctory in that it only makes cursory conclusions.[16] Again, the Provider failed to so develop its position paper notwithstanding 42

[16] For example, CHS cites to *Forrest General Hosp.*, 926 F.3d 221 (5th Cir. 2019) for the proposition that "the plain language of the statute and regulations require inclusion in the Medicaid Fraction of the days belong to individual who are included in a section 1115 demonstration project that provides benefits through an uncompensated care pool." However, CHS fails to explain why this sweeping statement is relevant to the § 1115 waiver days at issue. Is CHS asserting that the § 1115 waiver days at issue relate to an uncompensated care pool? Is that pool similar to that

C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 (Aug. 2018) as applied via Board Rule 27.2.

The Board's finding that neither the appeal request nor the final position paper met the Board content requirements is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[17] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[18] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[19] The Court found that this description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[20] Here, the Board makes the same finding based on similar *overly generalized language.*

* * * * *

Based on the foregoing, the Board dismisses the last remaining issue in this case – Medicaid Eligible Days (Issue No. 5). As no issues remain, the Board hereby closes Case No. 21-1428 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:

9/25/2025

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: PIV

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

in *Forrest General Hosp.*? CHS fails to brief the merits of its claims and fails to establish the Board's jurisdiction over the § 1115 waiver day issue as required by 42 C.F.R. § 405.1853(b)(2). Indeed, the quoted sentence is the only time the final position paper references "uncompensated care pool."

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

[18] *Id*. at *11.

[19] *Id.*

[20] *Id.*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Dismissal of Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Groups***
25-1578GC *et al.* (*See* Attached Listing of 93 Cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the appeal requests in the 93 above-referenced cases. Set forth below is the decision of the Board to dismiss the above-captioned common issue related party ("CIRP") group appeals. The pertinent facts and the Board's determination are set forth below.

Introduction

Quality Reimbursement Services, Inc. ("QRS") filed the above-referenced 93 CIRP group appeals in the Office of Hearings Case & Document Management System ("OH CDMS"). The issue statements in these groups are materially identical. The Providers contend that the that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to 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. 25-1578GC, Providers' 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] This case involves the hospital-specific disproportionate share hospital ("DSH") adjustment, which requires the Secretary to provide increased IPPS 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 Transmittal 12785

The Providers in these groups state that they are appealing from the publication of Medicare/SSI Fractions on CMS' website on August 13, 2024, that was done pursuant to CMS Transmittal 12785, "Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013." Transmittal 12785 replaced and updated Transmittal 12747 that was originally issued on July 26, 2024. The original 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.

The original Transmittal 12747 which Transmittal 12785 updates 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).

Medicare Contractor Jurisdictional Challenge

The Transmittal is Not an Appealable Final Determination

The Medicare Contractor asserts that the Board does not have jurisdiction over the issue in these group appeals "because the appeal does not arise from a 'final determination' as that term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 1835(a) (as also cross-referenced in 42 C.F.R. § 405.1837(a)(1))."[14] The Medicare Contractor explains that the Providers appealed from Transmittal 12747 and/or Transmittal 12785, and argues that these documents are not appealable final determinations.[15]

The Medicare Contractor also argues that the court decisions the Provider referenced in their appeals are inapplicable to the instant appeals. The Medicare Contractor explains that the Providers recognized the Board's previous dismissal of appeals from the publication of SSI percentages by stating:

> The Provider [Group] is aware that the PRRB has taken the position that the publication of SSI Ratio is not a final determination and that providers must await a Notice of Program Reimbursement (NPR) setting its total reimbursement before challenging its Medicare Fraction, but the Provider [Group] respectfully submits that the PRRB is incorrect, as decided in two recent court decisions. *See Battle Creek Health Sys. v. Becerra*, Civil Action 17-0545 (CKK) (D.D.C. Oct. 31, 2023); *Baylor All Saints Med Ctr. v. Becerra,* Civil Action 4:24-cv-00432-P (N.D. TX Aug. 15, 2-24).[16]

The Medicare Contractor points to a prior Board decision in which it distinguished the decision in *Battle Creek* from the facts of the appeal before the Board, and argues that the Board should make a similar finding here with respect to the applicability of *Battle Creek* to these transmittal appeals.[17] With respect to *Baylor All Saints*, the Medicare Contractor argues that "[b]ecause the Court failed to address the statutory requirements for Board jurisdiction, the Providers' reliance on [the case] is without merit."[18]

Next, the Medicare Contractor argues that even if the Transmittals constituted an appealable final determination, the appeals were not timely filed. The final determination support included for each Provider in these groups is a copy of either the July 26, 2024 CMS Transmittal 12747 or the August 13, 2024 Transmittal 12785, both of which implement the Medicare Part C final rule which was issued on June 9, 2023.[19]

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[14] *See, e.g*., Case No. 25-1578GC, Jurisdictional Challenge at 2 (Apr. 23, 2025).
[15] *Id.*
[16] *Id.* at 5.
[17] *Id.* at 5-6.
[18] *Id.* at 6.
[19] *Id* at 6-7.

Providers' Jurisdictional Response

The Board Rules require that Providers' Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[20] Here, the Providers have not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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 12785 on August 13, 2024, "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 Group "is dissatisfied with this determination . . . the PRRB has jurisdiction over this appeal."[21] However, the publication of Medicare/SSI Fractions in conjunction with 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" is 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 93 groups.

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);[22] and second, where the provider is dissatisfied with a "final determination" "as to the amount of the payment" under the prospective payment system.[23] In this case, the Providers in these groups 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 Transmittal 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."[24] But the Providers also note disagreement with the Board's position, citing *Battle Creek Health Sys. v. Becerra*,[25] and *Baylor All Saints Med. Ctr. v. Becerra*,[26] decisions where courts held that

[20] Board Rule 44.4.3, v. 3.0 (Dec. 2023).
[21] *See e.g.* Case No 25-1578GC, Providers' Issue Statement at 1.
[22] 42 U.S.C. § 1395oo(a)(1)(A)(i).
[23] *Id*. § 1395oo(a)(1)(A)(ii).
[24] *See e.g.* Case No 25-1578GC, Providers' Issue Statement at 1.
[25] 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *rev'd*, No. 23-5310, 2025 WL 2423686 (D.C. Cir. Aug. 22, 2025).
[26] 2024 WL 3833278 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 34-10934 (5th Cir. Oct. 17, 2024).

providers met the requirements for a Board appeal before receiving a final appealable determination as to the amount of DSH payment.[27]

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*."[28] 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."[29] On appeal, however, the 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.[30]

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).[31]

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.

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[27] *See e.g.* Case No 25-1578GC, Providers' Issue Statement at 1.
[28] *Battle Creek*, 2023 WL 7156125 at *5.
[29] *Id*.
[30] *Battle Creek Health Sys. v. Kennedy*, No. 23-5310, 2025 WL 2423686, at *1 (D.C. Cir. Aug. 22, 2025).
[31] *Id.* at *6.

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*.[32] The Board maintains that *Memorial Hospital v. Becerra*,[33] 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 93 groups. 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.

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.'"[34] 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."[35] 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).'"[36]

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.[37] 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 August 13, 2024, pursuant to CMS transmittal 12785, were determined incorrectly due to the "inclusion of Medicare Part C days in the denominator of the Fraction" and . . . "exclusion of

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[32] *See, e.g.*, Board decisions in PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.
[33] 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[34] *Id*. at *8.
[35] *Id*. at *9
[36] *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).").
[37] 42 C.F.R. § 412.106(d)(2)(i)-(ii).

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."[38] Transmittal 12785 bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 in order to ensure that the SSI Ratio column is consistently rounded to four decimals in all files. This information is published so that providers have sufficient information available to inform whether they want to request realignment. Providers cannot claim that with publication of Medicare/SSI Fraction data on CMS' website in a new decimal format pursuant to Transmittal 12785, they are somehow "dissatisfied with a final determination of Secretary as to the amount of payment."[39]

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). Moreover, appeal of Transmittal 12785 which only rounded the published Medicare/SSI Fraction data to four decimal places, concerns only one factor of the DPP and is almost certainly unlikely to result in a change in DSH reimbursement sufficient to meet the amount in controversy required for a group appeal ($50,000 or more).[40] 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.

B. Appeals Not Timely Filed

Assuming *arguendo* that the Providers could persuade the Board that the Transmittals and accompanying SSI Fraction data are final appealable determinations, the Board must still dismiss the majority of the Providers' appeals because such appeal requests would be untimely. Pursuant to 42 U.S.C. § 1395oo(a)(3), a provider's request for a hearing must be filed within 180 days of the date of receipt of the final determination.[41] Given the nature of the Groups' challenge, it

[38] *See e.g.* Case No 25-1578GC, 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.
[39] *See* 42 U.S.C. § 1395oo(a)(1)(A)(ii).
[40] *See* 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).
[41] *See also* 42 C.F.R. § 405.1835(a)(3)

appears that they are actually challenging Final Ruling CMS-1739-F rather than the Transmittals and accompanying SSI Fraction data. The Transmittals merely implement the Ruling in providing the providers with SSI Fractions recalculated or "realigned" based on the hospitals' cost reporting period instead of the federal fiscal year. Final Ruling CMS-1739-F was issued June 9, 2023, and the Providers' appeals were all filed in early 2025, long past the expiration of the 180-day period to file an appeal. Moreover, CMS Transmittal 12747 was originally issued on July 26, 2024, and a large majority of the Providers filed their appeals between February 5 and 14, 2025, nearly two weeks or more after the 180-day period had expired, if calculated from that date. Even if such Providers were to argue that the appeals were timely based on the later issuance of Transmittal 12785 on August 13, 2024, this Transmittal bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 so that the SSI Ratio column is consistently rounded to four decimals in all files.

1. Providers Not Timely Directly Added to Appeals

Additionally, in these groups currently before the Board, there are Providers in each group[42] that were directly added to the groups between February 11, 2025 and February 14, 2025, which is between 182 and 185 days, from the August 13, 2024 Transmittal date. Even if the Board were to have found that the Transmittal is an appealable final determination, the Board would find that the Providers listed in Appendix B did not timely file their appeals.

42 C.F.R. § 405.1835(a)(3) indicates that, "unless the Provider qualifies for a good cause extension", the Board must receive a Provider's hearing request "***no later than 180 days after the date of receipt by the Provider of the final contractor or Secretary determination."***[43]

Board Rule 4.3, Commencement of Appeal Period, specifies various types of final determinations and states:

> 4.3.1 **Contractor/CMS/Secretary Final Determination**
>
> Final Determinations include:
> - Notices of Program Reimbursement;
> - Revised Notices of Program Reimbursement;
> - Exception Determinations;
> - Quality Reporting Program Payment Reduction Determinations; and
> - Other determinations issued by CMS or its ***contractors with regard to the amount of total reimbursement due the provider***.
>
> The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of

[42] *See* Appendix B.
[43] Emphasis added.

> issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).[44]

This rule also explains that there is no five (5) day mailing presumption for appeals from Federal Register Notices:

> 4.3.2 **Federal Register Notice**
>
> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the ***date of publication*** and ends 180 days from that date.[45]

Board Rule 4.5, Date of Receipt by the Board, states that "[t]he timeliness of a filing is determined based on the date of receipt by the Board," and "[t]he date of receipt is presumed to be [] the date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system."[46]

Here, the Board finds that the Transmittal, if it were an appealable final determination, is akin to a Federal Register Notice appeal, thus there is no 5-day mailing presumption. If that is the case, then the Providers that were directly added to the group appeals between February 11, 2025 and February 14, 2025, which is between 182 to 185 days from the August 13, 2024 Transmittal date, were not timely filed.

2. Groups Not Timely Filed

In addition to the numerous groups that include Providers that were not timely added, there are also nine (9) groups that were not timely established.[47] These groups were all filed on February 12, 2025, and were all established with direct add providers (i.e. the Providers used to establish the group appeals were also untimely). The Board similarly finds that the Transmittal, if it were an appealable final determination, is akin to a Federal Register Notice appeal, thus there is no 5-day mailing presumption. As that is the case, then these group appeals that were established with Providers that were directly added on February 12, 2025, which is 183 days from the August 13, 2024 Transmittal date, were not timely filed.

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[44] Emphasis added.
[45] Emphasis added.
[46] *See also* 42 C.F.R. § 405.1801(a)(2)(iii).
[47] PRRB Case Nos. 25-2568GC; 25-2569GC; 25-2570GC; 25-2571GC; 25-2572GC; 25-2573GC; 25-2574GC; 25-2575GC; and 25-2576GC. *See also* Appendix C.

C. Letters of Representation Issues

Last, the Board notes that there are nine (9) Community Health Systems ("CHS") groups that have incorrect letters of representation. There are a number of Providers[48] in these nine (9) groups[49] which filed individual appeals with the Board and then requested to transfer to various group appeals. Board Rule 16.1 (2023) addresses transfer requests from individual appeals to group appeals and states:

> **16.1 Filing Requirements for Requests to Transfer from Individual Appeal**
>
> **16.1.1 Transfer Requests via OH CDMS**
>
> Transfers made through OH CDMS must be initiated within the individual case and must:
> - Identify the specific issue;
> - Identify the group case number and confirm the group name of the case to which the issue is to be transferred; and
> - ***Upload a copy of the representative letter associated with the group appeal***.[50]

For these transfer requests identified in Appendix D, QRS submitted the same generic letter of representation which included a listing of the subject Providers as an appendix. The letter of representation identifies the years that it covers as 2004-2025. The Board notes a problem, in that the last sentence of the rep letter states:

> This authorization extends to handling the subject year(s) in the context of both an individual appeal as well as any related QRS group appeals ***for Part C Days Retroactive Final Rule issue.***[51]

The issue under appeal for the individual appeals and the groups is not the Part C days issue. Based on this, the Board finds that these transfers were not proper. Because the Board has also found, as discussed above, that these Providers are not appealing from an appropriately appealable final determination, the Board will not be taking any further action with respect to these improper transfers (e.g., requesting updated letters of representation or denying the transfers and reinstating the issue in the individual appeals).

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[48] *See* Appendix D for a listing of these Providers and groups.
[49] PRRB Case Nos. 25-2056GC; 25-2058GC; 25-2060GC; 25-2061GC; 25-2062GC; 25-2063GC; 25-2064GC; 25-2065GC; and 25-2066GC.
[50] Emphasis added.
[51] See, e.g., Case No. 25-2056GC, Provider No. 01-0055, Flowers Hospital, Appointment of Designated Representative at 1 (July 23, 2024).

Conclusion

As the Medicare/SSI Fraction data published pursuant to Transmittal 12785 is not an appropriately appealable final determination, the Providers have failed to meet the jurisdictional requirements for a hearing. Further, the Board finds that the Providers included in Appendix B were not timely directly added into group appeals, and that the groups included in Appendix C were not timely established. Last, the Board finds that the Providers in Appendix D did not have proper letters of representation for their transfer requests. Thus, the Board hereby dismisses the 93 group 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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

9/26/2025

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators

Enclosures: Appendix A – Listing of 93 Cases
Appendix B – Providers that Did Not Timely Direct Add Issue to Group
Appendix C – Groups Not Timely Filed
Appendix D – Providers with Incorrect Transfer Letters of Representation

Appendix A

Listing of 93 Cases

25-1578GC	BJC Healthcare CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1800GC	BJC Healthcare CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1801GC	BJC Healthcare CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1802GC	BJC Healthcare CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1861GC	St. Luke's Health CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1862GC	St. Luke's Health CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1863GC	St. Luke's Health CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-1864GC	St. Luke's Health CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2034GC	CHS CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2036GC	CHS CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2037GC	CHS CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2038GC	CHS CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2040GC	CHS CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2041GC	CHS CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2043GC	CHS CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2044GC	CHS CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2046GC	CHS CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2047GC	CHS CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2051GC	CHS CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2052GC	CHS CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2053GC	CHS CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2054GC	CHS CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2055GC	CHS CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2056GC	CHS CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2057GC	CHS CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2058GC	CHS CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2059GC	CHS CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2060GC	CHS CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2061GC	CHS CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2062GC	CHS CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2063GC	CHS CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2064GC	CHS CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2065GC	CHS CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2066GC	CHS CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2068GC	CHS CY 2014 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2097GC	Quorum Health CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

25-2098GC Quorum Health CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2099GC Quorum Health CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2100GC Quorum Health CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2101GC Quorum Health CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2102GC Quorum Health CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2103GC Quorum Health CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2104GC Quorum Health CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2105GC Quorum Health CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2106GC Quorum Health CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2107GC Quorum Health CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2108GC Quorum Health CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2109GC Quorum Health CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2110GC Quorum Health CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2111GC Quorum Health CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2112GC Quorum Health CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2113GC Quorum Health CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2114GC Quorum Health CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2115GC Quorum Health CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2116GC Quorum Health CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2117GC Quorum Health CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2118GC Quorum Health CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2119GC Quorum Health CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2120GC Quorum Health CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2121GC Quorum Health CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2122GC Quorum Health CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2123GC Quorum Health CY 2014 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2206GC BJC Healthcare CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2207GC BJC Healthcare CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2208GC BJC Healthcare CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2211GC BJC Healthcare CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2216GC BJC Healthcare CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2218GC BJC Healthcare CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2220GC BJC Healthcare CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2221GC BJC Healthcare CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2222GC BJC Healthcare CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2302GC BJC Healthcare CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2303GC BJC Healthcare CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2304GC BJC Healthcare CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2305GC BJC Healthcare CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2306GC BJC Healthcare CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

25-2307GC	BJC Healthcare CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2378GC	BJC Healthcare CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2382GC	BJC Healthcare CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2386GC	BJC Healthcare CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2396GC	BJC Healthcare CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2403GC	BJC Healthcare CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2410GC	BJC Healthcare CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2431GC	BJC Healthcare CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2568GC	CHS CY 2015 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2569GC	CHS CY 2016 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2570GC	CHS CY 2017 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2571GC	CHS CY 2018 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2572GC	CHS CY 2019 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2573GC	CHS CY 2020 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2574GC	CHS CY 2021 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2575GC	CHS CY 2022 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2576GC	CHS CY 2023 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group

Appendix B

Providers that Did Not Timely Direct Add Issue to Group

01 **25-2097GC Quorum Health CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
14-0033	Vista Medical Center West	02/29/1988	02/14/2025	08/13/2024
04-0019	Forrest City Medical Ctr.	06/30/1988	02/14/2025	08/13/2024
05-0194	Watsonville Community Hospital	06/30/1988	02/14/2025	08/13/2024
32-0003	Alta Vista Regional Hosp.	06/30/1988	02/14/2025	08/13/2024
11-0046	Piedmont Walton Hosp.	10/31/1988	02/14/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/1988	02/14/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/1988	02/14/2025	08/13/2024

02 **25-2098GC Quorum Health CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
04-0019	Forrest City Medical Ctr.	06/30/1989	02/14/2025	08/13/2024
05-0194	Watsonville Community Hospital	06/30/1989	02/14/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	06/30/1989	02/14/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	08/31/1989	02/14/2025	08/13/2024
11-0046	Piedmont Walton Hosp.	10/31/1989	02/14/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/1989	02/14/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/1989	02/14/2025	08/13/2024

03 **25-2099GC Quorum Health CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
04-0019	Forrest City Medical Ctr.	06/30/1990	02/14/2025	08/13/2024
05-0194	Watsonville Community Hospital	06/30/1990	02/14/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	06/30/1990	02/14/2025	08/13/2024
32-0003	Alta Vista Regional Hosp.	06/30/1990	02/14/2025	08/13/2024
11-0045	NGMC Barrow, LLC	07/31/1990	02/14/2025	08/13/2024
14-0033	Vista Medical Ctr. West	08/31/1990	02/14/2025	08/13/2024
18-0078	Paul B. Hall Reg. Med. Ctr.	09/30/1990	02/14/2025	08/13/2024
34-0133	Martin General Hosp.	09/30/1990	02/14/2025	08/13/2024
11-0046	Piedmont Walton Hosp.	10/31/1990	02/14/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/1990	02/14/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/1990	02/14/2025	08/13/2024
36-0151	Affinity Medical Ctr.	12/31/1990	02/14/2025	08/13/2024

04 **25-2100GC Quorum CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0012	DeKalb Regional Medical Ctr.	06/30/1991	02/14/2015	08/13/2024
04-0019	Forrest City Medical Ctr.	06/30/1991	02/14/2025	08/13/2024
05-0194	Watsonville Community Hospital	06/30/1991	02/14/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	06/30/1991	02/14/2025	08/13/2024
32-0003	Alta Vista Regional Hosp.	06/30/1991	02/14/2025	08/13/2024
11-0045	NGMC Barrow, LLC	07/31/1991	02/14/2025	08/13/2024
14-0033	Vista Medical Ctr. West	08/31/1991	02/14/2025	08/13/2024

18-0128	Three Rivers Medical Ctr.	08/31/1991	02/14/2025	08/13/2024
18-0078	Paul B. Hall Reg. Med. Ctr.	09/30/1991	02/14/2025	08/13/2024
11-0046	Piedmont Walton Hosp.	10/31/1991	02/14/2025	08/13/2024
04-0085	Helena Reg. Med. Ctr.	12/31/1991	02/14/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/1991	02/14/2025	08/13/2024

05 **25-2101GC Quorum Health CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
18-0139	Kentucky River Med. Ctr.	05/31/1992	02/14/2025	08/13/2024
01-0012	DeKalb Regional Medical Ctr.	06/30/1992	02/14/2025	08/13/2024
04-0019	Forrest City Medical Ctr.	06/30/1992	02/14/2025	08/13/2024
05-0194	Watsonville Community Hospital	06/30/1992	02/14/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	12/30/1992	02/14/2025	08/13/2024
32-0003	Alta Vista Regional Hosp.	06/30/1991	02/14/2025	08/13/2024
11-0045	NGMC Barrow, LLC	07/31/1992	02/14/2025	08/13/2024
14-0033	Vista Medical Ctr. West	08/31/1992	02/14/2025	08/13/2024
18-0128	Three Rivers Medical Ctr.	08/31/1992	02/14/2025	08/13/2024
18-0078	Paul B. Hall Reg. Med. Ctr.	09/30/1992	02/14/2025	08/13/2024
11-0046	Piedmont Walton Hosp.	10/31/1992	02/14/2025	08/13/2024
04-0085	Helena Reg. Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
14-0118	Metrosouth Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
36-0151	Affinity Med. Ctr.	12/31/1992	02/14/2025	08/13/2024

44-0182	McKenzie Regional Hosp.	12/31/1992	02/14/2025	08/13/2024

06 **25-2102GC Quorum Health CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
38-0020	McKenzie-Willamette Med. Ctr.	01/02/1993	02/14/2025	08/13/2024
01-0012	DeKalb Regional Med. Ctr.	06/30/1993	02/14/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	06/30/1993	02/14/2025	08/13/2024
05-0194	Watsonville Community Hosp.	06/30/1993	02/14/2025	08/13/2024
32-0003	Alta Vista Reg. Hosp.	06/30/1993	02/14/2025	08/13/2024
11-0045	NGMC Barrow, LLC	07/31/1993	02/14/2025	08/13/2024
14-0033	Vista Medical Ctr. West	08/31/1993	02/14/2025	08/13/2024
18-0078	Paul B. Hall Regional Med. Ctr.	09/30/1993	02/14/2025	08/13/2024
34-0106	Sandhills Reg. Med. Ctr.	09/30/1993	02/14/2025	08/13/2024
34-0133	Martin General Hosp.	09/30/1993	02/14/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	11/16/1993	02/14/2025	08/13/2024
04-0085	Helena Reg. Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
14-0084	Vista Med. Ctr. East	12/31/1993	02/14/2025	08/13/2024
14-0118	Metrosouth Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
36-0151	Affinity med. Ctr.	12/31/1993	02/14/2025	08/13/2024
44-0182	McKenzie Reg. Hosp.	12/31/1993	02/14/2025	08/13/2024

07 **25-2103GC Quorum Health CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Determination	
18-0128	Three Rivers Med. Ctr.	03/31/1994	02/14/2025	08/13/2024	08/13/2024
01-0012	Dekalb Regional Med. Ctr.	06/30/1994	02/14/2025	08/13/2024	
04-0019	Forrest City Med. Ctr.	06/30/1994	02/14/2025	08/13/2024	
05-0194	Watsonville Community Hosp.	06/30/1994	02/14/2025	08/13/2024	
11-0039	Trinity Hosp. of Augusta	06/30/1994	02/14/2025	08/13/2024	
32-0003	Alta Vista Reg. Hosp.	06/30/1994	02/14/2025	08/13/2024	
11-0045	NGMC Barrow, LLC	07/31/1994	02/14/2025	08/13/2024	
14-0033	Vista Med. Ctr. West	08/31/1994	02/14/2025	08/13/2024	
04-0019	Forrest City Med. Ctr.	09/30/1994	02/14/2025	08/13/2024	
18-0078	Paul B. Hall Regional Med. Ctr.	09/30/1994	02/14/2025	08/13/2024	
34-0106	Sandhills Regional Med. Ctr.	09/30/1994	02/14/2025	08/13/2024	
34-0133	Martin General Hosp.	09/30/1994	02/14/2025	08/13/2024	
04-0085	Helena Regional Med. Ctr.	12/31/1994	02/14/2025	08/13/2024	
14-0118	Metrosouth Med. Ctr.	12/31/1994	02/14/2025	08/13/2024	
14-0125	Gateway Reg. Med. Ctr.	12/31/1994	02/14/2025	08/13/2024	
18-0139	Kentucky River Med. Ctr.	12/31/1994	02/14/2025	08/13/2024	
36-0151	Affinity Med. Ctr.	12/31/1994	02/14/2025	08/13/2024	
38-0020	McKenzie-Willamette Med. Ctr.	12/31/1994	02/14/2025	08/13/2024	
44-0182	McKenzie Reg. Hosp.	12/31/1994	02/14/2025	08/13/2024	
14-0084	Vista Med. Ctr. East	12/31/1994	02/14/2025	08/13/2024	

08 **25-2104GC Quorum Health CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Determination
18-0128	Three Rivers Med. Ctr.	03/31/1995	02/14/2025	08/13/2024
01-0012	Dekalb Regional Med. Ctr.	06/30/1995	02/14/2025	08/13/2024
05-0194	Watsonville Community Hosp.	06/30/1995	02/14/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	06/30/1995	02/14/2025	08/13/2024
32-0003	Alta Vista Reg. Hosp.	06/30/1995	02/14/2025	08/13/2024
11-0045	NGMC Barrow, LLC	07/31/1995	02/14/2025	08/13/2024
14-0033	Vista Med. Ctr. West	08/31/1995	02/14/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/1995	02/14/2025	08/13/2024
18-0078	Paul B. Hall Regional Med. Ctr.	09/30/1995	02/14/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
14-0118	Metrosouth Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
36-0151	Affinity Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
38-0020	McKenzie-Willamette Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
44-0182	McKenzie Reg. Hosp.	12/31/1995	02/14/2025	08/13/2024
14-0084	Vista Med. Ctr. East	12/31/1995	02/14/2025	08/13/2024

09 **25-2105GC Quorum Health CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Determination
04-0019	Forrest City Med. Ctr.	09/30/1996	02/11/2025	08/13/2024

04-0085	Helena Regional Med. Ctr.	12/31/1996	02/11/2025	08/13/2024
14-0084	Vista Med. Ctr. East	12/31/1996	02/11/2025	08/13/2024
18-0078	Paul B. Hall Regional Med. Ctr.	09/30/1996	02/11/2025	08/13/2024
34-0113	Martin General Hosp.	09/301996	02/11/2025	08/13/2024
36-0151	Affinity Medical Ctr.	10/31/1996	02/11/2025	08/13/2024
38-0020	McKenzie-Willamette Med. Ctr.	12/31/1996	02/11/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	12/31/1996	02/11/2025	08/13/2024

10 **25-2106GC Quorum Health CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0150	L.V. Stabler Memorial Hosp.	01/31/1997	02/11/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/1997	02/11/2025	08/13/2024
04-0085	Helena Reg. Med. Ctr.	12/31/1997	02/11/2025	08/13/2024
14-0033	Vista Med. Ctr. West	11/30/1997	02/11/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/1997	02/11/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/1997	02/11/2025	08/13/2024
18-0139	Kentucky Reg. Med. Ctr.	08/31/1997	02/11/2025	08/13/2024
32-0003	Alta Vista Reg. Hosp.	06/30/1997	02/11/2025	08/13/2024
34-0133	Martin Gen. Hosp.	09/30/1997	02/11/2025	08/13/2024
38-0020	McKenzie-Willamette Med. Ctr.	12/31/1997	02/11/2025	08/13/2024
44-0182	McKenzie Reg. Hosp.	12/31/1997	02/11/2025	08/13/2024

11 **25-2107GC Quorum Health CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0012	DeKalb Reg. Med. Ctr.	06/30/1998	02/11/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/1998	02/11/2025	08/13/2024
04-0085	Helena Reg. Med. Ctr.	12/31/1998	02/11/2025	08/13/2024
05-0194	Watsonville Community Hosp.	06/30/1998	02/11/2025	08/13/2024
05-0194	Watsonville Community Hosp.	08/31/1998	02/11/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	06/30/1998	02/11/2025	08/13/2024
11-0045	NGMC Barrow, LLC	07/31/1998	02/11/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/1998	02/11/2025	08/13/2024
32-0003	Alta Vista Reg. Hosp.	06/30/1998	02/11/2025	08/13/2024
34-0133	Martin General Hosp.	09/30/1998	02/11/2025	08/13/2024
34-0133	Martin General Hosp.	10/31/1998	02/11/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/1998	02/11/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	12/31/1998	02/11/2025	08/13/2024

12 **25-2108GC Quorum Health CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0012	DeKalb Reg. Med. Ctr.	06/30/1999	02/11/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/1999	02/11/2025	08/13/2024
14-0084	Vista Med. Ctr. East	12/31/1999	02/11/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/1999	02/11/2025	08/13/2024
18-0078	Paul B. Hall Reg. Med. Ctr.	09/30/1999	02/12/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/1999	02/12/2025	08/13/2024

34-0133	Martin General Hosp.	04/30/1999	02/12/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/1999	02/12/2025	08/13/2024
38-0020	McKenzie-Willamette Med. Ctr.	12/31/1999	02/12/2025	08/13/2024

13 **25-2109GC Quorum Health CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0012	DeKalb Reg. Med. Ctr.	06/30/2000	02/12/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2000	02/12/2025	08/13/2024
04-0085	Helena Reg. Med. Ctr.	12/31/2000	02/12/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	06/30/2000	02/12/2025	08/13/2024
14-0084	Vista Med. Ctr. East	12/31/2000	02/12/2025	08/13/2024
14-0125	Gateway Reg. Med. Ctr.	12/31/2000	02/12/2025	08/13/2024
18-0078	Paul B. Hall Reg. Med. Ctr.	09/30/2000	02/12/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2000	02/12/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	08/31/2000	02/12/2025	08/13/2024
34-0133	Martin Gen. Hosp.	04/30/2000	02/12/2025	08/13/2024
36-0161	MH St. Joseph Warren Hosp.	06/30/2000	02/12/2025	08/13/2024
45-0653	Scenic Mountain Med. Ctr.	12/31/2000	02/12/2025	08/13/2024

14 **25-2110GC Quorum Health CY 2001 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0012	DeKalb Reg. Med. Ctr.	06/30/2001	02/12/2025	08/13/2024
01-0022	Cherokee Med. Ctr.	06/30/2001	02/12/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2001	02/12/2025	08/13/2024

04-0019	Forrest City Med. Ctr.	09/30/2001	02/12/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/2001	02/12/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	06/30/2001	02/12/2025	08/13/2024
11-0045	NGMC Burrow, LLC	12/31/2001	02/12/2025	08/13/2024
11-0046	Piedmont Walton Hosp.	10/31/2001	02/12/2025	08/13/2024
14-0040	Galesburg Cottage Hosp.	12/31/2001	02/12/2025	08/13/2024
14-0125	Gateway Regional Med. Ctr.	12/31/2001	02/12/2025	08/13/2024
14-0184	Heartland Reg. Med. Ctr.	04/30/2001	02/12/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2001	02/12/2025	08/13/2024
18-0078	Paul B. Hall Reg. Med. Ctr.	09/30/2001	02/12/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2001	02/12/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	08/31/2001	02/12/2025	08/13/2024
32-0003	Alta Vista Reg. Hosp.	08/31/2001	02/12/2025	08/13/2024
34-0106	Sandhills Reg. Med. Ctr.	09/30/2001	02/12/2025	08/13/2024
34-0133	Martin General Hosp.	04/30/2001	02/12/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/2001	02/12/2025	08/13/2024
44-0008	Henderson County Community Hosp.	12/31/2001	02/12/2025	08/13/2024
44-0182	McKenzie Reg. Hosp.	12/31/2001	02/12/2025	08/13/2024
45-0653	Scenic Mountain Med. Ctr.	12/31/2001	02/12/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2001	02/12/2025	08/13/2024

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0022	Cherokee Med. Ctr.	06/30/2002	02/12/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2002	02/12/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2002	02/12/2025	08/13/2024
04-0085	Helena Reg. Med. Ctr.	02/28/2002	02/12/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2002	02/12/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2002	02/12/2025	08/13/2024
11-0046	Piedmont Walton Hosp.	10/31/2002	02/12/2025	08/13/2024
11-0189	Fannin Reg. Hospital	12/31/2002	02/12/2025	08/13/2024
14-0184	Heartland Reg. Med. Ctr.	04/30/2002	02/12/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2002	02/12/2025	08/13/2024
18-0078	Paul B. Hall Reg. Med. Ctr.	09/30/2002	02/12/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2002	02/12/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	08/31/2002	02/12/2025	08/13/2024
32-0003	Alta Vista Reg. Hosp.	08/31/2002	02/12/2025	08/13/2024
34-0106	Sandhills Reg. Med. Ctr.	09/30/2002	02/12/2025	08/13/2024
34-0133	Martin General Hosp.	04/30/2002	02/12/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/2002	02/12/2025	08/13/2024
39-0071	UPMC Lock Haven	07/31/2002	02/12/2025	08/13/2024
39-0071	UPMC Lock Haven	07/31/2002	02/12/2025	08/13/2024
44-0088	Henderson County Community Hosp.	12/31/2002	02/12/2025	08/13/2024
44-0182	McKenzie Reg. Hosp.	12/31/2002	02/12/2025	08/13/2024

45-0653	Scenic Mountain Med. Ctr.	12/31/2002	02/12/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2002	02/12/2025	08/13/2024
53-0032	Evanston Reg. Hosp.	04/30/2002	02/12/2025	08/13/2024

16 **25-2112GC Quorum Health CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
32-0003	Alta Vista Reg. Med. Ctr.	08/31/2003	02/12/2025	08/13/2024
38-0020	McKenzie-Willamette Med. Ctr.	12/31/2003	02/12/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2003	02/12/2025	08/13/2024
44-0008	Henderson County Community Hosp.	12/31/2003	02/12/2025	08/13/2024
44-0182	McKenzie Reg. Hosp.	12/31/2003	02/12/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2003	02/12/2025	08/13/2024
53-0032	Evanston Reg. Hosp.	04/30/2003	02/12/2025	08/13/2024

17 **25-2113GC Quorum Health CY 2004 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0022	Cherokee Med. Ctr.	06/30/2004	02/12/2025	08/13/2024
01-0150	L.V. Stabler Mem. Hosp.	01/31/2004	02/12/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2004	02/12/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2004	02/12/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2004	02/12/2025	08/13/2024
14-0040	Galesburg Cottage Hosp.	06/30/2004	02/12/2025	08/13/2024

14-0294	Crossroads Community Hosp.	12/31/2004	02/12/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2004	02/12/2025	08/13/2024
32-0003	Alta Vista Reg. Hosp.	08/31/2004	02/12/2025	08/13/2024
34-0133	Martin General Hosp.	04/30/2004	02/12/2025	08/13/2024
44-0008	Henderson County Community Hosp.	12/31/2004	02/12/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	12/31/2004	02/12/2025	08/13/2024
53-0032	Evanston Regional Hosp.	04/30/2004	02/12/2025	08/13/2024

18 **25-2114GC Quorum Health CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
04-0019	Forrest City Med. Ctr.	09/30/2005	02/12/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2005	02/12/2025	08/13/2024
14-0084	Vista Med. Ctr. East	12/31/2005	02/12/2025	08/13/2024
14-0040	Galesburg Cottage Hosp.	04/30/2005	02/12/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2005	02/12/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/2005	02/12/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2005	02/12/2025	08/13/2024
44-0008	Henderson County Community Hosp.	12/31/2005	02/12/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	12/31/2005	02/12/2025	08/13/2024
45-0653	Scenic Mountain Med. Ctr.	12/31/2005	02/12/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2005	02/12/2025	08/13/2024

53-0032	Evanston Regional Hosp.	04/30/2005	02/12/2025	08/13/2024

19 **25-2115GC Quorum Health CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0012	DeKalb Regional Med. Ctr.	03/31/2006	02/12/2025	08/13/2024
01-0022	Cherokee Med. Ctr.	03/31/2006	02/12/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2006	02/12/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	02/28/2006	02/12/2025	08/13/2024
11-0039	Trinity Hospital of Augusta	10/31/2006	02/12/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2006	02/12/2025	08/13/2024
14-0040	Galesburg Cottage Hosp.	04/30/2006	02/12/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2006	02/12/2025	08/13/2024
32-0003	Alta Vista Regional Hosp.	08/31/2006	02/12/2025	08/13/2024
34-0133	Martin General Hosp.	04/30/2006	02/12/2025	08/13/2024
36-0151	Affinity Med. Ctr.	01/31/2006	02/12/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/2006	02/12/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2006	02/12/2025	08/13/2024
39-0084	Sunbury Community Hosp.	06/30/2006	02/12/2025	08/13/2024
44-0008	Henderson County Community Hosp.	12/31/2006	02/12/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	12/31/2006	02/12/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2006	02/12/2025	08/13/2024
53-0032	Evanston Regional Hosp.	04/30/2006	02/12/2025	08/13/2024

20 **25-2116GC Quorum Health CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0022	Cherokee Med. Ctr.	03/31/2007	02/12/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2007	02/12/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2007	02/12/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/2007	02/12/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2007	02/12/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	06/30/2007	02/12/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2007	02/12/2025	08/13/2024
14-0040	Galesburg Cottage Hosp.	04/30/2007	02/12/2025	08/13/2024
14-0184	Heartland Reg. Med. Ctr.	04/30/2007	02/12/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2007	02/12/2025	08/13/2024
18-0078	Paul B. Hall Regional Med. Ctr.	09/30/2007	02/12/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2007	02/12/2025	08/13/2024
32-0003	Alta Vista Regional Hosp.	08/31/2007	02/12/2025	08/13/2024
34-0133	Martin General Hosp.	04/30/2007	02/12/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/2007	02/12/2025	08/13/2024
38-0020	McKenzie-Willamette Med. Ctr.	12/31/2007	02/12/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2007	02/12/2025	08/13/2024
39-0084	Sunbury Community Hosp.	06/30/2007	02/12/2025	08/13/2024
44-0008	Henderson County Community Hosp.	12/31/2007	02/12/2025	08/13/2024

44-0182	McKenzie Regional Hosp.	12/31/2007	02/12/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2007	02/12/2025	08/13/2024
53-0032	Evanston Regional Hosp.	04/30/2007	02/12/2025	08/13/2024

21 **25-2117GC Quorum Health CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0022	Cherokee Med. Ctr.	03/31/2008	02/12/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2008	02/12/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2008	02/12/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/2008	02/12/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2008	02/12/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2008	02/12/2025	08/13/2024
11-0046	Piedmont Walton Hosp.	09/30/2008	02/12/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2008	02/12/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2008	02/12/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	08/31/2008	02/12/2025	08/13/2024
32-0003	Alta Vista Regional Hosp.	08/31/2008	02/12/2025	08/13/2024
34-0106	Sandhills Regional Med. Ctr.	09/30/2008	02/12/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/2008	02/12/2025	08/13/2024
38-0020	McKenzie-Willamette Medical Ctr.	12/31/2008	02/12/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2008	02/12/2025	08/13/2024
44-0008	Henderson County	12/31/2008	02/12/2025	08/13/2024

	Community Hosp.			
44-0182	McKenzie Regional Hosp.	12/31/2007	02/12/2025	08/13/2024
45-0653	Scenic Mountain Med. Ctr.	12/31/2008	02/12/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2008	02/12/2025	08/13/2024
53-0032	Evanston Regional Hosp.	04/30/2008	02/12/2025	08/13/2024

22	**25-2118GC Quorum Health CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
01-0022	Cherokee Med. Ctr.	03/31/2009	02/12/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2009	02/12/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2009	02/12/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/2009	02/12/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2009	02/12/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	06/30/2009	02/12/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2009	02/12/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2009	02/12/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2009	02/12/2025	08/13/2024
32-0003	Alta Vista Regional Hosp.	08/31/2009	02/12/2025	08/13/2024
38-0020	McKenzie-Willamette Med. Ctr.	12/31/2009	02/12/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2009	02/12/2025	08/13/2024
39-0084	Sunbury Community Hosp.	06/30/2009	02/12/2025	08/13/2024

45-0653	Scenic Mountain Med. Ctr.	12/31/2009	02/12/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2009	02/12/2025	08/13/2024
53-0032	Evanston Regional Hosp.	04/30/2009	02/12/2025	08/13/2024

23 **25-2119GC Quorum Health CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0022	Cherokee Medical Ctr.	03/31/2010	02/13/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2010	02/13/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2010	02/13/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/2010	02/13/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2010	02/13/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	06/30/2010	02/13/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2010	02/13/2025	08/13/2024
14-0040	Galesburg Cottage Hosp.	04/30/2010	02/13/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2010	02/13/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2010	02/13/2025	08/13/2024
32-0003	Alta Vista Reg. Hosp.	08/31/2010	02/13/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2010	02/13/2025	08/13/2024
39-0084	Sunbury Community Hosp.	06/30/2010	02/13/2025	08/13/2024
44-0008	Henderson County Community Hosp.	01/31/2010	02/13/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	01/31/2010	02/13/2025	08/13/2024

45-0653	Scenic Mountain Med. Ctr.	12/31/2010	02/13/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2010	02/13/2025	08/13/2024
53-0032	Evanston Regional Hosp.	04/30/2010	02/13/2025	08/13/2024

24 **25-2120GC Quorum Health CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0022	Cherokee Med. Ctr.	03/31/2011	02/13/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2011	02/13/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2011	02/13/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	12/31/2011	02/13/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2011	02/13/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	06/30/2011	02/13/2025	08/13/2024
11-00475	NGMC Barrow, LLC	12/31/2011	02/13/2025	08/13/2024
11-0189	Fannin Regional Hosp.	12/31/2011	02/13/2025	08/13/2024
14-0040	Galesburg Cottage	04/30/2011	02/13/2025	08/13/2024
18-0078	Paul B. Hall Regional Med. Ctr.	09/30/2011	02/13/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2011	02/13/2025	08/13/2024
32-0003	Alta Vista Regional Hosp.	08/31/2011	02/13/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/2011	02/13/2025	08/13/2024
38-0020	McKenzie-Willamette Med. Ctr.	12/31/2011	02/13/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2011	02/13/2025	08/13/2024
39-0084	Sunbury Community Hosp.	06/30/2011	02/13/2025	08/13/2024

44-0008	Henderson County Community Hosp.	01/31/2011	02/13/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	01/31/2011	02/13/2025	08/13/2024
45-0653	Scenic Mountain Med. Ctr.	12/31/2011	02/13/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2011	02/13/2025	08/13/2024
53-0032	Evanston Regional Hosp.	04/30/2011	02/13/2025	08/13/2024

25 **25-2121GC Quorum CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0022	Cherokee Med. Ctr.	03/31/2012	02/13/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2012	02/13/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2012	02/13/2025	08/13/2024
04-0085	Helena Regional Med. Ctr.	09/30/2012	02/13/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2012	02/13/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	09/30/2012	02/13/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2012	02/13/2025	08/13/2024
11-0189	Fannin Regional Hosp.	12/31/2012	02/13/2025	08/13/2024
14-0040	Galesburg Cottage Hosp.	04/30/2012	02/13/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2012	02/13/2025	08/13/2024
18-0078	Paul B. Hall Regional Med. Ctr.	09/30/2012	02/13/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2012	02/13/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	08/31/2012	02/13/2025	08/13/2024

32-0003	Alta Vista Regional Hosp.	08/31/2012	02/13/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2012	02/13/2025	08/13/2024
39-0084	Sunbury Community Hosp.	06/30/2012	02/13/2025	08/13/2024
44-0008	Henderson County Hosp.	01/31/2012	02/13/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	01/31/2012	02/13/2025	08/13/2024
45-0653	Scenic Mountain Med. Ctr.	12/31/2012	02/13/2025	08/13/2024
53-0032	Evanston Regional Hosp.	04/30/2012	02/13/2025	08/13/2024

26 **25-2122GC Quorum Health CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0022	Cherokee Med. Ctr.	03/31/2013	02/13/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2013	02/13/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2013	02/13/2025	08/13/2024
04-0085	Helena Reg. Med. Ctr.	12/31/2013	02/13/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2013	02/13/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	09/30/2013	02/13/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2013	02/13/2025	08/13/2024
11-0189	Fannin Regional Hosp.	12/31/2013	02/13/2025	08/13/2024
14-0040	Galesburg Cottage Hosp.	04/30/2013	02/13/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2013	02/13/2025	08/13/2024
18-0078	Paul B. Hall Regional Med. Ctr.	09/30/2013	02/13/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2013	02/13/2025	08/13/2024

18-0139	Kentucky River Med. Ctr.	08/31/2013	02/13/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2013	02/13/2025	08/13/2024
39-0084	Sunbury Community Hosp.	01/31/2013	02/13/2025	08/13/2024
44-0008	Henderson County Community Hosp.	01/31/2013	02/13/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	01/31/2013	02/13/2025	08/13/2024
45-0653	Scenic Mountain Med. Ctr.	12/31/2013	02/13/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2013	02/13/2025	08/13/2024
53-0032	Evanston Reg. Hosp.	04/30/2013	02/13/2025	08/13/2024

27 **25-2123GC Quorum Health CY 2014 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
01-0012	DeKalb Regional Med. Ctr.	03/31/2014	02/13/2025	08/13/2024
01-0022	Cherokee Med. Ctr.	03/31/2014	02/13/2025	08/13/2024
01-0150	L.V. Stabler Memorial Hosp.	01/31/2014	02/13/2025	08/13/2024
04-0019	Forrest City Med. Ctr.	09/30/2014	02/13/2025	08/13/2024
04-0085	Helena Reg. Med. Ctr.	12/31/2014	02/13/2025	08/13/2024
05-0298	Barstow Community Hosp.	01/31/2014	02/13/2025	08/13/2024
11-0039	Trinity Hosp. of Augusta	09/30/2014	02/13/2025	08/13/2024
11-0045	NGMC Barrow, LLC	12/31/2014	02/13/2025	08/13/2024
11-0046	Piedmont Walton Hosp.	09/30/2014	02/13/2025	08/13/2024
11-0189	Fannin Regional Hosp.	12/31/2014	02/13/2025	08/13/2024

14-0040	Galesburg Cottage Hosp.	04/30/2014	02/13/2025	08/13/2024
14-0125	Gateway Regional Med. Ctr.	12/31/2014	02/13/2025	08/13/2024
14-0294	Crossroads Community Hosp.	12/31/2014	02/13/2025	08/13/2024
18-0078	Paul B. Hall Regional Med. Ctr.	09/30/2014	02/13/2025	08/13/2024
18-0128	Three Rivers Med. Ctr.	03/31/2014	02/13/2025	08/13/2024
18-0139	Kentucky River Med. Ctr.	08/31/2014	02/13/2025	08/13/2024
34-0106	Sandhills Regional Med. Ctr.	09/30/2014	02/13/2025	08/13/2024
34-0133	Martin General Hosp.	04/30/2014	02/13/2025	08/13/2024
36-0151	Affinity Med. Ctr.	06/30/2014	02/13/2025	08/13/2024
38-0020	McKenzie-Willamette Med. Ctr.	12/31/2014	02/13/2025	08/13/2024
39-0071	UPMC Lock Haven	06/30/2014	02/13/2025	08/13/2024
39-0084	Sunbury Community Hosp.	06/30/2014	02/13/2025	08/13/2024
44-0008	Henderson County Community Hosp.	01/31/2014	02/13/2025	08/13/2024
44-0182	McKenzie Regional Hosp.	01/31/2014	02/13/2025	08/13/2024
45-0653	Scenic Mountain Med. Ctr.	12/31/2014	02/13/2025	08/13/2024
46-0014	Mountain West Med. Ctr.	12/31/2014	02/13/2025	08/13/2024
53-0032	Evanston Reg. Hosp.	04/30/2014	02/13/2025	08/13/2024

28	25-2034GC CHS CY 1988 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
10-0032	Bayfront Health – St. Petersburg	06/30/1988	02/14/2025	08/13/2024
45-0029	Laredo Med. Ctr.	06/30/1988	02/14/2025	08/13/2024
25-0072	Merit Health Central	09/30/1988	02/14/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1988	02/14/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	12/31/1988	02/14/2025	08/13/2024
44-0120	Physicians Regional Med. Ctr.	12/31/1988	02/14/2025	08/13/2024
01-0040	Gadsden Regional Med. Ctr.	12/31/1988	02/14/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/1988	02/14/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/1988	02/14/2025	08/13/2024
50-0012	Yakima Regional Med. Ctr.	12/31/1988	02/14/2025	08/13/2024
04-0055	Baptist Health-Fort Smith	06/30/1988	02/14/2025	08/13/2024

29	25-2036GC CHS CY 1989 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
45-0029	Laredo Med. Ctr.	06/30/1989	02/14/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	06/30/1989	02/14/2025	08/13/2024
25-0072	Merit Health Central	09/30/1989	02/14/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1989	02/14/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	12/31/1989	02/14/2025	08/13/2024

44-0120	Physicians Regional Med. Ctr.	12/31/1989	02/14/2025	08/13/2024
01-0040	Gadsden Regional Med. Ctr.	12/31/1989	02/14/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/1989	02/14/2025	08/13/2024
50-0012	Yakima Regional Med. Ctr.	12/31/1989	02/14/2025	08/13/2024
04-0055	Baptist Health-Fort Smith	06/30/1989	02/14/2025	08/13/2024
44-0035	Tennova Healthcare – Clarksville	06/30/1989	02/14/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	10/31/1989	02/14/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1989	02/14/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/1989	02/14/2025	08/13/2024

30 **25-2037GC CHS CY 1990 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
45-0029	Laredo Med. Ctr.	06/30/1990	02/14/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	06/30/1990	02/14/2025	08/13/2024
04-0055	Baptist Health-Fort Smith	06/30/1990	02/14/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/1990	02/14/2025	08/13/2024
25-0072	Merit Health Central	09/30/1990	02/14/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	12/31/1990	02/14/2025	08/13/2024
44-0120	Physicians Regional Med. Ctr.	12/31/1990	02/14/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1990	02/14/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/1990	02/14/2025	08/13/2024

01-0040	Gadsden Regional Med. Ctr.	12/31/1990	02/14/2025	08/13/2024
50-0012	Yakima Regional Med. Ctr.	12/31/1990	02/14/2025	08/13/2024
44-0035	Tennova Healthcare – Clarksville	06/30/1990	02/14/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	10/31/1990	02/14/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1990	02/14/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	07/31/1990	02/14/2025	08/13/2024
26-0019	Popular Bluff Regional Med. Ctr.	12/31/1990	02/14/2025	08/13/2024
15-0047	St. Joseph Health System	12/31/1990	02/14/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	05/31/1990	02/14/2025	08/13/2024

31	**25-2038GC CHS CY 1991 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
45-0029	Laredo Med. Ctr.	06/30/1991	02/14/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	06/30/1991	02/14/2025	08/13/2024
04-0055	Baptist Health-Fort Smith	06/30/1991	02/14/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/1991	02/14/2025	08/13/2024
25-0072	Merit Health Central	09/30/1991	02/14/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/1991	02/14/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	12/31/1991	02/14/2025	08/13/2024
44-0120	Physicians Regional Med. Ctr.	12/31/1991	02/14/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1991	02/14/2025	08/13/2024

10-0062	AdventHealth Ocala	09/30/1991	02/14/2025	08/13/2024
01-0040	Gadsden Regional Med. Ctr.	12/31/1991	02/14/2025	08/13/2024
50-0012	Yakima Regional Med. Ctr.	12/31/1991	02/14/2025	08/13/2024
44-0035	Tennova Healthcare – Clarksville	06/30/1991	02/14/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	10/31/1991	02/14/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1991	02/14/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	07/31/1991	02/14/2025	08/13/2024
26-0019	Popular Bluff Regional Med. Ctr.	12/31/1991	02/14/2025	08/13/2024
15-0047	St. Joseph Health System	12/31/1991	02/14/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	05/31/1991	02/14/2025	08/13/2024
15-0017	Lutheran Hosp. of Indiana	12/31/1991	02/14/2025	08/13/2024
26-0022	Northeast Regional Med. Ctr.	05/31/1991	02/14/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/1991	02/14/2025	08/13/2024
10-0122	North Okaloosa Med. Ctr.	06/30/1991	02/14/2025	08/13/2024
39-0068	UPMC Lititz	06/30/1991	02/14/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	12/31/1991	02/14/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	09/30/1991	02/14/2025	08/13/2024

32	**25-2040GC CHS CY 1992 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**

45-0029	Laredo Med. Ctr.	06/30/1992	02/14/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	06/30/1992	02/14/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
25-0072	Merit Health Central	09/30/1992	02/14/2025	08/13/2024
04-0055	Baptist Health-Fort Smith	06/30/1992	02/14/2025	08/13/2024
44-0120	Physicians Regional Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
01-0055	Flowers Hosp.	05/31/1992	02/14/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/1992	02/14/2025	08/13/2024
01-0040	Gadsden Regional Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
44-0035	Tennova Healthcare – Clarksville	06/30/1992	02/14/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/1992	02/14/2025	08/13/2024
26-0022	Northeast Regional Med. Ctr.	05/31/1992	02/14/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/1992	02/14/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	05/31/1992	02/14/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	07/31/1992	02/14/2025	08/13/2024
42-0010	Carolina Pines Regional Med. Ctr.	09/30/1992	02/14/2025	08/13/2024
50-0012	Yakima Regional Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1992	02/14/2025	08/13/2024

26-0019	Popular Bluff Regional Med. Ctr.	12/31/1992	02/14/2025	08/13/2024
15-0047	St. Joseph Health System	12/31/1992	02/14/2025	08/13/2024
04-0018	Baptist Health – Van Buren	12/13/1992	02/14/2025	08/13/2024
10-0092	Steward Rockledge Hosp.	09/30/1992	02/14/2025	08/13/2024
15-0017	Lutheran Hosp. of Indiana	12/31/1992	02/14/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	10/31/1992	02/14/2025	08/13/2024
25-0031	Merit Health River Region	05/31/1992	02/14/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	09/30/1992	02/14/2025	08/13/2024
10-0102	Shands Lake Shore Regional Med. Ctr.	09/30/1992	02/14/2025	08/13/2024
10-0122	North Okaloosa Med. Ctr.	06/30/1992	02/14/2025	08/13/2024
51-0002	CAMC Greenbrier Valley Med. Ctr.	08/31/1992	02/14/2025	08/13/2024
39-0068	UPMC Lititz	06/30/1992	02/14/2025	08/13/2024
34-0144	Davis Regional Med. Ctr.	02/29/1992	02/14/2025	08/13/2024
39-0137	WilkesBarre General Hospital	06/30/1992	02/14/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	05/31/1992	02/14/2025	08/13/2024
39-0061	Lancaster Regional Med. Ctr.	06/30/1992	02/14/2025	08/13/2024

33 **25-2041GC CHS CY 1993 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
45-0029	Laredo Med. Ctr.	06/30/1993	02/14/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	06/30/1993	02/14/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	12/31/1993	02/14/2025	08/13/2024

25-0072	Merit Health Central	12/31/1993	02/14/2025	08/13/2024
04-0055	Baptist Health-Fort Smith	06/30/1993	02/14/2025	08/13/2024
44-0120	Physicians Regional Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/1993	02/14/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/1993	02/14/2025	08/13/2024
01-0040	Gadsden Regional Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
44-0035	Tennova Healthcare – Clarksville	06/30/1993	02/14/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/1993	02/14/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/1993	02/14/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	05/31/1993	02/14/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	07/31/1993	02/14/2025	08/13/2024
50-0012	Yakima Regional Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1993	02/14/2025	08/13/2024
26-0019	Popular Bluff Regional Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
04-0088	South Arkansas Regional Hosp.	06/30/1993	02/14/2025	08/13/2024
15-0047	St. Joseph Health System	12/31/1993	02/14/2025	08/13/2024
04-0018	Baptist Health – Van Buren	12/13/1993	02/14/2025	08/13/2024
10-0092	Steward Rockledge Hosp.	09/30/1993	02/14/2025	08/13/2024

10-0124	Santa Rosa Med. Ctr.	10/31/1993	02/14/2025	08/13/2024
25-0031	Merit Health River Region	05/31/1993	02/14/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	09/30/1993	02/14/2025	08/13/2024
10-0122	North Okaloosa Med. Ctr.	06/30/1993	02/14/2025	08/13/2024
51-0002	CAMC Greenbrier Valley Med. Ctr.	08/31/1993	02/14/2025	08/13/2024
39-0068	UPMC Lititz	06/30/1993	02/14/2025	08/13/2024
34-0144	Davis Regional Med. Ctr.	02/28/1993	02/14/2025	08/13/2024
39-0137	WilkesBarre General Hospital	06/30/1993	02/14/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	05/31/1993	02/14/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	06/30/1993	02/14/2025	08/13/2024
51-0071	Bluefield Regional Med. Ctr.	06/30/1993	02/14/2025	08/13/2024
01-0049	Medical Ctr. Enterprise	08/31/1993	02/14/2025	08/13/2024
31-0091	Salem Med. Ctr.	12/31/1993	02/14/2025	08/13/2024
04-0022	Northwest Med. Ctr. – Springdale	06/30/1993	02/14/2025	08/13/2024

34 **25-2043GC CHS CY 1994 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
45-0029	Laredo Med. Ctr.	06/30/1994	02/14/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	12/31/1994	02/14/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	05/31/1994	02/14/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1994	02/14/2025	08/13/2024

44-0120	Physicians Regional Med. Ctr.	12/31/1994	02/14/2025	08/13/2024
44-0035	Tennova healthcare – Clarksville	06/30/1994	02/14/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/1994	02/14/2025	08/13/2024
42-0091	MUSC Health Florence Med. Ctr.	09/30/1994	02/14/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	05/31/1994	02/14/2025	08/13/2024
50-0012	Yakima Regional Med. Ctr.	12/31/1994	02/14/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	07/31/1994	02/14/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	12/31/1994	02/14/2025	08/13/2024
51-0071	Bluefield Regional Med. Ctr.	06/30/1994	02/14/2025	08/13/2024
39-0137	WilkesBarre General Hosp.	06/30/1994	02/14/2025	08/13/2024
34-0144	Davis Regional Med. Ctr.	02/28/1994	02/14/2025	08/13/2024
39-0068	UPMC Lititz	06/30/1994	02/14/2025	08/13/2024
39-0072	Berwick Hosp. Ctr.	06/30/1994	02/14/2025	08/13/2024
37-0006	Integris Health Ponca City	09/30/1994	02/14/2025	08/13/2024
01-0040	Gadsen Regional Med. Ctr.	12/31/1994	02/14/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1994	02/14/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/1994	02/14/2025	08/13/2024
04-0018	Baptist Health Van Buren	12/31/1994	02/14/2025	08/13/2024
04-0055	Baptist Health Fort Smith	06/30/1994	02/14/2025	08/13/2024
04-0088	South Arkansas Regional Hosp.	06/30/1994	02/14/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	06/30/1994	02/14/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/1994	02/14/2025	08/13/2024

10-0077	ShorePoint Health Port Charlotte	08/31/1994	02/14/2025	08/13/2024
10-0092	Steward Rockledge Hosp.	09/30/1994	02/14/2025	08/13/2024
10-0122	North Okaloosa Med. Ctr.	06/30/1994	02/14/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	10/31/1994	02/14/2025	08/13/2024
15-0047	St. Joseph Health System, LLC	12/31/1994	02/14/2025	08/13/2024
25-0031	Merit Health River Region	05/31/1994	02/14/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/1994	02/14/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	09/30/1994	02/14/2025	08/13/2024
25-0072	Merit Health Central	12/31/1994	02/14/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	06/30/1994	02/14/2025	08/13/2024
31-0091	Salem Med. Ctr.	12/31/1994	02/14/2025	08/13/2024
26-0019	Popular Bluff Regional Med. Ctr.	12/31/1994	02/14/2025	08/13/2024
19-0086	Northern Louisiana Med. Ctr.	04-30-1994	02/14/2025	08/13/2024

35	**25-2044GC CHS CY 1995 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
45-0029	Laredo Med. Ctr.	06/30/1995	02/14/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	05/31/1995	02/14/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1995	02/14/2025	08/13/2024

44-0120	Physicians Regional Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
44-0035	Tennova healthcare – Clarksville	06/30/1995	02/14/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/1995	02/14/2025	08/13/2024
42-0091	MUSC Health Florence Med. Ctr.	06/30/1995	02/14/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	05/31/1995	02/14/2025	08/13/2024
50-0012	Yakima Regional Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	07/31/1995	02/14/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
51-0071	Bluefield Regional Med. Ctr.	06/30/1995	02/14/2025	08/13/2024
39-0137	WilkesBarre General Hosp.	06/30/1995	02/14/2025	08/13/2024
34-0144	Davis Regional Med. Ctr.	02/28/1995	02/14/2025	08/13/2024
39-0068	UPMC Lititz	06/30/1995	02/14/2025	08/13/2024
37-0006	Integris Health Ponca City	09/30/1995	02/14/2025	08/13/2024
01-0040	Gadsen Regional Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1995	02/14/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/1995	02/14/2025	08/13/2024
04-0018	Baptist Health Van Buren	12/31/1995	02/14/2025	08/13/2024
04-0055	Baptist Health Fort Smith	06/30/1995	02/14/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	06/30/1995	02/14/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/1995	02/14/2025	08/13/2024
10-0077	ShorePoint Health Port Charlotte	08/31/1995	02/14/2025	08/13/2024

10-0092	Steward Rockledge Hosp.	09/30/1994	02/14/2025	08/13/2024
10-0122	North Okaloosa Med. Ctr.	06/30/1995	02/14/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	10/31/1994	02/14/2025	08/13/2024
15-0047	St. Joseph Health System, LLC	12/31/1995	02/14/2025	08/13/2024
25-0031	Merit Health River Region	05/31/1995	02/14/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	09/30/1995	02/14/2025	08/13/2024
25-0072	Merit Health Central	12/31/1995	02/14/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	06/30/1995	02/14/2025	08/13/2024
31-0091	Salem Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
26-0019	Popular Bluff Regional Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
51-0002	CAMC Greenbrier Valley Med. Ctr.	12/31/1995	02/14/2025	08/13/2024
37-0014	Alliance Health Durant	09/30/1995	02/14/2025	08/13/2024
45-0558	Abilene Regional Med. Ctr.	08/31/1995	02/14/2025	08/13/2024
44-0033	Lafollette Med. Ctr.	06/30/1995	02/14/2025	08/13/2024
44-0083	Jamestown Regional Med. Ctr.	12/13/1995	02/14/2025	08/13/2024
44-0067	Lakeway Regional Hosp.	05/31/1995	02/14/2025	08/13/2024
04-0022	Northwest Med. Ctr. – Springdale	06/30/1995	02/14/2025	08/13/2024

36 **25-2046GC CHS CY 1996 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**

10-0062	AdventHealth Ocala	09/30/1996	02/12/2025	08/13/2024
01-0040	Gadsden Regional Med. Ctr.	12/31/1996	02/12/2025	08/13/2024
10-0092	Steward Rockledge Hosp.	09/30/1996	02/12/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	12/31/1996	02/12/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1996	02/12/2025	08/13/2024
31-0091	Salem Med. Ctr.	12/31/1996	02/12/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/1996	02/12/2025	08/13/2024
50-0012	Yakima Regional Medical and Cardiac Ctr.	12/31/1996	02/12/2025	08/13/2024
44-0120	Physicians Regional Med. Ctr.	12/31/1996	02/12/2025	08/13/2024
15-0047	St. Joseph Health System, LLC	12/31/1996	02/12/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/1996	02/12/2025	08/13/2024

37 **25-2047GC CHS CY 1997 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
25-0094	Merit Health Wesley	03/31/1997	02/12/2025	08/13/2024
44-0035	Tennova Healthcare – Clarksville	03/31/1997	02/12/2025	08/13/2024
25-0031	Merit Health River Region	05/31/1997	02/12/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	05/31/1997	02/12/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	05/31/1997	02/12/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1997	02/12/2025	08/13/2024

42-0043	Cherokee Med. Ctr.	09/30/1997	02/12/2025	08/13/2024
37-0014	AllianceHealth Durant	09/30/1997	02/12/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	07/31/1997	02/12/2025	08/13/2024
15-0047	St. Joseph Health System, LLC	12/31/1997	02/12/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	06/30/1997	02/12/2025	08/13/2024

38 **25-2051GC CHS CY 1998 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
04-0055	Baptist Health – Fort Smith	06/30/1998	02/12/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	06/30/1998	02/12/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	06/30/1998	02/12/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1998	02/12/2025	08/13/2024
01-0040	Gadsden Regional Med. Ctr.	12/31/1998	02/12/2025	08/13/2024
44-0035	Tennova Healthcare – Clarksville	12/31/1998	02/12/2025	08/13/2024
50-0012	Yakima Regional Medical and Cardiac Ctr.	12/31/1998	02/12/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/1998	02/12/2025	08/13/2024
25-0007	Merit Health	09/30/1998	02/12/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hospital	05/31/1998	02/12/2025	08/13/2024
01-0055	Flowers Hospital	06/30/1998	02/12/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	05/31/1998	02/12/2025	08/13/2024

45-0558	Abilene Regional Med. Ctr.	08/31/1998	02/12/2025	08/13/2024
31-0091	Salem Medical Ctr.	12/31/1998	02/12/2025	08/13/2024
11-0075	East Georgia Regional Med. Ctr.	09/30/1998	02/12/2025	08/13/2024
10-0092	Steward Rockledge Hosp.	09/30/1998	02/12/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	12/31/1998	02/12/2025	08/13/2024
25-0094	Merit Health Wesley	03/31/1998	02/12/2025	08/13/2024
37-0014	AllianceHealth Durant	09/30/1998	02/12/2025	08/13/2024
10-0122	North Okaloosa Med. Ctr.	03/31/1998	02/12/2025	08/13/2024

39 **25-2052GC CHS CY 1999 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
10-0032	Bayfront Health – St. Petersburg	06/30/1999	02/12/2025	08/13/2024
25-0031	Merit Health River Region	06/30/1999	02/12/2025	08/13/2024
04-0055	Baptist Health – Fort Smith	06/30/1999	02/12/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/1999	02/12/2025	08/13/2024
42-0055	MUSC Health Marion Med. Ctr.	09/30/1999	02/12/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/1999	02/12/2025	08/13/2024
01-0040	Gadsden Regional Med. Ctr.	12/31/1999	02/12/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/1999	02/12/2025	08/13/2024
25-0094	Merit Health Wesley	03/31/1999	02/12/2025	08/13/2024

31-0091	Salem Med. Ctr.	12/31/1999	02/12/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/1999	02/12/2025	08/13/2024
44-0035	Tennova Healthcare – Clarksville	12/31/1999	02/12/2025	08/13/2024
50-0012	Yakima Regional Medical and Cardiac Ctr.	12/31/1999	02/12/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	12/31/1999	02/12/2025	08/13/204
44-0193	Vanderbilt Wilson County Hospital	05/31/1999	02/12/2025	08/13/2024
10-0092	Steward Rockledge Hosp.	09/30/1999	02/12/2025	08/13/2024
39-0137	WilkesBarre General Hosp.	06/30/1999	02/12/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/1999	02/12/2025	08/13/2024
11-0075	East Georgia Regional Med. Ctr.	09/30/1999	02/12/2025	08/13/2024
45-0558	Abilene Regional Med. Ctr.	08/31/1999	02/12/2025	08/13/2024
37-0014	AllianceHealth Durant	09/30/1999	02/12/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	12/31/1999	02/12/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	05/31/1999	02/12/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	12/31/1999	02/12/2025	08/13/2024
45-0702	Longview Regional Med. Ctr.	12/31/1999	02/12/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/1999	02/12/2025	08/13/2024
01-0104	Grandview Med. Ctr.	06/30/1999	02/12/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	05/31/1999	02/12/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	05/31/1999	02/12/2025	08/13/2024

40	25-2053GC CHS CY 2000 Medicare Fraction (SSI) - Statutory & Systemic Errors Group			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
25-0094	Merit Health Wesley	03/31/2000	02/12/2025	08/13/2024
25-0072	Merit Health Central	03/31/2000	02/12/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	05/31/2000	02/12/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	05/31/2000	02/12/2025	08/13/2024
15-0047	St. Joseph Health System, LLC	05/31/2000	02/12/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	05/31/2000	02/12/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	05/31/2000	02/12/2025	08/13/2024
04-0088	South Arkansas Regional Hosp.	06/30/2000	02/12/2025	08/13/2024
39-0137	WilkesBarre General Hosp.	06/30/2000	02/12/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/2000	02/12/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/2000	02/12/2025	08/13/2024
25-0031	Merit Health River Region	06/30/2000	02/12/2025	08/13/2024
04-0055	Baptist Health-Fort Smith	06/30/2000	02/12/2025	08/13/2024
45-0558	Abilene Regional Med. Ctr.	08/31/2000	02/12/2025	08/13/204
37-0014	AllianceHealth Durant	09/30/2000	02/12/2025	08/13/2024
10-0092	Steward Rockledge Hosp.	09/30/2000	02/12/2025	08/13/2024
11-0075	East Georgia Regional Med. Ctr.	09/30/2000	02/12/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/2000	02/12/2025	08/13/2024
42-0055	MUSC Health Marion Med. Ctr.	09/30/2000	02/12/2025	08/13/2024

04-0022	Northwest Med. Ctr. Springdale	12/31/1999	02/12/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	05/31/1999	02/12/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	12/31/1999	02/12/2025	08/13/2024
45-0702	Longview Regional Med. Ctr.	12/31/1999	02/12/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/1999	02/12/2025	08/13/2024
01-0104	Grandview Med. Ctr.	06/30/1999	02/12/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	05/31/1999	02/12/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	05/31/1999	02/12/2025	08/13/2024

41 **25-2055GC CHS CY 2002 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
25-0031	Merit Health River Region	06/30/2002	02/12/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	12/31/2002	02/12/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/2002	02/12/2025	08/13/2024
25-0042	Delta Health-Northwest Regional	12/31/2002	02/12/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/2002	02/12/2025	08/13/2024
25-0094	Merit Health Wesley	03/31/2002	02/12/2025	08/13/2024
44-0035	Tennova Healthcare – Clarksville	12/31/2002	02/12/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	12/31/2002	02/12/2025	08/13/2024
01-0040	Gadsden Regional Med. Ctr.	12/31/2002	02/12/2025	08/13/2024
25-0138	Merit Health River Oaks	12/31/2002	02/12/2025	08/13/2024

25-0007	Merit Health Biloxi	09/30/2002	02/12/2025	08/13/2024
11-0075	East Georgia Regional Med. Ctr.	09/30/2002	02/12/2025	08/13/2024
44-0120	Physicians Regional Med. Ctr.	12/31/2002	02/12/2025	08/13/2024
51-0071	Bluefield Regional Med. Ctr.	06/30/2002	02/12/2025	08/13/204
50-0012	Yakima Regional Med. Ctr.	12/31/2002	02/12/2025	08/13/2024
45-0702	Longview Regional Med. Ctr.	12/31/2002	02/12/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	12/31/2002	02/12/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	04/30/2002	02/12/2025	08/13/2024
45-0558	Abilene Regional Med. Ctr.	08/31/2002	02/12/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	08/31/2002	02/12/2025	08/13/2024
45-0299	College Station Med. Ctr.	10/31/2002	02/12/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	05/31/2002	02/12/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/2002	02/12/2025	08/13/2024
42-0036	MUSC Health Lancaster Med. Ctr.	11/30/2002	02/12/2025	08/13/2024
37-0094	SSM Health St. Anthony Hospital-Midwest	06/30/2002	02/12/2025	08/13/2024
37-0014	AllianceHealth Durant	09/30/2002	02/12/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	05/31/2002	02/12/2025	08/13/2024
26-0119	Poplar Bluff Med. Ctr.	12/31/2002	02/12/2025	08/13/2024

10-0092	Steward Rockledge Hosp.	09/30/2002	02/12/2025	08/13/2024
04-0022	Northwest Med. Ctr. – Springdale	10/31/2002	02/12/2025	08/13/2024
03-0085	Northwest Med. Ctr.	11/30/2002	02/12/2025	08/13/2024
01-0104	Grandview Med. Ctr.	06/30/2002	02/12/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	05/31/2002	02/12/2025	08/13/2024
15-0047	St. Joseph Health System, LLC	05/31/2002	02/12/2025	08/13/2024
10-0071	Bravera Health Brooksville	09/30/2002	02/12/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/2002	02/12/2025	08/13/2024
15-0017	Lutheran Hosp. of Indiana	06/30/2002	02/12/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	12/31/2002	02/12/2025	08/13/2024
04-0018	Baptist Health – Van Buren	12/31/2002	02/12/2025	08/13/2024
04-0088	South Arkansas Reg. Hosp.	06/30/2002	02/12/2025	08/13/2024

42 **25-2059GC CHS CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
10-0122	North Okaloosa Med. Ctr.	03/31/2006	02/11/2025	08/13/2024
32-0085	Mountain View Regional Med. Ctr.	03/31/2006	02/11/2025	08/13/2024
51-0002	CAMC Greenbrier Valley Med. Ctr., Inc.	04/30/2006	02/11/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	05/31/2006	02/11/2025	08/13/2024
15-0047	St. Joseph Health System, LLC	05/31/2006	02/11/2025	08/13/2024

26-0022	Northeast Regional Med. Ctr.	05/31/2006	02/11/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	05/31/2006	02/11/2025	08/13/2024
44-0067	Lakeway Regional Hosp.	05/31/2006	02/11/2025	08/13/2024
44-0144	Vanderbilt Tullahoma-Harton Hosp.	05/31/2006	02/11/2025	08/13/2024
01-0046	Riverview Regional Med. Ctr.	06/30/2006	02/11/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/2006	02/11/2025	08/13/2024
01-0104	Grandview Med. Ctr.	06/30/2006	02/11/2025	08/13/2024
04-0088	South Arkansas Regional Hosp.	06/30/2006	02/11/2025	08/13/2024
10-0102	Shands Lake Shore Regional Med. Ctr.	06/30/2006	02/11/2025	08/13/204
15-0017	Lutheran Hosp. of Indiana	06/30/2006	02/11/2025	08/13/2024
19-0164	Byrd Regional Hosp.	06/30/2006	02/11/2025	08/13/2024
37-0094	SSM Health St. Anthony Hosp. Midwest	06/30/2006	02/11/2025	08/13/2024
39-0119	Moses Taylor Hosp.	06/30/2006	02/11/2025	08/13/2024
39-0137	WilkesBarre General Hosp.	06/30/2006	02/11/2025	08/13/2024
50-0012	Yakima Regional Medical and Cardiac Ctr.	06/30/2006	02/11/2025	08/13/2024
51-0071	Bluefield Regional Med. Ctr.	06/30/2006	02/11/2025	08/13/2024
03-0101	Western Arizona Regional Med. Ctr.	08/31/2006	02/11/2025	08/13/2024
32-0063	Carlsbad Med. Ctr.	08/31/2006	02/11/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	08/31/2006	02/11/2025	08/13/2024

45-0558	Abilene Regional Med. Ctr.	08/31/2006	02/11/2025	08/13/2024
10-0071	Bravera Health Brooksville	09/30/2006	02/11/2025	08/13/2024
10-0092	Steward Rockledge Hosp.	09/30/2006	02/11/2025	08/13/2024
19-0086	Northern Louisiana Med. Ctr.	09/30/2006	02/11/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/2006	02/11/2025	08/13/2024
25-0084	Merit Health Natchez	09/30/2006	02/11/2025	08/13/2024
34-0144	Davis Regional Med. Ctr.	09/30/2006	02/11/2025	08/13/2024
37-0014	AllianceHealth Durant	09/30/2006	02/11/2025	08/13/2024
42-0010	Carolina Pines Regional Med. Ctr.	09/30/2006	02/11/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/2006	02/11/2025	08/13/2024
42-0055	MUSC Health Marion Med. Ctr	09/30/2006	02/11/2025	08/13/2024
45-0587	Hendrick Med. Ctr. Brownwood	09/30/2006	02/11/2025	08/13/2024
04-0022	Northwest Med. Ctr. Springdale	10/31/2006	02/11/2025	08/13/2024
37-0032	AllianceHealth Deaconess	10/31/2006	02/11/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hospital	10/31/2006	02/11/2025	08/13/2024
45-0299	College Station Med. Ctr.	10/31/2006	02/12/2025	08/13/2024
03-0085	Northwest Med. Ctr.	11/30/2006	02/12/2025	08/13/2024
42-0036	MUSC Health Lancaster Med. Ctr.	11/30/2006	02/12/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	12/31/2006	02/12/2025	08/13/2024
25-0138	Merit Health River Oaks	12/31/2006	02/12/2025	08/13/2024
31-0091	Salem Medical Center	12/31/2006	02/12/2025	08/13/2024

45-0035	Tennova Healthcare – Clarksville	12/31/2006	02/12/2025	08/13/2024
44-0072	Dyersburg Regional Med. Ctr.	12/31/2006	02/12/2025	08/13/2024
44-0120	Physicians Regional Med. Ctr.	12/31/2006	02/12/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	12/31/2006	02/12/2025	08/13/2024
45-0047	Navarro Regional Hosp.	12/31/2006	02/12/2025	08/13/2024
45-0484	Woodland Heights Med. Ctr.	12/31/2006	02/12/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	12/31/2006	02/12/2025	08/13/2024
45-0702	Longview Regional Med. Ctr.	12/31/2006	02/12/2025	08/13/2024

43	**25-2061GC CHS CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
01-0046	Riverview Regional Med. Ctr.	06/30/2008	02/11/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/2008	02/11/2025	08/13/2024
44-0067	Lakeway Regional Hosp.	05/31/2008	02/11/2025	08/13/2024
44-0072	Dyersburg Regional Med. Ctr.	12/31/2008	02/11/2025	08/13/2024
44-0144	Vanderbilt Tullahoma-Harton Hosp.	05/31/2008	02/11/2025	08/13/2024
44-0185	Tennova Healthcare – Cleveland	08/31/2008	02/11/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	12/31/2008	02/11/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	10/31/2008	02/11/2025	08/13/2024
04-0088	South Arkansas Regional Hosp.	06/30/2008	02/11/2025	08/13/2024

19-0086	Northern Louisiana Med. Ctr.	09/30/2008	02/11/2025	08/13/2024
19-0164	Byrd Regional Hosp.	06/30/2008	02/11/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/2008	02/11/2025	08/13/2024
25-0081	Anderson Regional Med. Ctr. South Campus	12/31/2008	02/11/2025	08/13/2024
25-0096	Crossgates River Oaks Hosp.	12/31/2008	02/11/2025	08/13/204
25-0138	Merit Health River Oaks	12/31/2008	02/11/2025	08/13/2024
32-0063	Carlsbad Med. Ctr.	08/31/2008	02/11/2025	08/13/2024
32-0065	Covenant Health Hobbs Hosp.	12/31/2008	02/11/2025	08/13/2024
32-0085	Mountain View Regional Med. Ctr.	03/31/2008	02/11/2025	08/13/2024
37-0032	AllianceHealth Deaconess	10/31/2008	02/11/2025	08/13/2024
37-0094	SSM Health St. Anthony Hosp. – Midwest	06/30/2008	02/11/2025	08/13/2024
45-0299	College Station Med. Ctr.	10/31/2008	02/11/2025	08/13/2024
45-0447	Navarro Regional Hosp.	12/31/2008	02/11/2025	08/13/2024
45-0484	Woodland Heights Med. Ctr.	12/31/2008	02/11/2025	08/13/2024
45-0558	Abilene Regional Med. Ctr.	08/31/2008	02/11/2025	08/13/2024
45-0587	Hendrick Medical Ctr. Brownwood	09/30/2008	02/11/2025	08/13/2024
45-0702	Longview Regional Med. Ctr.	12/31/2008	02/11/2025	08/13/2024

44	**25-2062GC CHS CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**

10-0150	Lower Keys Med. Ctr.	09/30/2009	02/11/2025	08/13/2024
44-0185	Tennova Healthcare - Cleveland	08/31/2009	02/11/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	08/31/2009	02/11/2025	08/13/2024
45-0558	Abilene Regional Med. Ctr.	08/31/2009	02/11/2025	08/13/2024
19-0086	Northern Louisiana Med. Ctr.	09/30/2009	02/11/2025	08/13/2024
25-0007	Merit Health Biloxi	09/30/2009	02/11/2025	08/13/2024
25-0122	Merit Health Natchez-Community Campus	09/30/2009	02/11/2025	08/13/2024
45-0587	Hendrick Med. Ctr. Brownwood	09/30/2009	02/11/2025	08/13/2024
34-0129	Lake Norman Regional Med. Ctr.	09/30/2009	02/11/2025	08/13/2024
42-0043	Cherokee Med. Ctr.	09/30/2009	02/11/2025	08/13/2024
42-0055	MUSC Health Marion Med. Ctr.	09/30/2009	02/11/2025	08/13/2024
37-0032	AllianceHealth Deaconess	10/30/2009	02/11/2025	08/13/2024
45-0299	College Station Med. Ctr.	10/31/2009	02/11/2025	08/13/2024
44-0193	Vanderbilt Wilson County Hosp.	10/31/2009	02/11/2025	08/13/204
04-0055	Baptist Health-Fort Smith	11/30/2009	02/11/2025	08/13/2024
03-0101	Western Arizona Reg. Med. Ctr.	08/31/2009	02/11/2025	08/13/2024
42-0036	MUSC Health Lancaster Med. Ctr.	11/30/2009	02/11/2025	08/13/2024
50-0012	Yakima Regional Medical and Cardiac Ctr.	06/30/2009	02/11/2025	08/13/2024

10-0286	Physicians Regional Medical Center – Pine Ridge	12/31/2009	02/11/2025	08/13/2024
26-0022	Northeast Regional Med. Ctr.	05/31/2009	02/11/2025	08/13/2024
25-0138	Merit Health River Oaks	12/31/2009	02/11/2025	08/13/2024
10-0122	North Oskaloosa Medical Ctr.	03/31/2009	02/11/2025	08/13/2024
10-0124	Santa Rosa Med. Ctr.	05/31/2009	02/11/2025	08/13/2024
45-0447	Navarro Regional Med. Ctr.	12/31/2009	02/11/2025	08/13/2024
39-0137	WilkesBarre General Hosp.	04/30/2009	02/11/2025	08/13/2024
45-0688	Dallas Regional Med. Ctr.	12/31/2009	02/11/2025	08/13/2024
39-0119	Moses Taylor Hospital	06/30/2009	02/11/2025	08/13/2024
42-0083	Mary Black Memorial Hosp.	06/30/2009	02/11/2025	08/13/2024
31-0091	Salem Medical Ctr.	12/31/2009	02/11/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	02/28/2009	02/11/2025	08/13/2024
44-0120	Physicians Regional Med. Ctr.	12/31/2009	02/11/2025	08/13/2024
51-0002	CAMC Greenbrier Valley Med. Ctr.	04/30/2009	02/11/2025	08/13/2024
15-0006	Northwest Health – La Porte	12/31/2009	02/11/2025	08/13/2024
51-0071	Bluefield Reg. Med. Ctr.	06/30/2009	02/11/2025	08/13/2024
01-0038	Stringfellow Memorial Hosp.	06/30/2009	02/11/2025	08/13/2024
01-0046	Riverview Reg. Med. Ctr.	06/30/2009	02/11/2025	08/13/2024
01-0055	Flowers Hosp.	06/30/2009	02/11/2025	08/13/2024
44-0067	Lakeway Reg. Hosp.	05/31/2009	02/11/2025	08/13/2024

44-0144	Vanderbilt Tullahoma-Harton Hosp.	05/31/2009	02/11/2025	08/13/2024
04-0088	South Arkansas Reg. Hosp.	06/30/2009	02/11/2025	08/13/2024
19-0164	Byrd Regional Hosp.	06/30/2009	02/11/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	05/31/2009	02/11/2025	08/13/2024
32-0085	Mountain View Reg. Med. Ctr.	03/31/2009	02/11/2025	08/13/2024
37-0006	Integris Health Ponca City	05/31/2009	02/11/2025	08/13/2024
37-0094	SSM Health St. Anthony	06/30/2009	02/11/2025	08/13/2024

45 **25-2064GC CHS CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
34-0129	Lake Norman Regional Med. Ctr.	09/30/2011	02/11/2025	08/13/2024
34-0144	Davis Regional Med. Ctr.	09/30/2011	02/11/2025	08/13/2024
37-0006	Integris Health Ponca City	05/31/2011	02/11/2025	08/13/2024
37-0032	AllianceHealth Deaconess	10/31/2011	02/11/2025	08/13/2024
39-0119	Moses Taylor Hospital	06/30/2011	02/11/2025	08/13/2024
39-0119	Moses Taylor Hospital	12/31/2011	02/11/2025	08/13/2024
39-0137	WilkesBarre General Hosp.	06/30/2011	02/11/2025	08/13/2024
42-0036	MUSC Health Lancaster Med. Ctr.	11/30/2011	02/11/2025	08/13/2024
42-0083	Mary Black Memorial Hosp.	06/30/2011	02/11/2025	08/13/2024
44-0067	Lakeway Regional Hosp.	05/31/2011	02/11/2025	08/13/2024
44-0072	Dyersburg Regional Med. Ctr.	01/31/2011	02/11/2025	08/13/2024
44-0144	Vanderbilt Tullahoma-Harton Hosp.	05/31/2011	02/11/2025	08/13/2024

45-0299	College Station Med. Ctr.	10/31/2011	02/11/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	08/31/2011	02/11/2025	08/13/204
45-0447	Navarro Regional Hosp.	12/31/2011	02/11/2025	08/13/2024
45-0484	Woodland Heights Med. Ctr.	12/31/2011	02/11/2025	08/13/2024
45-0587	Hendrick Med. Ctr. Brownwood	09/30/2011	02/11/2025	08/13/2024
51-0002	CAMC Greenbrier Valley Med. Ctr.	04/30/2011	02/11/2025	08/13/2024

46 **25-2065GC CHS CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
37-0032	Alliance Health Deaconess	10/31/2012	02/11/2025	08/13/2024
02-0006	Mat-Su Regional Med. Ctr.	12/31/2012	02/11/2025	08/13/2024
03-0085	Northwest Med. Ctr.	09/30/2012	02/11/2025	08/13/2024
03-0101	Western Arizona Reg. Med. Ctr.	08/31/2012	02/11/2025	08/13/2024
04-0088	South Arkansas Reg. Med. Ctr.	06/30/2012	02/11/2025	08/13/2024
10-0121	Bartow Reg. Med. Ctr.	03/31/2012	02/11/2025	08/13/2024
10-0286	Physicians Reg. Med. Ctr. – Pine Ridge	12/31/2012	02/11/2025	08/13/2024
15-0006	Northwest Health – La Porte	12/31/2012	02/11/2025	08/13/2024
15-0035	Northwest Health – Porter	12/31/2012	02/11/2025	08/13/2024
19-0164	Byrd Regional Hosp.	07/31/2012	02/11/2025	08/13/2024
25-0122	Merit Helath Natchez-Community Campus	09/30/2012	02/11/2025	08/13/2024

26-0022	Northeast Reg. Med. Ctr.	05/31/2012	02/11/2025	08/13/2024
31-0091	Salem Med. Ctr.	12/31/2012	02/11/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	05/31/2012	02/11/2025	08/13/204
32-0065	Covenant Health Hobbs Hosp.	12/31/2012	02/11/2025	08/13/2024
37-0006	Integris Health Ponca City	05/31/2012	02/11/2025	08/13/2024
39-0119	Moses Taylor Hosp.	06/30/2012	02/11/2025	08/13/2024
39-0137	Wilkes Barre General Hosp.	06/30/2012	02/11/2025	08/13/2024
42-0083	Mary Black Memorial Hosp.	06/30/2012	02/11/2025	08/13/2024
44-0072	Dyersburg Reg. Med. Ctr.	01/31/2012	02/11/2025	08/13/2024
45-0340	San Angelo Community Med. Ctr.	08/31/2012	02/11/2025	08/13/2024
45-0484	Woodland Heights Med. Ctr.	12/31/2012	02/11/2025	08/13/2024
45-0587	Hendrick Med. Ctr. Brownwood	09/30/2012	02/11/2025	08/13/2024
51-0002	CAMC Greenbrier Valley Med. Ctr., Inc.	04/30/2012	02/11/2025	08/13/2024

47	**25-2066GC CHS CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**			
Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
44-0072	Dyersburg Reg. Med. Ctr.	01/31/2013	02/11/2025	08/13/2024
10-0122	North Okaloosa Med. Ctr.	03/31/2013	02/11/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	03/31/2013	02/11/2025	08/13/2024
51-0002	CAMC Greenbrier Valley Med. Ctr., Inc.	04/30/2013	02/11/2025	08/13/2024
37-0006	Integris Health Ponca City	05/31/2013	02/11/2025	08/13/2024

26-0022	Northeast Reg. Med. Ctr.	05/31/2013	02/11/2025	08/13/2024
10-0249	Bayfront Health Seven Rivers	05/31/2013	02/11/2025	08/13/2024
44-0067	Lakeway Reg. Hosp.	05/31/2013	02/11/2025	08/13/2024
04-0088	South Arkansas Regional Hosp.	06/30/2013	02/11/2025	08/13/2024
42-0083	Mary Black Memorial Hosp.	06/30/2013	02/11/2025	08/13/2024
19-0164	Byrd Regional Hosp.	07/31/2013	02/11/2025	08/13/2024
45-0587	Hendrick Med. Ctr. Brownwood	09/30/2013	02/11/2025	08/13/2024
45-0702	Longview Regional Med. Ctr.	12/31/2013	02/11/2025	08/13/2024
45-0447	Navarro Reg. Med. Ctr.	12/31/2013	02/11/2025	08/13/204
31-0091	Salem Med. Ctr.	12/31/2013	02/11/2025	08/13/2024
45-0484	Woodland Heights Med. Ctr.	12/31/2013	02/11/2025	08/13/2024
15-0006	Northwest Health – La Porte	12/31/2013	02/11/2025	08/13/2024

48 **25-2066GC CHS CY 2014 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	**Provider Name**	**FYE**	**Date of Direct Add**	**Date of Transmittal**
45-0029	Laredo Med. Ctr.	09/30/2014	02/12/2025	08/13/2024
10-0032	Bayfront Health – St. Petersburg	03/31/2014	02/12/2025	08/13/2024
25-0072	Merit Health Central	03/31/2014	02/12/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	02/28/2014	02/12/2025	08/13/2024
25-0031	Merit Health River Region	06/30/2014	02/12/2025	08/13/2024
42-0091	MUSC Health Florence Med. Ctr.	06/30/2014	02/12/2025	08/13/2024
25-0094	Merit Health Wesley	03/31/2014	02/12/2025	08/13/2024
32-0085	Mountain View Reg. Med. Ctr.	03/31/2014	02/12/2025	08/13/2024

50-0044	Deaconess Med. Ctr.	09/30/2014	02/12/2025	08/13/2024
04-0022	Northwest Med. Ctr. – Springdale	10/31/2014	02/12/2025	08/13/2024
44-0189	Regional Hosp. of Jackson	01/31/2014	02/12/2025	08/13/2024
26-0119	Poplar Bluff Reg. Med. Ctr.	12/31/2014	02/12/2025	08/13/2024
01-0104	Grandview Med. Ctr.	06/30/2014	02/12/2025	08/13/2024
15-0017	Lutheran Hosp. of Indiana	06/30/2014	02/12/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	05/31/2014	02/12/2025	08/13/2024
04-0055	Baptist Health-Fort Smith	09/30/2014	02/12/2025	08/13/2024
01-0040	Gadsden Reg. Med. Ctr.	09/30/2014	02/12/2025	08/13/2024
50-0012	Yakima Reg. Medical and Cardiac Ctr.	06/30/2014	02/12/2025	08/13/2024
39-0119	Moses Taylor Hosp.	06/30/2014	02/12/2025	08/13/2024
39-0137	WilkesBarre Gen. Hosp.	06/30/2014	02/12/2025	08/13/2024
25-0042	Delta Health-Northwest Reg.	12/31/2014	02/12/2025	08/13/2024
10-0122	North Okaloosa Med. Ctr.	03/31/2014	02/12/2025	08/13/2024
15-0047	St. Joseph Health System, LLC	05/31/2014	02/12/2025	08/13/2024
37-0014	AllianceHealth Durant	09/30/2014	02/12/2025	08/13/2024
51-0071	Bluefield Reg. Med. Ctr.	06/30/2014	02/12/2025	08/13/2024
51-0002	CAMC Greenbrier Valley Med. Ctr.	04/30/2014	02/12/2025	08/13/2024
44-0072	Dyersburg Reg. Med. Ctr.	01/31/2014	02/12/2025	08/13/2024
11-0075	East Georgia Reg. Med. Ctr.	09/30/2014	02/12/2025	08/13/2024

Prov No.	Provider Name	FYE	Date of Direct Add	Date of Transmittal
26-0119	Poplar Bluff Med. Ctr.	12/31/2015	02/12/2025	08/13/2024
03-0085	Northwest Med. Ctr.	09/30/2015	02/12/2025	08/13/2024
50-0044	Deaconess Med. Ctr.	09/30/2015	02/12/2025	08/13/2024
10-0032	Bayfront Health St. Petersburg	09/30/2015	02/12/2025	08/13/2024
10-0062	AdventHealth Ocala	09/30/2015	02/12/2025	08/13/2024
42-0091	MUSC Health Florence Med. Ctr.	06/30/2015	02/12/2025	08/13/2024
49-0067	Bon Secours Southside Med. Ctr.	02/28/2015	02/12/2025	08/13/2024
01-0040	Gadsden Reg. Med. Ctr.	09/30/2015	02/12/2025	08/13/2024
01-0104	Grandview Med. Ctr.	06/30/2015	02/12/2025	08/13/2024
44-0120	Physicians Reg. Med. Ctr.	09/30/2015	02/12/2025	08/13/2024
04-0022	Northwest Med. Ctr. – Springdale	10/31/2015	02/12/2025	08/13/2024
04-0055	Baptist Health – Fort Smith	09/30/2015	02/12/2025	08/13/2024
25-0031	Merit Health River Region	06/30/2015	02/12/2025	08/13/2024
25-0042	Delta Health-Northwest Regional	12/31/2015	02/12/2025	08/13/2024
25-0072	Merit Health Central	09/30/2015	02/12/2025	08/13/2024
25-0094	Merit Health Wesley	03/31/2015	02/12/2025	08/13/2024
32-0006	Eastern New Mexico Med. Ctr.	05/31/2015	02/12/2025	08/13/2024
32-0085	Mountain View Reg. Med. Ctr.	03/31/2015	02/12/2025	08/13/2024
45-0029	Laredo Med. Ctr.	09/30/2015	02/12/2025	08/13/2024

Appendix C

Groups that Were not Timely Established

01	**25-2568GC CHS CY 2015 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
02	**25-2569GC CHS CY 2016 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
03	**25-2570GC CHS CY 2017 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
04	**25-2571GC CHS CY 2018 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
05	**25-2572GC CHS CY 2019 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
06	**25-2573GC CHS CY 2020 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
07	**25-2574GC CHS CY 2021 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
08	**25-2575GC CHS CY 2022 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
09	**25-2576GC CHS CY 2023 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Appendix D

Providers with Incorrect Transfer Letters of Representation

1	**25-2056GC CHS CY 2003 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
01-0055	Flowers Hospital	25-2011	06/23/2025

2	**25-2058GC CHS CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
51-0002	CAMC Greenbrier Valley Med. Ctr.	25-2049	06/25/2025

3	**25-2060GC CHS CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
10-0092	Steward Rockledge Hosp.	25-1517	06/23/2025

4	**25-2061GC CHS CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
10-0092	Steward Rockledge Hosp.	25-1512	06/23/2025

5	**25-2062GC CHS CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
10-0049	HCA Florida Highlands Hosp	25-1537	06/23/2025
10-0071	Bravera Health Brooksville	25-1553	06/23/2025
10-0092	Steward Rockledge Hosp.	25-1523	06/24/2025
10-0107	Lehigh Regional Med. Ctr.	25-1571	06/24/2025

10-0302	Orlando Health St. Cloud Hosp.	25-1538	06/24/2025
25-0042	Delta Health-Northwest Reg.	25-1602	06/24/2025
25-0081	Anderson Reg. Med. Ctr. South Campus	25-1613	06/24/2025
25-0096	Crossgates River Oaks Hosp.	25-1615	06/24/2025
26-0015	Twin Rivers Reg. Med. Ctr.	25-1651	06/24/2025
34-0144	Davis Reg. Med. Ctr.	25-1614	06/24/2025
42-0010	Carolina Pines Med. Ctr.	25-1570	06/25/2025
50-0012	Yakima Reg. Medical and Cardiac Ctr.	25-1603	06/25/2025

6 **25-2063GC CHS CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Transfer Request
01-0038	Stringfellow Memorial Hosp.	25-1519	06/23/2025
01-0046	Riverview Reg. Med. Ctr.	25-1527	06/23/2025
10-0071	Bravera Health Brooksville	25-1555	06/23/2025
10-0107	Lehigh Regional Med. Ctr.	25-1573	06/23/2025
10-0092	Steward Rockledge Hosp.	25-1526	06/23/2025
10-0124	Santa Rosa Med. Ctr.	25-1543	06/23/2025
25-0081	Anderson Reg. Med. Ctr. South Campus	25-1613	06/24/2025
25-0096	Crossgates River Oaks Hosp.	25-1615	06/24/2025
26-0015	Twin Rivers Reg. Med. Ctr.	25-1651	06/24/2025
34-0144	Davis Reg. Med. Ctr.	25-1614	06/24/2025
42-0010	Carolina Pines Med. Ctr.	25-1570	06/25/2025

50-0012	Yakima Reg. Medical and Cardiac Ctr.	25-1603	06/25/2025

7	**25-2064GC CHS CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
01-0038	Stringfellow Memorial Hosp.	25-1522	06/23/2025
01-0046	Riverview Reg. Med. Ctr.	25-1528	06/23/2025
10-0071	Bravera Health Brooksville	25-1559	06/23/2025
10-0107	Lehigh Regional Med. Ctr.	25-1576	06/23/2025
10-0092	Steward Rockledge Hosp.	25-1529	06/23/2025
25-0007	Merit Health Biloxi	25-1590	06/24/2025
25-0138	Merit Health River Oaks	25-1641	06/24/2025
25-0096	Crossgates River Oaks Hosp.	25-1621	06/25/2025
37-0094	SSM Health St. Anthony Hosp. – Midwest	25-1627	06/25/2025
39-0058	UPMC Carlisle	25-1547	06/25/2025
39-0061	Lancaster Regional Med. Ctr.	25-1552	06/25/2025
39-0068	UPMC Lititz	25-1565	06/25/2025
42-0010	Carolina Pines Reg. Med. Ctr.	25-1574	06/25/2025
44-0193	Vanderbilt Wilson County Hosp.	25-1591	06/25/2025
45-0688	Dallas Reg. Med. Ctr.	25-1598	06/25/2025
50-0012	Yakima Reg. Medical and Cardiac Ctr.	25-1606	06/25/2025

8	**25-2065GC CHS CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**

01-0038	Stringfellow Memorial Hosp.	25-1524	06/23/2025
01-0046	Riverview Reg. Med. Ctr.	25-1530	06/23/2025
10-0071	Bravera Health Brooksville	25-1564	06/23/2025
10-0107	Lehigh Regional Med. Ctr.	25-1579	06/23/2025
10-0249	Bayfront Health Seven Rivers	25-1551	06/23/2025
25-0007	Merit Health Biloxi	25-1592	06/24/2025
25-0138	Merit Health River Oaks	25-1645	06/24/2025
25-0096	Crossgates River Oaks Hosp.	25-1624	06/24/2025
25-0136	Merit Health Women's Hosp.	25-1635	06/24/2025
34-0144	Davis Reg. Med. Ctr.	25-1617	06/24/2025
37-0014	AllianceHealth Durant	25-1623	06/24/2025
39-0061	Lancaster Reg. Med. Ctr.	25-1556	06/25/2025
39-0068	UPMC Lititz	25-1567	06/25/2025
42-0010	Carolina Pines Reg. Med. Ctr.	25-1577	06/25/2025
42-0019	MUSC Health Chester Med. Ctr.	25-1581	06/25/2025
44-0033	Lafollette Med. Ctr.	25-1540	06/25/2025
44-0120	Physicians Reg. Med. Ctr.	25-1542	06/25/2025
44-0193	Vanderbilt Wilson County Hosp.	25-1594	06/25/2025
45-0688	Dallas Reg. Med. Ctr.	25-1599	06/25/2025
50-0012	Yakima Reg. Medical and Cardiac Ctr.	25-1610	06/25/2025

9	**25-2066GC CHS CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**

01-0040	Gadsden Reg. Med. Ctr.	25-2009	06/23/2025
01-0046	Riverview Reg. Med. Ctr.	25-1532	06/23/2025
10-0071	Bravera Health Brooksville	25-1568	06/23/2025
10-0092	Steward Rockledge Hosp.	25-1531	06/23/2025
10-0107	Lehigh Regional Med. Ctr.	25-1582	06/23/2025
10-0124	Santa Rosa Med. Ctr.	25-1546	06/23/2025
10-0150	Lower Keys Med. Ctr.	25-1539	06/23/2025
25-0007	Merit Health Biloxi	25-1596	06/24/2025
25-0025	North Mississippi Med. Ctr. – Gilmore Armory	25-1541	06/24/2025
25-0038	Merit Health Madison	25-1600	06/24/2025
25-0042	Delta Health-Northwest Reg.	25-1609	06/24/2025
25-0096	Crossgates River Oaks Hosp.	25-1626	06/24/2025
25-0122	Merit Health Natzhez-Community Campus	25-1608	06/24/2025
25-0138	Merith Health River Oaks	25-1648	06/24/2025
34-0129	Lake Norman Reg. Med. Ctr.	25-1612	06/24/2025
34-0144	Davis Reg. Med. Ctr.	25-1620	06/24/2025
39-0061	Lancaster Reg. Med. Ctr.	25-1558	06/25/2025
42-0010	Carolina Pines Reg. Med. Ctr.	25-1580	06/25/2025
42-0019	MUSC Health Chester Med. Ctr.	25-1585	06/25/2025
44-0153	Tennova Healthcare – Newport Med. Ctr.	25-2035	06/25/2025

44-0193	Vanderbilt Wilson County Hosp.	25-1595	06/25/2025
45-0688	Dallas Regional Med. Ctr.	25-1601	06/25/2025

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Corinna Goron
Healthcare Reimbursement Services, Inc.
3900 American Drive, Suite 202
Plano, TX 75075

RE: ***Dismissal of Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Groups***
25-2397GC *et al.* (*See* Attached Listing of 19 Cases)

Dear Ms. Goron:

The Provider Reimbursement Review Board (the "Board") has reviewed the appeal requests in the 19 above-referenced cases. Set forth below is the decision of the Board to dismiss the above-captioned common issue related party ("CIRP") group appeals. The pertinent facts and the Board's determination are set forth below.

Introduction

Healthcare Reimbursement Services, Inc. ("HRS") filed the above-referenced 19 CIRP group appeals in the Office of Hearings Case & Document Management System ("OH CDMS"). The issue statements in these groups are materially identical. The Providers contend that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to 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. 25-2397GC, Providers' Issue Statement at 1 (Feb. 10, 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] This case involves 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 Transmittal 12785

The Providers in these groups state that they are appealing from the publication of Medicare/SSI Fractions on CMS' website on August 13, 2024, that was done pursuant to CMS Transmittal 12785, "Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013." Transmittal 12785 replaced and updated Transmittal 12747 that was originally issued on July 26, 2024. The original 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.

The original Transmittal 12747 which Transmittal 12785 updates 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).

Medicare Contractor Jurisdictional Challenge

The Transmittal is Not an Appealable Final Determination

The Medicare Contractor asserts that the Board does not have jurisdiction over the issue in these group appeals because "the appeal does not arise from a 'final determination' as that term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 1835(a) (as also cross-referenced in 42 C.F.R. § 405.1837(a)(1))."[14] The Medicare Contractor explains that the Providers appealed from Transmittal 12747 and/or Transmittal 12785, and argues that these documents are not appealable final determinations.[15]

The Medicare Contractor also argues that the court decisions the Providers referenced in their appeals are inapplicable to the instant appeals. The Medicare Contractor explains that the Providers recognized the Board's previous dismissal of appeals from the publication of SSI percentages by quoting the Groups' issue statements, stating:

> The Provider [Group] is aware that the PRRB has taken the position that the publication of SSI Ratio is not a final determination and that providers must await a Notice of Program Reimbursement (NPR) setting its total reimbursement before challenging its Medicare Fraction, but the Provider [Group] respectfully submits that the PRRB is incorrect, as decided in two recent court decisions. *See Battle Creek Health Sys. v. Becerra*, Civil Action 17-0545 (CKK) (D.D.C. Oct. 31, 2023); *Baylor All Saints Med Ctr. v. Becerra,* Civil Action 4:24-cv-00432-P (N.D. TX Aug. 15, 2-24).[16]

The Medicare Contractor points to a prior Board decision in which it distinguished the decision in *Battle Creek* from the facts of the appeal before the Board, and argues that the Board should make a similar finding here with respect to the applicability of *Battle Creek* to these transmittal appeals.[17] With respect to *Baylor All Saints*, the Medicare Contractor argues that "[b]ecause the Court failed to address the statutory requirements for Board jurisdiction, the Providers' reliance on [the case] is without merit."[18]

Next, the Medicare Contractor argues that even if the Transmittals constituted an appealable final determination, the appeals were not timely filed. The final determination support included for each Provider in these groups is a copy of either the July 26, 2024 CMS Transmittal 12747 or the August 13, 2024 Transmittal 12785, both of which implement the Medicare Part C final rule which was issued on June 9, 2023.[19]

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[14] *See, e.g.*, Case No. 25-2397GC, Jurisdictional Challenge at 2 (May 1, 2025).
[15] *Id.*
[16] *Id.* at 5.
[17] *Id.* at 5-6.
[18] *Id.* at 6.
[19] *Id.*at 6-7.

Providers' Jurisdictional Response

The Providers explain that they are "aware that the [Board] has taken the position that the "publication of SSI ratio is not a final determination and that providers must await a [NPR] setting its total reimbursement before challenging its Medicare fraction," but argues that the Board is incorrect based on the decisions in *Battle Creek Health Sys. v. Becerra*, Civil Action 17-0545 (CKK) (D.D.C. Oct. 31, 2023) and *Baylor All Saints Med Ctr. v. Becerra,* Civil Action 4:24-cv-00432-P (N.D. TX Aug. 15, 2024).[20] The Providers continue by arguing:

> The fundamental flaw in the PRRB's conclusion that providers must wait to receive an NPR is that romanette (i) of section 1878(a)(1)(A) of the Act already requires an NPR for an intermediary determination. The PRRB's approach renders romanette (ii) superfluous – a cardinal sin when it comes to statutory interpretation. As for the idea that the SSI Ratio determination is not a determination "as to the amount of payment" within the meaning of romanette (ii) because it does not resolve every remaining variable that would affect DSH payments, that finds no basis in the statutory text, its context or its purpose. Congress was quite aware of the DSH payment adjustment when it enacted romanette (ii), and there is no indication that Congress intended to except DSH determinations from the clear rule under romanette (ii) that PPS determinations "as to" the amount of payment (broad language indeed).[21]

Last, the Providers acknowledge that some of the appeals were filed 183 days after the issuance of the Change Request, however the Providers were not aware of the Change Request until several days later, thus the appeals were filed "within 180 days of receipt of the Change Request."[22]

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 12785 on August 13, 2024, "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 Group "is dissatisfied with this determination . . . the PRRB has jurisdiction over this appeal."[23] However, the publication of Medicare/SSI Fractions in conjunction with Transmittal 12785, which merely requires a formatting change to the Medicare/SSI Fraction data posted on CMS' website so that the "SSI

[20] *See, e.g.,* Case No. 25-2397GC, Providers' Response to Jurisdictional Challenge at 1 (June 2, 2025).
[21] *Id.* at 1-2.
[22] *Id.* at 2.
[23] *See e.g.* Case No 25-2397GC, Providers' Issue Statement at 1.

Ratio column is consistently rounded to four (4) decimals in all files" is 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 19 groups.

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);[24] and second, where the provider is dissatisfied with a "final determination" "as to the amount of the payment" under the prospective payment system.[25] In this case, the Providers in these groups 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 Transmittal 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."[26] But the Providers also note disagreement with the Board's position, citing *Battle Creek Health Sys. v. Becerra*,[27] and *Baylor All Saints Med. Ctr. v. Becerra*,[28] 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.[29]

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*."[30] 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."[31] On appeal, however, the 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.[32]

The Court also distinguished *Battle Creek* from *Washington Hospital Center*, and continued:

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[24] 42 U.S.C. § 1395oo(a)(1)(A)(i).
[25] *Id*. § 1395oo(a)(1)(A)(ii).
[26] *See e.g.* Case No. 25-2397GC, Providers' Issue Statement at 1.
[27] 2023 WL 7156125 (D.D.C. Oct. 31, 2023), *rev'd*, No. 23-5310, 2025 WL 2423686 (D.C. Cir. Aug. 22, 2025).
[28] 2024 WL 3833278 (N.D. Tex. Aug. 15, 2024), *appeal docketed*, No. 34-10934 (5th Cir. Oct. 17, 2024).
[29] *See e.g.* Case No 25-2397GC, Providers' Issue Statement at 1.
[30] *Battle Creek*, 2023 WL 7156125 at *5.
[31] *Id*.
[32] *Battle Creek Health Sys. v. Kennedy*, No. 23-5310, 2025 WL 2423686, at *1 (D.C. Cir. Aug. 22, 2025).

> 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).[33]

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*.[34] The Board maintains that *Memorial Hospital v. Becerra*,[35] 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 19 groups. 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.

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.'"[36] 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."[37] 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

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[33] *Id.* at *6.
[34] *See, e.g.*, Board decisions in PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.
[35] 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[36] *Id*. at *8.
[37] *Id*. at *9.

ha[s] firmly established 'the only variable factor in the final determination as to the amount of payment under § 1395ww(d).'"[38]

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 final a 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.[39] 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 August 13, 2024, pursuant to 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."[40] Transmittal 12785 bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 in order to ensure that the SSI Ratio column is consistently rounded to four decimals in all files. This information is published so that providers have sufficient information available to inform whether they want to request realignment. Providers cannot claim that with publication of Medicare/SSI Fraction data on CMS' website in a new decimal format pursuant to Transmittal 12785, they are somehow "dissatisfied with a final determination of Secretary as to the amount of payment."[41]

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

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[38] *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).").

[39] 42 C.F.R. § 412.106(d)(2)(i)-(ii).

[40] *See e.g.* Case No. 25-2397GC, 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.

[41] *See* 42 U.S.C. § 1395oo(a)(1)(A)(ii).

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). Moreover, appeal of Transmittal 12785 which only rounded the published Medicare/SSI Fraction data to four decimal places, concerns only one factor of the DPP and is almost certainly unlikely to result in a change in DSH reimbursement sufficient to meet the amount in controversy required for a group appeal ($50,000 or more).[42] 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.

B. Appeals Not Timely Filed

Assuming *arguendo* that the Providers could persuade the Board that the Transmittals and accompanying SSI Fraction data are final appealable determinations, the Board must still dismiss the majority of the Providers' appeals because such appeal requests would be untimely. Pursuant to 42 U.S.C. § 1395oo(a)(3), a provider's request for a hearing must be filed within 180 days of the date of receipt of the final determination.[43] Given the nature of the Groups' challenge, it appears that they are actually challenging Final Ruling CMS-1739-F rather than the Transmittals and accompanying SSI Fraction data. The Transmittals merely implement the Ruling in providing the providers with SSI Fractions recalculated or "realigned" based on the hospitals' cost reporting period instead of the federal fiscal year. Final Ruling CMS-1739-F was issued June 9, 2023, and the Providers' appeals were all filed in early 2025, long past the expiration of the 180-day period to file an appeal. Moreover, CMS Transmittal 12747 was originally issued on July 26, 2024, and a large majority of the Providers filed their appeals between February 5 and 14, 2025, nearly two weeks or more after the 180-day period had expired, if calculated from that date. Even if such Providers were to argue that the appeals were timely based on the later issuance of Transmittal 12785 on August 13, 2024, this Transmittal bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 so that the SSI Ratio column is consistently rounded to four decimals in all files.

Additionally, here, there are eight (8) groups[44] that were established on February 13, 2025, and with Providers that were all directly added on that same date, which is 184 days from the August 13, 2024 Transmittal date. Even if the Board were to have found that the Transmittal is an appealable final determination, the Board would find that the groups listed in Appendix B, and all of the Providers therein, did not timely file their appeals.

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[42] *See* 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).
[43] *See also* 42 C.F.R. § 405.1835(a)(3).
[44] Groups are listed in Appendix B.

42 C.F.R. § 405.1835(a)(3) indicates that, "unless the Provider qualifies for a good cause extension", the Board must receive a Provider's hearing request "***no later than 180 days after the date of receipt by the Provider of the final contractor or Secretary determination.***"[45]

Board Rule 4.3, Commencement of Appeal Period, specifies various types of final determinations and states:

> 4.3.1 **Contractor/CMS/Secretary Final Determination**
>
> Final Determinations include:
> - Notices of Program Reimbursement;
> - Revised Notices of Program Reimbursement;
> - Exception Determinations;
> - Quality Reporting Program Payment Reduction Determinations; and
> - Other determinations issued by CMS or its ***contractors with regard to the amount of total reimbursement due the provider***.
>
> The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).[46]

This rule also explains that there is no five (5) day mailing presumption for appeals from Federal Register Notices:

> 4.3.2 **Federal Register Notice**
>
> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the ***date of publication*** and ends 180 days from that date.[47]

Board Rule 4.5, Date of Receipt by the Board, states that "[t]he timeliness of a filing is determined based on the date of receipt by the Board," and "[t]he date of receipt is presumed to be [] the date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system."[48]

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[45] Emphasis added.
[46] Emphasis added.
[47] Emphasis added.
[48] *See also* 42 C.F.R. § 405.1801(a)(2)(iii).

Here, the Board finds that the Transmittal, if it were an appealable final determination, is akin to a Federal Register Notice appeal, thus there is no 5-day mailing presumption. If that is the case, then the Providers that were directly added to the group appeals on February 13, 2025, which is 184 days from the August 13, 2024 Transmittal date, were not timely filed and the groups were not timely established.

Conclusion

As the Medicare/SSI Fraction data published pursuant to Transmittal 12785 is not an appropriately appealable final determination, the Providers have failed to meet the jurisdictional requirements for a hearing. Further, the Board finds that the groups included in Appendix B were not timely established. Thus, the Board hereby dismisses the 19 group 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.

FOR THE BOARD:

9/29/2025

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
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source

Enclosures: Appendix A – Listing of 19 Cases
Appendix B – Groups Not Timely Established

Appendix A

Listing of 19 Cases

25-2397GC	LSU Health CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2399GC	LSU Health CY 2006 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2408GC	LSU Health CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2409GC	LSU Health CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2412GC	LSU Health CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2418GC	LSU Health CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2422GC	LSU Health CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2424GC	LSU Health CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2425GC	Willis-Knighton CY 2005 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2426GC	Willis-Knighton CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2427GC	LSU Health CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2622GC	Franciscan Missionaries CY 2006 Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Group
25-2625GC	Franciscan Missionaries CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2629GC	Franciscan Missionaries CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2637GC	Franciscan Missionaries CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2646GC	Franciscan Missionaries CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2649GC	Franciscan Missionaries CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2650GC	Franciscan Missionaries CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-2653GC	Franciscan Missionaries CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

Appendix B

Groups that Were not Timely Established

01	**25-2622GC Franciscan Missionaries CY 2006 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
02	**25-2625GC Franciscan Missionaries CY 2007 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
03	**25-2629GC Franciscan Missionaries CY 2008 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
04	**25-2637GC Franciscan Missionaries CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
05	**25-2646GC Franciscan Missionaries CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
06	**25-2649GC Franciscan Missionaries CY 2011 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
07	**25-2650GC Franciscan Missionaries CY 2012 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**
08	**25-2653GC Franciscan Missionaries CY 2013 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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

RE: ***Dismissal of Medicare Fraction (SSI) – Statutory & Systemic Errors CIRP Groups***
25-5044G *et al.* (*See* Attached Listing of 12 Cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the "Board") has reviewed the appeal requests in the 12 above-referenced cases. Set forth below is the decision of the Board to dismiss the above-captioned optional and common issue related party ("CIRP") group appeals. The pertinent facts and the Board's determination are set forth below.

Introduction

Quality Reimbursement Services, Inc. ("QRS") filed the above-referenced 12 optional and CIRP group appeals in the Office of Hearings Case & Document Management System ("OH CDMS"). The issue statements in these groups are materially identical. The Providers contend that the Medicare/SSI Fractions published on CMS' website on August 13, 2024, pursuant to 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. 25-5044G, Providers' Issue Statement at 1 (July 19, 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] This case involves 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 Transmittal 12785

The Providers in these groups state that they are appealing from the publication of Medicare/SSI Fractions on CMS' website on August 13, 2024, that was done pursuant to CMS Transmittal 12785, "Instructions for Processing Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013." Transmittal 12785 replaced and updated Transmittal 12747 that was originally issued on July 26, 2024. The original 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.

The original Transmittal 12747 which Transmittal 12785 updates 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:

The Board has reviewed jurisdiction in these 12 appeals on its own motion, noting that no Jurisdictional Challenges were filed by the applicable Medicare contractors.

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 12785 on August 13, 2024, "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 Group "is dissatisfied with this determination . . . the PRRB has jurisdiction over" this appeal.[14] However, the publication of Medicare/SSI Fractions in conjunction with 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" is 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 12 groups.

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 this case, the Providers in these groups 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 Transmittal 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

[14] *See e.g.* Case No 25-5044G, Providers' 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 25-5044G, Providers' 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 25-5044G, Providers' Issue Statement at 1.
[21] *Battle Creek*, 2023 WL 7156125 at *5.

finality, advance knowledge of the amount of [the DSH] payment."[22] On appeal, however, the 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 12 groups. 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

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[22] *Id*.
[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 PRRB Case Nos. 24-0491, 24-1531GC, and 24-0413GC.
[26] 2022 WL 888190 (D.D.C. Mar. 25, 2022).

in *Memorial Hospital* ultimately agreed with the Board that CMS' publication of Medicare/SSI Fractions was not an appealable final determination.

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 August 13, 2024, pursuant to 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."[31] Transmittal 12785 bears no connection to

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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 25-5044G, 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

the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 in order to ensure that the SSI Ratio column is consistently rounded to four decimals in all files. This information is published so that providers have sufficient information available to inform whether they want to request realignment. Providers cannot claim that with publication of Medicare/SSI Fraction data on CMS' website in a new decimal format pursuant to Transmittal 12785, 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). Moreover, appeal of Transmittal 12785 which only rounded the published Medicare/SSI Fraction data to four decimal places, concerns only one factor of the DPP and is almost certainly unlikely to result in a change in DSH reimbursement sufficient to meet the amount in controversy required for a group appeal ($50,000 or more).[33] 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.

B. Appeals Not Timely Filed

1. Groups Not Timely Filed From Final Ruling CMS-1739-F

Assuming *arguendo* that the Providers could persuade the Board that the Transmittals and accompanying SSI Fraction data are final appealable determinations, the Board must still dismiss the majority of the Providers' appeals because such appeal requests would be untimely. Pursuant to 42 U.S.C. § 1395oo(a)(3), a provider's request for a hearing must be filed within 180 days of the date of receipt of the final determination.[34] Given the nature of the Groups' challenge, it appears that they are actually challenging Final Ruling CMS-1739-F rather than the Transmittals and accompanying SSI Fraction data. The Transmittals merely implement the Ruling in providing the providers with SSI Fractions recalculated or "realigned" based on the hospitals' cost reporting period instead of the federal fiscal year. Final Ruling CMS-1739-F was issued June 9, 2023, and the Providers' appeals were all filed in early 2025, long past the expiration of the 180-day period to file an appeal. Moreover, CMS Transmittal 12747 was originally issued on July 26, 2024, and a large majority of the Providers filed their appeals between February 5

interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." *See also* PRRB Rule 13.

[32] *See* 42 U.S.C. § 1395oo(a)(1)(A)(ii).

[33] *See* 42 U.S.C. § 1395oo(b); 42 C.F.R. § 405.1837(a)(3).

[34] *See also* 42 C.F.R. § 405.1835(a)(3).

and 14, 2025, nearly two weeks or more after the 180-day period had expired, if calculated from that date. Even if such Providers were to argue that the appeals were timely based on the later issuance of Transmittal 12785 on August 13, 2024, this Transmittal bears no connection to the issue under appeal as the Transmittal merely implements a formatting change to the SSI Fraction data that was previously made available through the earlier Transmittal 12747 so that the SSI Ratio column is consistently rounded to four decimals in all files.

2. Individual Appeals Not Timely Filed

Additionally, in these groups currently before the Board, there are Providers in ten (10) of the groups[35] that were transferred to these groups, however, the individual appeal requests were filed on February 13, 2025 and February 14, 2025, which is 184 and 185 days, respectively, from the August 13, 2024 Transmittal date. Even if the Board were to have found that the Transmittal is an appealable final determination, the Board would find that the Providers listed in Appendix B did not timely file their appeals.

42 C.F.R. § 405.1835(a)(3) indicates that, "unless the Provider qualifies for a good cause extension", the Board must receive a Provider's hearing request "***no later than 180 days after the date of receipt by the Provider of the final contractor or Secretary determination."***[36]

Board Rule 4.3, Commencement of Appeal Period, specifies types of final determinations and states:

> 4.3.1 **Contractor/CMS/Secretary Final Determination**
>
> Final Determinations include:
> - Notices of Program Reimbursement;
> - Revised Notices of Program Reimbursement;
> - Exception Determinations;
> - Quality Reporting Program Payment Reduction Determinations; and
> - Other determinations issued by CMS or its ***contractors with regard to the amount of total reimbursement due the provider***.
>
> The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).[37]

[35] *See* Appendix B.
[36] Emphasis added.
[37] Emphasis added.

This rule also explains that there is no five (5) day mailing presumption for appeals from Federal Register Notices:

> 4.3.2 **Federal Register Notice**
>
> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the ***date of publication*** and ends 180 days from that date.[38]

Board Rule 4.5, Date of Receipt by the Board, states that "[t]he timeliness of a filing is determined based on the date of receipt by the Board," and "[t]he date of receipt is presumed to be [] the date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system."[39]

Here, the Board finds that the Transmittal, if it were an appealable final determination, is akin to a Federal Register Notice appeal, thus there is no 5-day mailing presumption. If that is the case, then the Providers that filed their individual appeals on February 13, 2025 or February 14, 2025, which is 184 or 185 days, respectively, from the August 13, 2024 Transmittal date, were not timely filed.

C. Letters of Representation Issues

Last, the Board notes that there are ten groups that include one or more Providers that have incorrect letters of representation. These Providers, listed in Appendix C, filed individual appeals with the Board and then requested to transfer to various group appeals. Board Rule 16.1 (2023) addresses transfer requests from individual appeals to group appeals and states:

> **16.1 Filing Requirements for Requests to Transfer from Individual Appeal**
>
> **16.1.1 Transfer Requests via OH CDMS**
>
> Transfers made through OH CDMS must be initiated within the individual case and must:
> a. Identify the specific issue;
> b. Identify the group case number and confirm the group name of the case to which the issue is to be transferred; and
> c. ***Upload a copy of the representative letter associated with the group appeal***.[40]

For these transfer requests identified in Appendix C, the letter of representation included with the transfer request states:

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[38] Emphasis added.
[39] *See also* 42 C.F.R. § 405.1801(a)(2)(iii).
[40] Emphasis added.

> This authorization extends to handling the subject year(s) in the context of both individual appeals as well as group appeals ***for the Part C Days Retroactive Final Rule issue.***[41]

The issue under appeal for the individual appeals and the groups is not the Part C days issue. Based on this, the Board finds that these transfers were not proper. Because the Board has also found, as discussed above, that these Providers are not appealing from an appropriately appealable final determination, the Board will not be taking any further action with respect to these improper transfers (e.g., requesting updated letters of representation or denying the transfers and reinstating the issue in the individual appeals).

Conclusion

As the Medicare/SSI Fraction data published pursuant to Transmittal 12785 is not an appropriately appealable final determination, the Providers have failed to meet the jurisdictional requirements for a hearing. Further, the Board finds that the Providers included in Appendix B did not timely file their individual appeal requests, and that the Providers in Appendix C did not have proper letters of representation for their transfer requests. Thus, the Board hereby dismisses the 12 group 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:
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
Shakeba DuBose, Esq.

FOR THE BOARD:

9/29/2025

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.

Enclosures: Appendix A – Listing of 12 Cases
Appendix B – Individual Appeal Requests Not Timely Filed
Appendix C – Providers with Incorrect Transfer Letters of Representation

[41] *See, e.g.,* Case No. 25-5044G, Provider Number 07-0020 (Middlesex Hospital), Letter of Representation at 1 (Sept. 16, 2024).

Appendix A

Listing of 12 Cases

25-5044G	QRS CY 2014 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-5045G	QRS CY 2015 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-5046G	QRS CY 2016 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-5047G	QRS CY 2017 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-5048G	QRS CY 2018 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-5049G	QRS CY 2019 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-5050G	QRS CY 2020 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-5051G	QRS CY 2021 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-5052G	QRS CY 2022 Medicare Fraction (SSI) - Statutory & Systemic Errors Group
25-5053G	QRS CY 2023 Medicare Fraction (SSI) - Statutory & Systemic Error Group
25-5368GC	Yale-New Haven CY 2009 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group
25-5369GC	Yale-New Haven CY 2010 Medicare Fraction (SSI) - Statutory & Systemic Errors CIRP Group

Appendix B

Individual Appeal Requests Not Timely Filed

01 **25-5044G QRS CY 2014 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2793	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2656	02/13/2025	08/13/2024

02 **25-5045G QRS CY 2015 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2794	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2658	02/13/2025	08/13/2024

03 **25-5046G QRS CY 2016 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2796	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2659	02/13/2025	08/13/2024

04 **25-5047G QRS CY 2017 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2798	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2661	02/13/2025	08/13/2024

05 **25-5048G QRS CY 2018 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2799	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2662	02/13/2025	08/13/2024

06 **25-5049G QRS CY 2019 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2800	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2664	02/13/2025	08/13/2024

07 **25-5050G QRS CY 2020 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2801	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2665	02/13/2025	08/13/2024

08 **25-5051G QRS CY 2021 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2803	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2667	02/13/2025	08/13/2024

09 **25-5052G QRS CY 2022 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2804	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2668	02/13/2025	08/13/2024

10 **25-5053G QRS CY 2023 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**

Prov No.	Provider Name	Individual Appeal No.	Date of Appeal	Date of Transmittal
07-0020	Middlesex Hosp.	25-2805	02/14/2025	08/13/2024
28-0032	Mary Lanning Healthcare	25-2669	02/13/2025	08/13/2024

Appendix C

Providers with Incorrect Transfer Letters of Representation

1	25-5044G QRS CY 2014 Medicare Fraction (SSI) - Statutory & Systemic Errors Group		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2793	07/19/2025
07-0005	Waterbury Hosp.	25-2417	07/29/2025

2	25-5045G QRS CY 2015 Medicare Fraction (SSI) - Statutory & Systemic Errors Group		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2794	07/19/2025

3	25-5046G QRS CY 2016 Medicare Fraction (SSI) - Statutory & Systemic Errors Group		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2796	07/19/2025

4	25-5047G QRS CY 2017 Medicare Fraction (SSI) - Statutory & Systemic Errors Group		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2798	07/19/2025

5	25-5048G QRS CY 2018 Medicare Fraction (SSI) - Statutory & Systemic Errors Group		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2799	07/19/2025

6	25-5049G QRS CY 2019 Medicare Fraction (SSI) - Statutory & Systemic Errors Group		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2800	07/19/2025

7	**25-5050G QRS CY 2020 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2801	07/19/2025

8	**25-5051G QRS CY 2021 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2803	07/19/2025

9	**25-5052G QRS CY 2022 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2804	07/19/2025

10	**25-5053G QRS CY 2023 Medicare Fraction (SSI) - Statutory & Systemic Errors Group**		
Prov No.	**Provider Name**	**Individual Appeal No.**	**Date of Transfer Request**
07-0020	Middlesex Hosp.	25-2805	07/19/2025

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

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

RE: ***Expedited Judicial Review Determination***
25-0958GC Univ. of Rochester CY 2007 Post-Allina II DSH Part C Days CIRP Group
25-5251 Lutheran Medical Center (Provider Number 33-0306) (FYE 12/31/2007)
25-4836 Kaleida Health (Provider Number 33-0005) (FYE 12/31/2007)
25-5229 New York-Presbyterian Brooklyn Methodist Hospital (Provider Number 33-0236) (FYE 12/31/2007)

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **September 17, 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 to establish a Common Issue Related Party ("CIRP") group for these four (4) cases between December, 2024 and July, 2025. All Providers in the CIRP group and all three individual cases are all appealing from revised Notices of Program Reimbursement ("RNPRs") which implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Providers' Fiscal Years Ending ("FYE") December 31, 2007. Each of the individual appeals contains just 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 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. 25-0958GC, Statement of Group Issue at 1 (Dec. 2, 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 IPPS 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.

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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).

Providers' Position:

A. Providers' Appeal Request

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" or "Statement of Issue" included with the appeal requests state that the issue concerns "the proper treatment in the Medicare [DSH] calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation."[48] 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.[49]

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 policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[50]

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

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."[51]

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[47] *See, e.g.*, Case No. 25-0958GC Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[48] *See, e.g.*, Case No. 25-0958GC Appeal Request, Statement of Group Issue at 1.
[49] *Id.*
[50] *Id.* (citing to 139 S. Ct. at 1816).
[51] *Id.* (citing 4 U.S.C. § 706(2)).

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."[52] 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.[53] The request states, "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."[54] Since the Board is bound by this regulation,[55] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **September 22, 2025**, the Medicare Contractor's representative, Federal Specialized Services, filed timely responses to the Requests for EJR in all four (4) 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."[56]

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

[52] *See e.g.*, Case 25-0958GC, Providers' Petition for Expedited Judicial Review at 12-13 (Sept. 17, 2025).
[53] *Id.* at 17.
[54] *Id.* at 1-2.
[55] 42 C.F.R. § 405.1867.
[56] *See e.g.*, Case 25-0985GC, Response to Provider's Request for Expedited Judicial Review at 1 (Sept. 22, 2025).

their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [57]

- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $10,000 or more for an individual provider, or $50,000 or more for a group of providers.[58]

For these four 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 of the Providers in Cases 25-5229, 25-5251, and 25-4836 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 Case 25-0958GC 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 25-5229, 25-5251, 25-4836, and 25-0958GC have all filed timely appeals from their revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy in each individual appeal exceeds $10,000 as required by 42 C.F.R. § 405.1835(a)(2), and for the one group appeal exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Cases 25-5229, 25-5251, 25-4836, and 25-0958GC 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 authority to decide the legal question of whether the Part C Days policy issue, as adopted on a retroactive basis in the June 9, 2023 Final Rule, is substantively or procedurally valid.

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[57] 42 U.S.C. § 1395oo(a)(1) and (3); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[58] 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 all four (4) cases, the Board hereby closes the cases and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

9/29/2025

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)
Scott Berends, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
North Okaloosa Medical Center (Prov. No. 10-0122), FYE 03/31/2018
Case No. 21-1742

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 21-1742. 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. 21-1742*

On **April 2, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end March 31, 2018. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **September 16, 2021**, CHS filed the Provider's individual appeal request which included three (3) issues:

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

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 **April 13, 2022**, the Provider transferred Issue 2 to a CHS CIRP group, Case No. 21-1206GC. As a result of the transfer and after the withdrawal of Issue 3, there is one (1) remaining issue in this appeal: Issue 1 - DSH Payment/SSI Percentage (Provider Specific).

[1] On May 30, 2023, this issue was transferred to PRRB Case No. 21-1206GC.
[2] On June 10, 2024, this issue was withdrawn.

On **September 17, 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.

On **May 5, 2022**, the Provider timely filed its preliminary position paper (*hereinafter* "PPP").

On **June 27, 2022**, the Medicare Contractor ("MAC") filed a jurisdictional challenge, requesting the dismissal of Issue 1 and 3. (*Issue 3 was subsequently withdrawn*). Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **August 24, 2022**, the MAC timely filed its PPP.

On **January 12, 2023**, the MAC uploaded a copy of the Final Request for a Medicaid Eligible Days listing it sent to the Provider. According to the MAC Exhibit, the MAC previously requested the listing from the Provider on Sept. 30, 2021.

On **March 21, 2025**, the Board scheduled Case No. 21-1742 for a hearing on December 8, 2025.

On **September 5, 2025**, CHS filed the Provider's final position paper.

On **September 23, 2025**, the Representative for Case No. 21-1742 was changed to Quality Reimbursement Services, Inc. ("QRS").

On **September 24, 2025**, QRS withdrew the Medicaid Eligible Days issue.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 21-1206GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

[3] Issue Statement at 1 (Sept. 16, 2021).

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue 2 (the SSI Percentage), reads in part:

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

On May 5, 2022, the Board received the Provider's PPP in Case No. 21-1742. 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 (March 31).

[4] Group Issue Statement, Case No. 21-1206GC.

> 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 ofCMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. See *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[5]

The amount in controversy listed for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $36,977.

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.[6] The MAC also asserts that the Provider failed to file a complete PPP with a fully developed narrative, including all exhibits, or alternatively, explain its efforts to obtain documents which are missing in accordance with Board Rule 25.2.2. 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.[7] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule

[5] Provider's PPP at 8-9 (May 5, 2022).
[6] MAC's Jurisdictional Challenge at 2 (June 27, 2022).
[7] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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

Board Analysis and Decision:

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

As set forth below, the Board hereby dismisses the Provider's Issue No. 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. 21-1206GC.

The SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[8] 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)."[9] The Provider argues that "its'[sic] SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [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."[10]

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case No. 21-1206GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with

[8] Issue Statement at 1.
[9] *Id.*
[10] *Id.*

42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Percentage (Provider Specific) issue in Case No. 21-1742 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[11], 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.[12] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and* *explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[13]

[11] PRRB Rules v. 2.0 (Aug. 2018).
[12] 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).
[13] (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.[14]

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."[15]

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case No. 21-1206GC are the same issue.[16] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

[14] Last accessed September 22, 2025.
[15] Emphasis added.
[16] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a CHS CIRP group per 42 C.F.R. § 405.1837(b)(1).

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. 21-1742 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:

9/30/2025

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)
Wilson C. Leong, Esq., Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
St. Cloud Regional Medical Center (Prov. No. 10-0302), FYE 12/31/2018
Case No. 23-0029

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 23-0029. 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. 23-0029***

On **April 8, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018. The Provider is commonly owned by Community Health Systems, Inc. ("CHS").

On **October 5, 2022**, CHS filed the Provider's individual appeal request which included five (5) issues:

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

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **May 30, 2023**, the Provider transferred Issues 2, 4 and 5 to CHS CIRP groups. As a

[1] On May 30, 2023, this issue was transferred to PRRB Case No. 21-1206GC.
[2] On June 10, 2024, this issue was withdrawn.
[3] On May 30, 2023, this issue was transferred to PRRB Case No. 20-2149GC.
[4] On May 30, 2023, this issue was transferred to PRRB Case No. 21-0066GC.

result of the transfers, and after the withdrawal of Issue 3, there is one (1) remaining issue in this appeal: Issue 1 - DSH Payment/SSI Percentage (Provider Specific).

On **October 12, 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.[5]

On **June 1, 2023**, the Provider timely filed its preliminary position paper (*hereinafter* "PPP").

On **August 22, 2023**, the Medicare Contractor ("MAC") filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3.[6] Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **August 23, 2023**, the Representative for Case No. 23-0029 was changed to Quality Reimbursement Services, Inc. ("QRS").

On **September 5, 2023**, the MAC timely filed its PPP.[7]

On **June 10, 2024**, QRS withdrew the Medicaid Eligible Days issue.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 21-1206GC

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

> The Provider contends that 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.

---

[5] (Emphasis added).
[6] Issue 3 (Medicaid Eligible Days) was subsequently withdrawn on June 10, 2024.
[7] On September 6, 2023, the MAC sent a corrected narrative as the original filing inadvertently referenced an incorrect case no.

> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator'. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[8]

The Group issue Statement in Case No. 21-1206GC, to which the Provider transferred Issue 2 (the SSI Percentage), reads in part:

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

[8] Issue Statement at 1 (Oct 5, 2022).

> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[9]

On June 1, 2023, the Board received the Provider's PPP in Case No. 23-0029. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[10]

The amount in controversy listed on the calculation support for both SSI Percentage Issues 1 and 2 in the Provider's individual appeal request is $18,296.

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[9] Group Issue Statement, Case No. 21-1206GC.
[10] Provider's PPP at 10 (June 1, 2023).

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.[11] The MAC also asserts that the Provider failed to file a complete PPP with a fully developed narrative, including all exhibits, or alternatively, explain its efforts to obtain documents which are missing in accordance with Board Rule 25.2.2. 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.[12] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

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

[11] MAC's Jurisdictional Challenge at 2, 6-7 (Aug. 22, 2023).
[12] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the MAC computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI Percentage (Systemic Errors) issue that the Provider transferred to Case No. 21-1206GC.

The SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[13] 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)."[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 [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."[15]

The Provider's SSI Percentage (*Systemic Errors*) issue in group Case No. 21-1206GC also alleges that the MAC and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to several factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds that the SSI Percentage (Provider Specific) issue in Case No. 23-0029 is duplicative of the DSH/SSI Percentage (*Systemic Errors*) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6[16], 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.[17] Accordingly, the Provider's reference to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently distinguish (by sufficient explanation or evidence) how the alleged "provider specific" errors averred in Issue 1 are distinguished from the alleged "systemic" issues argued in Issue 2, and why those alleged "provider specific" errors should not be subsumed into the "systemic errors" issue appealed in Case No. 21-1206GC.

To this end, the Board also reviewed the Provider's PPP to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in

[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*
[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] 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).

Case No. 21-1206GC but instead, refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's PPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of any alleged "errors" in its PPP and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> If documents necessary to support your position are still unavailable, *identify* the missing documents, *explain why* the documents remain unavailable, *state the efforts* made to obtain the documents, *and explain when* the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[18]

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

[18] (Italics and underline emphasis added.)

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.[19]

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."[20]

Accordingly, *based on the record before it*, the Board finds that SSI Percentage (Provider Specific) issue in the instant appeal and the group issue in Case No. 21-1206GC are the same issue.[21] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

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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. 23-0029 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[19] Last accessed September 22, 2025.
[20] Emphasis added.
[21] 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).

Board Members Participating:

Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.
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For the Board:

9/30/2025

X Nicole E. Musgrave

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Robert Roth
Hooper, Lundy & Bookman, P.C.
401 9th Street NW, Suite 550
Washington, DC 20004

RE: ***Board Decision***
The University of Chicago Medical Center (Provider Number 14-0088)
Case Numbers: 25-5235, *et al*. (*See* Appendix A for listing of cases)

Dear Mr. Roth,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced nine individual appeals. Set forth below is the decision of the Board to dismiss two specific issues from those appeals.

Background:

The Providers in these individual appeals are appealing from Revised Notices of Program Reimbursement ("RNPRs"). The Providers acknowledge the RNPRs were issued as a result of Change Request 13294 (Feb. 21, 2024), which implemented the June 9, 2023 Final Rule.

These nine cases each contain the following two (2) issues:[1]

1. FFY 1986 BNA Error – Impact on Medicare DSH
2. Standardized Amount Base Rate Accur – Impact on Medicare DSH

The Issue Statement for issue 1) the FFY 1986 BNA Error – Impact on Medicare DSH is:

> **Issue Statement: Standardized Amount Predicate Fact Error – FFY 1986 Budget Neutrality Adjustment – Impact on Medicare DSH**
>
> Whether the Hospital's [IPPS] payments for the fiscal year under appeal were incorrectly low because they were based on standardized amounts that unlawfully incorporated [FFY] 1985 [BNAs] that the Secretary unlawfully carried forward into FFY 1986 standardized amounts. The unlawful carry forward of the FFY 1985 BNAs has caused Medicare IPPS underpayments in all subsequent years, which also caused the Hospital's [DSH] payments to be too low for the fiscal year under review. *See* 42

[1] Six (6) of the nine (9) cases include other issues that will not be addressed as part of this determination.

> U.S.C. §1395ww(d)(2) & (d)(5)(F); *see also* 42 C.F.R. Part 412. Correction of erroneous FFY 1986 "predicate fact" standardized amounts to correct the Hospital's IPPS payments for the fiscal year under appeal is properly permitted under *Kaiser Found. Hosp. v. Sebelius*, 708 F.3d 226 (D.C. Cir. 2013). *See St. Francis Medical Center v. Azar*, 894 F. 3d 290 (D.C. Cir. 2018).
>
> The Secretary has continuously carried forward the effect of the BNAs, which could lawfully be applied only in FFY 1985 to account for the transition from the reasonable cost payment system to the IPPS. Similar to the hospitals in *St. Francis*, the Hospital argues that the predicate fact error (here, the unlawful carry forward of the FFY 1985 BNAs) that was embedded in the standardized amounts in FFY 1986, has detrimentally affected IPPS payment determinations ever since, and has also resulted in DSH underpayments made to the Hospital in the fiscal year under appeal because they are based, in part, on IPPS payments. *See* 42 U.S.C. §1395ww(d)(2), (d)(5)(F), and 42 C.F.R. Part 412.
>
> The United States District Court for the District of Columbia recently held that the Secretary's carry forward of the FFY 1985 BNA into the FFY 1986 standardized amount was *ultra vires* and unlawful. *See* Memorandum Opinion, ECF No. 37, *St. Mary's Regional Med. Center v. Becerra*, 23-cv-01594-RCL (D.D.C. Dec. 20. 2024) ("The statute simply supplies no basis for carrying forward the budget-neutralized standardized amounts from 1985 to 1986; to the contrary, it forbade the Secretary from doing so.").
>
> The Hospital seeks additional DSH payments that would result if its IPPS payments were increased by adjusted the standardized amounts to counteract the effect of FFY 1985 BNAs, plus interest calculated under 42 U.S.C. §1395oo(f)(2) and/or 42 U.S.C. §1395g(d). The Hospital estimates that the IPPS payments must be adjusted upward by approximately up to 5.92% to remove the effect of the FFY 1985 BNAs. The audit adjustment report is filed with this appeal, and the relevant adjustments are 3 and 5. The amount in controversy for this issue is approximately $758,214.[2]

The Issue Statement for issue 2) the Standardized Amount Base Rate Accur – Impact on Medicare DSH is:

> **Issue Statement: Standardized Amount Base Rate Accuracy Impact on Medicare DSH**

[2] *E.g.*, Case 25-5235, Issue Statement for FFY 1986 BNA Error – Impact on Medicare DSH.

> Whether the Hospital's [IPPS] payments for the fiscal year under appeal were incorrectly low because they were based on incorrectly low Operating IPPS payments that were based on 1981 discharge data that was improperly incorporated into the base payment rates for IPPS hospitals, thereby causing Medicare IPPS underpayments in all subsequent years, which also caused the Hospital's [DSH] payments to be too low for the fiscal year under review. *See* 42 U.S.C. §1395ww(d)(2); *see also* 42 C.F.R. Part 412. Correction of erroneous 1981 "predicate fact" data to correct the Hospital's IPPS payments for the fiscal year under appeal is properly permitted under *Kaiser Found. Hosp. v. Sebelius*, 708 F.3d 226 (D.C. Cir. 2013). *See St. Francis Medical Center v. Azar*, 894 F. 3d 290 (D.C. Cir. 2018). Notably, *St. Francis* specifically involved a challenge to the 1981 discharge data that is also at issue here. *Id*. at 293.
>
> The hospitals in *St. Francis* challenged their IPPS payments for the years under appeal as incorrectly understated because they were determined from errors in the application of 1981 cost-reporting data that was used to calculate the standardized amounts in 1983, which were then carried forward every year to the present. *Id*. More specifically, as in *St. Francis*, the Hospital argues that the 1981 data erroneously characterized transfers of patients from one hospital to another as patient discharges, thus overstating the number of discharges and understating the allowable operating costs, which are calculated on a "per discharge" basis. Because that determination was embedded in the standardized amounts in 1983, it has detrimentally affected IPPS payment determinations ever since, and has also resulted in DSH underpayments made to the Hospital in the fiscal year under appeal because they are based, in part, on IPPS payments. *See* 42 U.S.C. §1395ww(d)(2), (d)(5)(F) and 42 C.F.R Part 412.
>
> The United States District Court of the District of Columbia recently held that there is no preclusion of review over hospital appeals seeking to correct the Secretary's predicate fact error embedded in the standardized amounts in 1983. *See* Memorandum Opinion, ECF No. 37, *St. Mary's Regional Med. Center v. Becerra*, 23-cv-01594-RCL (D.D.C. Dec. 20. 2024) (holding that (1) statutory provisions precluding review of certain budget neutrality adjustments made in federal fiscal years 1984 and 1985 did not preclude review of the plaintiff hospitals' challenges to the determination of standardized amounts in 1983 and (2) "The statute simply supplies no basis for carrying forward the budget-neutralized standardized amounts from 1985 to 1986; to the contrary, it forbade the Secretary from doing so.").

> The Hospital seeks additional DSH payments that would result if its IPPS payments were increased by adjusting the standardized amounts to counteract the effect of the 1981 data having erroneously counted transfers of patients from one hospital to another as patient discharges, plus interest calculated under 42 U.S.C. §1395oo(f)(2) and/or 42 U.S.C. §1395g(d). The audit adjustment report is filed with this appeal, and the relevant adjustments are 3 and 5. The amount in controversy for this issue is approximately $115,269.[3]

Relevant Law:

A. RNPR Appeals

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

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

Additionally, 42 C.F.R. § 405.1889 (2023)[4] explains the effect of a cost report revision:

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

[3] *E.g.*, Case 25-5235, Issue Statement for Standardized Amount Base Rate Accur – Impact on Medicare DSH.
[4] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5]

B. Retroactive Part C Rule, Resulting RNPRs, and Associated Appeal Rights

i. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[8] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[13]

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[5] 42 C.F.R. § 405.1889(b)(1).
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (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.[14]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[15]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[16]

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

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to 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[17] stated that:

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

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

> Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[18]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who are entitled to Medicare Part A benefits may elect to receive managed care coverage under Medicare Part C, and following that election, the beneficiary's benefits are no longer administered under Medicare Part A.[21] As part of the federal fiscal year ("FFY") 2004 IPPS proposed rule, the Secretary noted she had received "questions whether patients enrolled in an M+C Plan should be counted in the Medicare fraction or the Medicaid fraction of the DSH patient percentage calculation." In response to those questions, the Secretary proposed "to clarify that once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage" but rather "[t]hese patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[22] The Secretary did not finalize that policy in the FFY 2004 IPPS final rule because the Secretary had not yet completed review of the large number of comments received.[23]

In the FFY 2005 IPPS proposed rule, the Secretary referenced the Part C proposal in the FFY 2004 IPPS proposed rule and stated her intention to address the comments received on that proposal in the FY 2005 IPPS final rule.[24] In the FFY 2005 IPPS final rule, The Secretary purportedly changed her proposal/position by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[25] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH*

[18] 55 Fed. Reg. 35990, 35994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[22] *Id.*
[23] 68 Fed. Reg. 45346, 45422 (Aug. 1, 2003).
[24] 69 Fed. Reg. 28196, 28286 (May 18, 2004).
[25] 69 Fed. Reg. at 48916, 49099 (Aug. 11, 2004).

> *calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[26]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, it was not codified into the Code of Federal Regulations. The Secretary did not codify the policy change until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[28] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[29]

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

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30]
In 2014, the D.C. Circuit, in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005

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[26] *Id.* (emphasis added).
[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.
[29] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[31] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for FFYs 2014 and beyond.[34] However, at that point, no new rule had been adopted for FFYs 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the Part C policy adopted in the FFY 2005 IPPS final rule. In 2014 the Secretary published Medicare fractions for FFY 2012 which included Part C days.[35] A number of hospitals appealed this action.[36] In *Azar v. Allina Health Services* ("*Allina II*"),[37] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[38] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[39] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[40]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[41] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in

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[32] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[33] *Id.* at 2011.
[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[35] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[36] The Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board, **pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).
[37] 139 S.Ct. 1804 (2019).
[38] *Id.* at 1817.
[39] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[40] 139 S.Ct. at 1814.
[41] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[42]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[43] The June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he 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.[44]

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> ***The Ruling was not intended to cut off appeal rights and will not operate to do so***. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[45]

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[42] CMS Ruling 1739-R at 1-2.
[43] 88 Fed. Reg. 37772 (June 9, 2023).
[44] *Id.* at 37774 (emphasis added).
[45] 88 Fed. Reg. at 37788 (bold emphasis added).

Finally, the following excerpts from the June 9, 2023 Final Rule discuss a hospital's right to challenge the Part C days policy adopted therein:

1. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II*. It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[46]

2. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and ***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary will likewise receive NPRs or revised NPRs reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and **the new or revised NPRs will provide hospitals with a vehicle to appeal the new final action *even if the Medicare fraction or DSH payment does not change numerically***."[47]

3. "When the Secretary's treatment of Part C days in this final action is reflected in NPRs and revised NPRs, providers, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], **will be able to challenge the agency's interpretation by appealing those NPRs and revised NPRs.** While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, **the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings.**"[48]

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

The same Final Rule also specifically notes that the Dual Eligible Days issue, related to the interpretation of "entitled to SSI benefits," is beyond the scope of these appeal rights. Indeed,

[46] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[47] *Id.* at 37788 (emphasis added).
[48] *Id.* (emphasis added).

some commenters noted the alleged inconsistency in the Secretary's interpretation of "entitled to benefits under Part A" and "entitled to [SSI] benefits." The Secretary responded that "[t]he meaning of 'entitled to [SSI] benefits' in the DSH statue is beyond the scope of this action." The Secretary referred the commenters to the FY 2014 and FY 2011 IPPS Final Rules for a more exhaustive discussion on the different interpretation of these two distinct phrases, explaining that this concern was addressed in separate, distinct notice-and-comment rulemaking.[49]

Decision of the Board:

42 C.F.R. § 405.1889 governs the scope of appeals once a contractor determination is "reopened as provided in § 405.1885[.]" In this circumstance, Providers have *limited* appeal rights and are only able to appeal issues or matters that were "specifically revised" in the RNPRs.

The appeal rights detailed in the June 9, 2023 Final Rule specifically limit a provider's appeal rights to specific matters related to the actual RNPR (*i.e.*, the Part C Days policy). First, the Secretary made clear that the Part C Days rule could be appealed following the issuance of a new NPR or RNPR "***even if the Medicare fraction or DSH payment does not change numerically.***"[50] Thus, the new rule could be appealed even if the treatment of Part C Days was not "specifically revised."

The appeal rights, however, are strictly limited to the policy related to the treatment of Part C days. Following the issuance of a RNPR, the Secretary stated that Providers "***will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions contained in the NPRs or revised NPRs***[,]" "**will be able to challenge the agency's interpretation** [of the treatment of Part C days in this final action] by appealing those NPRs and revised NPRs[,]" and further stated that they "**can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[51]

The participants in each of these appeals are appealing from RNPRs, and the two issues presented argue their IPPS rates are understated because (1) they are based on standardized amounts that unlawfully incorporated [FFY] 1985 [BNAs] that the Secretary unlawfully carried forward into FFY 1986 standardized amounts and (2) they were based on incorrectly low Operating IPPS payments that were based on 1981 discharge data that was improperly incorporated into the base payment rates for IPPS hospitals.

The RNPRs being appealed, however, were issued specifically to reflect and implement the treatment of Part C days as set forth in the June 23, 2023 Final Rule and CR 13294. The RNPRs make no changes at all to the Providers' standardized amount or historical IPPS payments, both of which are based on 1981 or 1986 rates. The Providers make no effort to demonstrate how the RNPRs or audit adjustments relate to those issues. The Provider is seeking "additional DSH payments that would result if its IPPS payments were increased,"[52] which clearly is unrelated to

[49] *Id.* at 37779-37780.
[50] *Id.* at 37788 (emphasis added).
[51] *Id.* at 37787-88 (emphasis added).
[52] *See, e.g*. Case No. 25-5235, Issue Statement for Standardized Amount Base Rate Accur – Impact on Medicare DSH at 1.

the Part C matter that was revised in the revised final determinations. Based on the foregoing, the Board hereby dismisses issues one and two from the 9 cases listed in Appendix A.

Conclusion:

The Provider in these appeals argues that an increase to IPPS payments, which they deem is necessary in the issue statements for the "FFY 1986 Budget Neutrality Adjustment" and the "Standardized Amount Base Rate Accuracy", will increase DSH payments. The Board finds that neither of those issues were addressed in the RNPRs issued solely to implement the June 9, 2023 Part C Final Rule. As prescribed in 42 C.F.R. § 405.1889, these RNPRs do not give the Provider the ability to appeal issues not specifically revised or adjusted in an RNPR. The Provider's failure to appeal those issues from their original final determinations, cannot be cured by the attempt to file appeals from RNPRs for issues that have not been specifically revised.

The Board finds that (1) the RNPRs did not "specifically revise" the Standardized Amount or IPPS payments and thus, pursuant to 42 C.F.R. § 405.1889(b)(1), both issues are beyond the scope of any appeal from the RNPRs, and (2) the only appeal rights afforded from the RNPRs as set forth in the June 23, 2023 Final Rule are to challenge the treatment of Part C Days in the RNPRs. Based on the foregoing, the Board hereby ***dismisses*** the two issues from the nine (9) appeals listed in **Appendix A.** Cases 25-5235, 25-5327 and 25-5328 are hereby closed and removed from the Board's docket as there are no issues remaining. The other six appeals (marked with an * on Appendix A) remain open for other pending issues.

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

Board Members Participating:

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

For the Board:

9/30/2025

X Kevin D. Smith, CPA

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

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

Attachment: Appendix A – List of Cases

Appendix A

(9 Cases)

Case No.	Case Name
25-5235	The University of Chicago Medical Center, FYE 06/30/1997
25-5236*	The University of Chicago Medical Center, FYE 06/30/1998
25-5237	The University of Chicago Medical Center, FYE 06/30/1999
25-5238	The University of Chicago Medical Center, FYE 06/30/2000
25-5239*	The University of Chicago Medical Center, FYE 06/30/2001
25-5240*	The University of Chicago Medical Center, FYE 06/30/2002
25-5241*	The University of Chicago Medical Center, FYE 06/30/2003
25-5242*	The University of Chicago Medical Center, FYE 06/30/2004
25-5243*	The University of Chicago Medical Center, FYE 06/30/2005

* These six cases have other issues pending in the appeals and will remain open.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

John Jacob
Akin Gump Strauss Hauer & Feld, LLP
Robert S. Strauss Tower
2001 K Street NW
Washington, D.C. 20006-1037

RE: ***Expedited Judicial Review Determination***
Cases Numbers: 25-3619GC *et al.* (16 Cases – *See* **Appendix A**)
Barnabas Health DSH/Medicare Part C CIRP Groups

Dear Mr. Jacob:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **September 18, 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 sixteen (16) groups in February and March, 2025. All sixteen (16) CIRP groups contain providers 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 2006 to 2013.

The issue in this appeal is "the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days")."[2] 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.

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *See, e.g.,* Case No. 25-3619GC, Statement of Group Issue at 1 (Mar. 10, 2025).
[3] *Id.*

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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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.

Providers' Position:

A. Providers' Appeal Request

The Provider's appeal requests argue "that all Medicaid eligible Part C days must be counted in the numerator of the Medicaid fraction, and that Part C days must be excluded from the Medicare Part A/SSI fraction[.]"[47] They seek to invalidate the Final Rule published on June 9, 2023 and the SSI Ratio published thereafter to implement the Final Rule. They argue that the rule is both substantively and procedurally invalid.[48]

The Providers 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.[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. They argue that the rule violates the Medicare statute's prohibitions on retroactive rulemaking and that none of the exceptions permitting such rulemaking apply.[50] The Providers also claim that the Final Rule is contrary the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's

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[46] *Id.* (emphasis added).
[47] *See, e.g.,* Case No. 25-3619GC, Statement of Group Issue at 1.
[48] *Id.*
[49] *Id.* at 1-2.
[50] *Id.* at 2.

interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[5152]

B. Providers' Petition for EJR

The Providers have requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. They argue that they filed their appeals within 180 days of the issuance of their NPRs and RNPRs; that the amount in controversy exceeds $50,000 in each case; that they challenge the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[53]

On **September 25, 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."[54]

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; [55]
- 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.[56]

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[51] *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024).
[52] *See, e.g.,* Case No. 25-3619GC, Statement of Group Issue at 3.
[53] *See, e.g*., Case No. 25-3619GC, Provider's Request for Expedited Judicial Review at 8-9 (Sept. 18, 2025).
[54] *See, e.g.,* Case No. 25-3619GC, Response to Provider's request for expedited judicial review at 1 (Sept. 25, 2025).
[55] 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).
[56] 42 U.S.C. § 1395oo(b); 42 C.F.R. §§ 405.1835 – 1840.

For these CIRP Groups, the providers all appealed from original or revised NPRs which implement the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule. All of the providers 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 sixteen (16) cases listed in **Appendix A** have all filed timely appeals from their original or revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these NPRs and 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.

However, the Board also notes that these sixteen (16) groups are eight (8) pairs of duplicate cases since they have the same issue for the same year as well as the same participants. In the 2014 decision for *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in *Allina* stated: "*the **statute** unambiguously requires* that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[57] Accordingly, there are no separate Medicare or Medicaid fraction issues since Part C days must be counted in one fraction or the other (*i.e.*, excluding them from one means they must be counted in the other). Rather than dismissing one group for each fiscal year or consolidating, the Board is treating each pair as one group for purposes of its actions below which results in the closure of these cases.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

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

2) Consistent with the D.C. Circuit's decision in Allina, each pair of Barnabas Health CIRP Group listed in **Appendix A** concerning the same fiscal year (one for the SSI Fraction and one for the Medicaid Fraction) are duplicates since they have the same issue for the same year as well as the same participants; however, for purposes of administrative ease, rather than dismissing one group for each FY or consolidating, the Board is treating each pair as one group for purposes of its actions below which will result in the closure of these cases;

[57] 746 F.3d 1102, 1108 (D.C. Cir. 2014) (emphasis added).

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

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

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

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

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 sixteen (16) cases and removes them from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD:

9/30/2025

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-L)
Scott Berends, Federal Specialized Services

Appendix A

25-3948GC	*Barnabas Health CY 2013 DSH/Medicare Part C Days - SSI Fraction CIRP Group*
25-3944GC	*Barnabas Health CY 2013 DSH/Medicare Part C Days - Medicaid Fraction CIRP Group*
25-3738GC	*Barnabas Health CY 2012 DSH/Medicare Part C Days - SSI Fraction CIRP Group*
25-3737GC	*Barnabas Health CY 2012 DSH/Medicare Part C Days - Medicaid Fraction CIRP Group*
25-3723GC	*Barnabas Health CY 2011 DSH/Medicare Part C Days - SSI Fraction CIRP Group*
25-3722GC	*Barnabas Health CY 2011 DSH/Medicare Part C Days - Medicaid Fraction CIRP Group*
25-3564GC	*Barnabas Health CY 2010 DSH/Medicare Part C Days - SSI Fraction CIRP Group*
25-3563GC	*Barnabas Health CY 2010 DSH/Medicare Part C Days - Medicaid Fraction CIRP Group*
25-3491GC	*Barnabas Health CY 2009 DSH/Medicare Part C Days - Medicaid Fraction CIRP Group*
25-3489GC	*Barnabas Health CY 2009 DSH/Medicare Part C Days - SSI Fraction CIRP Group*
25-3919GC	*Barnabas Health CY 2008 DSH/Medicare Part C Days - SSI Fraction CIRP Group*
25-3917GC	*Barnabas Health CY 2008 DSH/Medicare Part C Days - Medicaid Fraction CIRP Group*
25-1934GC	*Barnabas Health CY 2007 DSH/Medicare Part C Days - Medicaid Fraction CIRP Group*
25-1933GC	*Barnabas Health CY 2007 DSH/Medicare Part C Days - SSI Fraction CIRP Group*
25-3625GC	*Barnabas Health CY 2006 DSH/Medicare Part C Days - SSI Fraction CIRP Group*
25-3619GC	*Barnabas Health CY 2006 DSH/Medicare Part C Days - Medicaid Fraction CIRP Group*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway
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Plano, TX 75093-8724

RE: ***Expedited Judicial Review Determination***
25-4989GC *Baystate Health CY 2007 DSH Medicare Part C CIRP Group*
25-0947GC *RegionalCare Hosp Part CY 2014 Medicare Part C CIRP Group*
25-4029GC *Allegheny Health CY 2011 DSH Medicare Part C CIRP Group*
25-4005GC *Summit Health CY 2012 DSH Medicare Part C CIRP Group*
25-3995GC *Lehigh Valley Health CY 2009 DSH Medicare Part C CIRP Group*
25-3815GC *Excela Health CY 2009 DSH Medicare Part C CIRP Group*

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Petitions for Expedited Judicial Review ("EJR") filed on **September 16, 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 six (6) groups between **November, 2024** and **July, 2025**. All six (6) 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' Fiscal Year Ends ("FYEs") spanning from 2007 to 2014.

The issue in this appeal is "the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days") in the aftermath of the *Allina II* litigation. The Providers contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction for patients eligible for Medicaid."[2] The Providers are seeking to challenge the CMS policy adopted in the June 2023 Final Rule to be applied *retroactively* for periods prior to October 1, 2013.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *See, e.g.*, Case No. 25-4989GC, Statement of Group Issue at 1 (Jul. 12, 2025).
[3] *Id.*

Statutory and Regulatory Background:

A. Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

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

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

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

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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

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

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

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

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

> *associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[24]

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

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

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

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

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[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.
[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).

IPPS rule.[30] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[31] However, the Secretary has not acquiesced to that decision.

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

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

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding

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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).

> 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":

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.

[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).

Providers' Position:

A. Providers' Appeal Request

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 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."[48] The Providers contend that Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.[49]

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."[50]

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

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

[47] *See, e.g.,* Case No. 25-4989GC, Appeal Request, Statement of Jurisdiction at 1 (citations omitted).
[48] *See, e.g.,* Case No. 25-4989GC, Appeal Request, Statement of Group Issue at 1.
[49] *Id.*
[50] *Id.* (citing to 139 S. Ct. at 1816).

agency's statutory authority, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[51]

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."[52] 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.[53] The request states, "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."[54] Since the Board is bound by this regulation,[55] it lacks the authority to provide the relief requested, and thus the Providers believe EJR is appropriate.

On **September 22, 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."[56]

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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[51] *Id.* (citing 4 U.S.C. § 706(2)).
[52] *See, e.g.*, Case No. 25-4989GC, Providers' Petition for Expedited Judicial Review at 12 (Sept. 15, 2025).
[53] *Id.* at 15.
[54] *Id.* at 1-2.
[55] 42 C.F.R. § 405.1867.
[56] *See, e.g.*, Case No. 25-4989GC, Response to Provider's request for Expedited Judicial Review at 1 (Sept. 22, 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; [57]
- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[58]

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 Cases 25-4989GC, 25-0947GC, 25-4029GC, 25-4005GC, 25-3995GC, and 25-3815GC have all filed timely appeals from their revised NPRs concerning the same common issue related to the June 9, 2023 Final Rule which set forth a retroactive policy regarding the treatment of Part C Days. The same Final Rule made clear that the Part C Days policy could be appealed from these RNPRs. The Board also finds that the amount in controversy in each case exceeds $50,000 as required by 42 C.F.R. § 405.1837(a)(3). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in Cases 25-4989GC, 25-0947GC, 25-4029GC, 25-4005GC, 25-3995GC, and 25-3815GC 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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[57] 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).
[58] 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 all six (6) cases and will remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

9/30/2025

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)
Cecile Huggins, Palmetto GBA (J-J)
Michael Redmond, Novitas Solutions, Inc. c/o GuideWell Source (J-L)
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 25-5100 Saint Peter's University Hospital (Provider Number 31-0070), FYE 12/31/2006
Case 25-3529 Saint Peter's University Hospital (Provider Number 31-0070), FYE 12/31/2007
Case 25-5102 Saint Peter's University Hospital (Provider Number 31-0070), FYE 12/31/2008
Case 25-5103 Saint Peter's University Hospital (Provider Number 31-0070), FYE 12/31/2009
Case 25-3981 Saint Peter's University Hospital (Provider Number 31-0070), FYE 12/31/2010
Case 25-3984 Saint Peter's University Hospital (Provider Number 31-0070), FYE 12/31/2011
Case 25-5630 Saint Peter's University Hospital (Provider Number 31-0070), FYE 12/31/2012
Case 25-5631 Saint Peter's University Hospital (Provider Number 31-0070), FYE 12/31/2013

Dear Mr. Jacob:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed on September 18, 2025 in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

Between March and August of 2025, the Board received eight (8) requests for hearing for Saint Peter's University Hospital ("Provider"). The Provider is appealing from revised Notices of Program Reimbursement ("RNPRs"), which all implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Provider's Fiscal Years Ending ("FYEs") in 2006 through 2013.

The issue in this appeal is "the proper treatment in the Medicare disproportionate share hospital ("DSH") adjustment calculation of days for patients who were enrolled in Medicare Advantage plans under part C of the Medicare statute ("part C days")."[2] The Provider contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[3] The Provider is

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *See, e.g.,* Case No. 25-5100, Issue Statement at 1 (Jul. 22, 2025).
[3] *Id.*

seeking to challenge the CMS policy adopted in the 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").[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 IPPS 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.

Provider's Position:

A. Provider's Appeal Requests

The Provider's appeal requests argue "that all Medicaid eligible Part C days must be counted in the numerator of the Medicaid fraction, and that Part C days must be excluded from the Medicare Part A/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. It argues that the rule is both substantively and procedurally invalid.[48]

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.[49]

Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule is substantively and procedurally invalid. It argues that the rule violates the Medicare statute's prohibitions on retroactive rulemaking and that none of the exceptions permitting such rulemaking apply.[50] The Provider also claims that the Final Rule is contrary to the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's

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[46] *Id.* (emphasis added).
[47] *See, e.g.,* Case No. 25-5100, Issue Statement at 1.
[48] *Id.*
[49] *Id.* at 1-2.
[50] *Id.* at 2.

interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[5152]

B. Provider's Petition for EJR

The Provider has requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. It argues that it filed its appeal within 180 days of the issuance of its RNPRs; that the amount in controversy exceeds $10,000 in each case; that it challenges the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[53]

On **September 25, 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."[54]

Decision of the Board:

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

A. Jurisdiction

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

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[55] and
- The amount in controversy is $10,000 or more.[56]

For these eight (8) individual appeal requests, the provider appealed from revised NPRs which implemented the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule.

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[51] *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024).
[52] *See, e.g.*, Case No. 25-5100, Issue Statement at 3.
[53] *See, e.g.,* Case No. 25-5100, Provider's Request for Expedited Judicial Review at 8-9 (Sept. 18, 2025).
[54] *See, e.g.,* Case No. 25-5100, Response to Provider's request for expedited judicial review at 1 (Sept. 25, 2025).
[55] 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).
[56] 42 U.S.C. § 1395oo(a)(2); 42 C.F.R. §§ 405.1835 – 1840.

The Provider appealed within 180 days of the issuance of its NPRs and the amount in controversy exceeds $10,000 in each case.

The Board finds that the Provider has filed timely eight appeals from its 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 exceeds $10,000 in each case as required by 42 C.F.R. § 405.1839(a)(1). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in these eight (8) cases and that the Provider is entitled to a hearing before the Board;

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

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

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

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as 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 Provider's request for EJR for the issue and the subject years.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since no additional issues remain in these eight (8) cases, the Board will close them and remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

9/30/2025

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

John Jacob
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RE: ***Expedited Judicial Review Determination***

Case 25-5615 United Health Services Hospitals, Inc. (Provider No. 33-0394), FYE 12/31/2006
Case 25-5616 United Health Services Hospitals, Inc. (Provider No. 33-0394), FYE 12/31/2007
Case 25-3769 United Health Services Hospitals, Inc. (Provider No. 33-0394), FYE 12/31/2008
Case 25-3773 United Health Services Hospitals, Inc. (Provider No. 33-0394), FYE 12/31/2009
Case 25-3778 United Health Services Hospitals, Inc. (Provider No. 33-0394), FYE 12/31/2010
Case 25-3783 United Health Services Hospitals, Inc. (Provider No. 33-0394), FYE 12/31/2011
Case 25-3785 United Health Services Hospitals, Inc. (Provider No. 33-0394), FYE 12/31/2012
Case 25-3698 United Health Services Hospitals, Inc. (Provider No. 33-0394), FYE 12/31/2013

Dear Mr. Jacob:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's Petition for Expedited Judicial Review ("EJR") filed on September 18, 2025 in the above-referenced appeals. The Board's decision on jurisdiction and EJR is set forth below.

Background and Issue:

Between March and August of 2025, the Board received eight (8) requests for hearing for United Health Services Hospitals, Inc. ("Provider"). The Provider is appealing from revised Notices of Program Reimbursement ("RNPRs"), which all implement the final rule published in the June 9, 2023 Federal Register ("June 2023 Final Rule")[1] as it pertains to the Provider's Fiscal Years Ending ("FYEs") in 2006 through 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")."[2] The Provider contends that part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[3] The Provider is seeking to

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *See, e.g.,* Case No. 25-5615, Issue Statement at 1 (Aug. 27, 2025).
[3] *Id.*

challenge the CMS policy adopted in the 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").[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.

Provider's Position:

A. Provider's Appeal Requests

The Provider's appeal requests argue "that all Medicaid eligible Part C days must be counted in the numerator of the Medicaid fraction, and that Part C days must be excluded from the Medicare Part A/SSI fraction[.]"[47] It seeks to invalidate the Final Rule published on June 9, 2023 and the SSI Ratios published thereafter to implement the Final Rule. It argues that the rule is both substantively and procedurally invalid.[48]

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.[49]

Based on the above, the Provider maintains that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule is substantively and procedurally invalid. It argues that the rule violates the Medicare statute's prohibitions on retroactive rulemaking and that none of the exceptions permitting such rulemaking apply.[50] The Provider also claims that the Final Rule is contrary the statutory language of 42 U.S.C. § 1395ww(d)(5)(F)(vi) and that Secretary's

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[46] *Id.* (emphasis added).
[47] *See, e.g.,* Case No. 25-5615, Issue Statement at 1.
[48] *Id.*
[49] *Id.* at 1-2.
[50] *Id.* at 2.

interpretation of this statute deserves no deference following the Supreme Court's decision in *Loper Bright.*[51][52]

B. Provider's Petition for EJR

The Provider has requested EJR over the post-*Allina* retroactive Part C policy issue outlined above. It argues that it filed its appeal within 180 days of the issuance of its RNPRs; that the amount in controversy exceeds $10,000 in each case; that it challenges the validity of the June 2023 Final Rule; and that the Board cannot grant this relief because it is bound by the policy.[53]

On **September 25, 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."[54]

Decision of the Board:

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

A. Jurisdiction

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

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[55] and
- The amount in controversy is $10,000 or more.[56]

For these eight (8) individual appeal requests, the provider appealed from revised NPRs which implemented the new, retroactive Part C days rule as published in the June 9, 2023 Final Rule.

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[51] *Loper Bright Enterprises v. Raimondo*, 603 U.S. 369 (2024).
[52] *See, e.g.,* Case No. 25-5615, Issue Statement at 3.
[53] *See, e.g.,* Case No. 25-5615, Provider's Petition for Expedited Judicial Review at 8-9 (Sept. 18, 2025).
[54] *See, e.g.*, Case No. 25-5615, Response to Provider's request for expedited judicial review at 1 (Sept. 25, 2025).
[55] 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).
[56] 42 U.S.C. § 1395oo(a)(2); 42 C.F.R. §§ 405.1835 – 1840.

The Provider appealed within 180 days of the issuance of its RNPRs and the amount in controversy exceeds $10,000 in each case.

The Board finds that the Provider has filed timely eight appeals from its 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 $10,000 in each case as required by 42 C.F.R. § 405.1839(a)(1). The Board, however, is without the authority to grant the relief requested: to declare the Part C Days policy set forth in the June 9, 2023 Final Rule invalid.

B. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over the Part C Days policy issue, as set forth in the June 9, 2023 Final Rule, for the subject years in these eight (8) cases and that the Provider is entitled to a hearing before the Board;

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

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

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

Accordingly, the Board finds that the question of the validity of the Part C Days policy issue, as 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 Provider's request for EJR for the issue and the subject years.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since no additional issues remain in these eight (8) cases, the Board will close them and remove them from its docket.

Board Members Participating:

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

FOR THE BOARD:

9/30/2025

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)
Scott Berends, Federal Specialized Services