DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview
Phone: 410-786-2671

Refer to: 08-2618GC

CERTIFIED MAIL

DEC 02 2015

Toyon Associates, Inc.
Thomas P. Knight
President
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Darwin San Luis
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation
Daughters of Charity 1998 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2618GC

Dear Mr. Knight and Mr. San Luis:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Daughters of Charity 1998 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Provider's ("CIRP")] Group's ("Daughters of Charity's") request for case bifurcation. The Board hereby grants Daughters of Charity's request for case bifurcation of the dual eligible Part A non-covered and HMO/Part C[1] days issues as set forth below.

Background

On July 25, 2008, the Board received Daughters of Charity's request to form a CIRP group comprised of two participants transferred from optional group appeals.[2] On July 19, 2010, the Board received Daughters of Charity's jurisdictional documentation for the participants within this appeal.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[3] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

---

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

[2] The two participants are O'Connor Hospital (Provider No. 05-0153) transferred from PRRB Case No. 04-1729G and Seton Medical Center (Provider No. 05-0289) transferred from PRRB Case No. 07-1426G.

[3] Toyon is the representative for Daughters of Charity's appeal.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2000), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

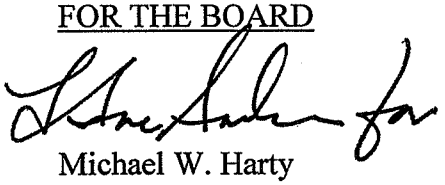
The Board acknowledges that at the time that Daughters of Charity's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and HMO/Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-0071GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[4] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO/Part C days issues into separate group appeals. The providers' HMO/Part C issue is now within newly formed PRRB Case No. 16-0279GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0279GC are included as enclosures along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated September 16, 2008
Group Acknowledgment Letter for PRRB Case No. 16-0279GC
Standard Remand Letter for PRRB Case No. 08-2618GC

cc: Wilson Leong, Federal Specialized Services

[4] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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Refer to: 08-2433GC

DEC 02 2015

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Noridian Healthcare Solutions, LLC
Darwin San Luis
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P.O. Box 6782
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RE: Request for Case Bifurcation
Hawaii Pacific Health 2003 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2433GC

Dear Mr. Knight and Mr. San Luis:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Hawaii Pacific Health 2003 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Provider's ("CIRP")] Group's ("Hawaii Pacific's") request for case bifurcation. The Board hereby grants Hawaii Pacific's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues as set forth below.

Background

On July 24, 2008, the Board received Hawaii Pacific's request to form a CIRP group comprised of two providers[1] within Toyon's 2003 DSH Dual Eligible Days Group Appeal, PRRB Case No. 06-1951G. The Board received Hawaii Pacific's jurisdictional documentation for these two providers on December 31, 2012.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[2] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is

[1] The two providers are Kapi'olani Medical Center at Pali Momi, Provider No. 12-0026, and Straub Clinic and Hospital, Provider No. 12-0022.
[2] Toyon is the representative for Hawaii Pacific's appeal.

$10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

The Board acknowledges that at the time that Hawaii Pacific's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2433GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The providers' Part C issue is now within newly formed PRRB Case No. 16-0258GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0258GC are included as enclosures along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated December 21, 2012
Group Acknowledgment Letter for PRRB Case No. 16-0258GC
Standard Remand Letter for PRRB Case No. 08-2433GC

cc: Wilson Leong, Federal Specialized Services

[3] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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RE: Board's Own Motion Reconsideration of Request for Case Bifurcation
Toyon 2003 DSH Dual Eligible Days Group
PRRB Case No.: 06-1951G

Dear Mr. Knight and Mr. San Luis:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in order to reconsider Toyon Associates, Inc.'s ("Toyon's")[1] request for case bifurcation of the dual eligible Part A non-covered and Part C days issues in the Toyon 2003 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days Group. Although the Board initially denied Toyon's bifurcation request in its March 13, 2014 decision ("March 13, 2014 Decision"), upon its own motion reconsideration, the Board hereby grants Toyon's request but dismisses one of the providers within this group, as explained below.

Background

On July 10, 2006, the Board received Toyon's group appeal request regarding DSH dual eligible days. The group was initially comprised of two providers but following its multiple transfer requests, Toyon's final Schedule of Providers, dated April 28, 2010, consists of eight providers listed on the Schedule as providers 1-4, 7-8 and 14-15.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's") request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue." In its March 13, 2014 Decision, the Board denied Toyon's request to bifurcate the providers' dual eligible days issue and establish a separate appeal for the Providers' Part C days because the Board "determined that [the Providers'] documents . . . are not sufficient to establish that the Providers intended the Part C days to be an issue in this group appeal . . ."[2]

Also within its March 13, 2014 Decision, the Board requested that Toyon submit additional

[1] Toyon is the providers' representative for this appeal.
[2] March 13, 2014 Decision at 3.

documentation for Provider 14, Valley Memorial Hospital ("Valley"), "[i]n order . . . to make a jurisdictional determination . . ." because Valley filed its appeal based on a revised notice of program reimbursement ("RNPR"). The Board received Valley's additional documentation on April 7, 2014.

Board's Decision

Applicable Regulatory Provisions

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2005), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

An RNPR is considered a separate and distinct determination from which the provider may appeal. Under 42 C.F.R. § 405.1889 (2006)

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened . . . such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

Jurisdiction for Provider 14

Based on the initial information contained within Toyon's April 28, 2010 Schedule of Providers and jurisdictional documentation, Toyon failed to support whether Valley's appeal of its September 20, 2006 RNPR was properly before the Board. Valley's September 20, 2006 RNPR stated that the Medicare Contractor issued a September 7, 2006 Notice of Reopening for Valley's cost report in order "[t]o revise the DSH adjustment amount based on review of the information submitted with [Valley's] request dated March 3, 2006[ ]"[3] but did not elaborate further. In its March 13, 2014 Decision, the Board requested that Valley submit additional documentation so that the Board may determine whether it has jurisdiction to hear Valley's appeal of dual eligible days. The Board received Valley's additional documentation on April 7, 2014. Valley's supplemental documentation, however, still failed to show that its dual eligible days were specifically reviewed within its September 20, 2006 RNPR, and, thus, the Board finds that it does not have jurisdiction to hear Valley's appeal of this issue.

This conclusion is consistent with the United States District Court for the District of Columbia's decision in *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In *HCA Health Services*, the Court held that when a fiscal intermediary[4] reopens it original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on

[3] September 6, 2006 RNPR at 1.
[4] Fiscal intermediary is now referred to as "Medicare contractor."

reopening and does not extend further to all determinations underlying the original NPR. In the instant appeal, Valley filed its appeal based on its September 20, 2006 RNPR. Within that RNPR, Valley has shown that the Medicare contractor adjusted Valley's DSH calculation generally but has not demonstrated that its dual eligible days were "revisited on reopening." The Board, therefore, lacks the jurisdiction to hear Valley's appeal of this issue and hereby dismisses Valley from the appeal.

Decision Regarding Bifurcation of Toyon's Dual Eligible Days Issue

Although the Board initially denied Toyon's request for case bifurcation, upon reconsideration, the Board acknowledges that at the time that the providers' individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original common issue-related provider group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 06-1951GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[5] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The providers' Part C issue is now within newly formed PRRB Case No. 16-0269G. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0269G are included as enclosures along with this determination.

Since the Board found that finds that Provider 14, Valley Memorial Hospital (Provider No. 05-0283), failed to file a jurisdictionally valid appeal of its dual eligible days and dismissed Valley from the instant appeal, this provider is also excluded from the newly formed appeal.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

[5] Both the regulation and Board Rule clearly state that a group appeal must only contain one issue.

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated December 21, 2012
Group Acknowledgment Letter for PRRB Case No. 16-0269GC
Standard Remand Letter for PRRB Case No. 06-1951G

cc: Wilson Leong, Federal Specialized Services

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Refer to: 08-2456GC

CERTIFIED MAIL

DEC 02 2015

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RE: Request for Case Bifurcation
Fremont-Rideout 1997 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2456GC

Dear Mr. Knight and Mr. San Luis:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Fremont-Rideout 1997 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Provider's ("CIRP")] Group's ("Fremont-Rideout's") request for case bifurcation. The Board hereby grants Fremont-Rideout's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues as set forth below.

Background

On July 24, 2008, the Board received Fremont-Rideout's request to form a CIRP group comprised of two providers[1] within Toyon's 1997 DSH Dual Eligible Days Group Appeal, PRRB Case No. 04-1728G. The Board received Fremont-Rideout's updated jurisdictional documentation for these two providers on April 26, 2010.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[2] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (1999), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is

[1] The two providers are Fremont Medical Center, Provider No. 05-0207, and Rideout Memorial Hospital, Provider No. 05-0133.
[2] Toyon is the representative for Fremont-Rideout's appeal.

$10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

The Board acknowledges that at the time that Fremont-Rideout's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2456GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The providers' Part C issue is now within newly formed PRRB Case No. 16-0270GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0270GC are included as enclosures along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated April 23, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0270GC
Standard Remand Letter for PRRB Case No. 08-2456GC

cc: Wilson Leong, Federal Specialized Services

[3] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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RE: Request for Case Bifurcation
Daughters of Charity 1994 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2448GC

Dear Mr. Knight and Mr. San Luis:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Daughters of Charity 1994 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Provider's ("CIRP")] Group's ("Daughters of Charity's") request for case bifurcation. The Board hereby grants Daughters of Charity's request for case bifurcation of the dual eligible Part A non-covered and HMO/Part C[1] days issues as set forth below.

Background

On July 24, 2008, the Board received Daughters of Charity's request to form a CIRP group comprised of two participants transferred from Toyon's 1994 DSH Dual Eligible Days Group Appeal, PRRB Case No. 04-1725G.[2] On July 19, 2010, the Board received Daughters of Charity's jurisdictional documentation for the participants within this appeal.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[3] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

---

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

[2] The two participants are O'Connor Hospital (Provider No. 05-0153) and Seton Medical Center (Provider No. 05-0289).

[3] Toyon is the representative for Daughters of Charity's appeal.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (1996), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

The Board acknowledges that at the time that Daughters of Charity's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and HMO/Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2488GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[4] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' HMO days issue is now within newly formed PRRB Case No. 16-0287GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0287GC are included as enclosures along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated September 17, 2008
Group Acknowledgment Letter for PRRB Case No. 16-0287GC
Standard Remand Letter for PRRB Case No. 08-2448GC

cc: Wilson Leong, Federal Specialized Services

[4] Both the regulation and Board Rule clearly state that a group appeal must contain only one issue.

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Refer to: 07-0420G

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RE: Jurisdictional Decision
Blumberg Ribner 2000/2002 Dual Eligible Days Group #2
FYEs: Various
PRRB Case No.: 07-0420G

Dear Mr. Blumberg and Mr. San Luis,

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

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2007), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Many of the Providers in this group appeal have filed appeals from revised Notices of Program Reimbursement (NPR) and some have appealed from both original and revised NPRs. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2007) provides in relevant part:

> A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary . . . either on motion of such intermediary . . . or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective through May 22, 2008, stated:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened . . . such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

More recently, 42 C.F.R. § 405.1889 was addressed in *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014). In that case, the Court held that the "issue-specific" interpretation of the revised NPR regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

Participants that only appealed from revised NPRs

Participant 4, Community Medical Center, provider no. 39-0001, 6/30/2001

Participant 4 included the dates for both an original and a revised NPR on the Schedule of Providers as well as audit adjustment reports related to both final determinations; however, after reviewing the remaining documents, the Provider has only actually appealed the dual eligible days issue from the revised NPR. Participant 4 only included the appeal request related to the revised NPR and it requested to transfer the dual eligible days issue from the appeal established from the March 2, 2007 revised NPR.

The Board finds that it does not have jurisdiction over Participant 4 because the revised NPR did not adjust dual eligible days. The Provider's audit adjustment report shows an adjustment to DSH for additional MA days, but there is no adjustment to dual eligible days. Therefore, Participant 4 is hereby dismissed because its appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

Participant 9, Eden Medical Center, provider no. 05-0488, 12/31/2000

Participant 9 included the dates for both an original and a revised NPR on the Schedule of Providers, as well as audit adjustment reports related to both final determinations; however, after reviewing all of the documents, the Provider has only actually appealed the dual eligible days issue from its revised NPR. Participant 9 only included the appeal request related to the revised NPR and it requested to transfer the dual eligible days issue from the appeal established from its August 17, 2006 revised NPR.

The Board finds that it does not have jurisdiction over Participant 9 because its revised NPR did not specifically adjust dual eligible days. The revised NPR indicates that the cost report was reopened in order to adjust DSH and the audit adjustment report states that DSH was adjusted in order to agree with the revised Medi-Cal inpatient days; however dual eligible days were not adjusted. Therefore, Participant 9 is hereby dismissed from this appeal.

Participant 10, Eden Medical Center, provider no. 05-0488, 12/31/2000

Participant 10 filed two separate appeals with the Board for FYE 12/31/2000 – one from an original NPR (case number 04-1423) and one from a revised NPR (case number 07-0812). The Provider did not include the dual eligible days issue in its appeal from the original NPR; nor did the Provider request to transfer the dual eligible days issue from that appeal to this group. The Provider did, however, include the dual eligible days issue in its appeal request from the revised NPR and did request to transfer the issue from that appeal, case number 07-0812, to this group. Based on all of the documents, the Board finds that Participant 10 has only properly appealed the dual eligible days issue from its revised NPR.

Furthermore, the Board finds that it does not have jurisdiction over the revised NPR appeal because it did not specifically adjust dual eligible days. The Provider's revised NPR indicates that the cost report was reopened in order to add additional Medi-Cal days to the DSH calculation. The audit adjustment report reflects an adjustment to Medicaid days as well as to the SSI percentage, but dual eligible days were not adjusted. Therefore, Participant 10 is hereby dismissed from this appeal.

Participant 13, Flushing Hospital Medical Center, provider no. 33-0193, 12/31/1995

Participant 13 included an original NPR and noted the date on the Schedule of Providers. However, after reviewing the other documents, the Board has determined that the Provider has only actually appealed from its revised NPR. Participant 13 only included the appeal request related to the revised NPR and it requested to transfer the dual eligible days issue from the appeal established from its March 1, 2001 revised NPR.

The Board finds that it does not have jurisdiction over Participant 13 because it is appealing from a revised NPR that did not specifically adjust dual eligible days. The Provider's revised NPR indicates that the cost report was reopened per the Provider's request for additional Medicaid eligible days. The Provider did not submit an audit adjustment report or any other documents to establish that dual eligible days were adjusted as part of the reopening. Therefore, Participant 13 is hereby dismissed from this appeal.

Participant 14, Flushing Hospital Medical Center, provider no. 33-0193, 12/31/1996

The Board finds that it does not have jurisdiction over Participant 14 because it is appealing from a revised NPR that did not specifically adjust dual eligible days. The Provider's revised NPR indicates that the cost report was reopened per the Provider's request for additional Medicaid eligible days. The Provider did not submit an audit adjustment report or any documentation to establish that dual eligible days were adjusted as part of the reopening; therefore, Participant 4 is hereby dismissed because its appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

Participant 15, Flushing Hospital Medical Center, provider no. 33-0193, 12/31/1997

The Board finds that it does not have jurisdiction over Participant 15 because it is appealing from a revised NPR that did not specifically adjust dual eligible days. The Provider submitted a page from its audit adjustment report that indicates that parts of DSH were adjusted; however the Provider did not submit any additional documents to establish that dual eligible days were adjusted as part of the reopening. Therefore, Participant 15 is hereby dismissed from this appeal.

Participant 16, Flushing Hospital Medical Center, provider no. 33-0193, 12/31/1998

The Board finds that it does not have jurisdiction over Participant 16 because it is appealing from a revised NPR that did not specifically adjust dual eligible days. The Provider submitted a page from its audit adjustment report that indicates adjustments to IME FTEs and Medicare bad debts; however the Provider did not submit any additional documentation to establish that dual eligible days were adjusted as part of the reopening. Therefore, Participant 16 is hereby dismissed from this appeal.

Participant 21, Jackson Park Hospital, provider no. 14-0177, 3/31/2002

Participant 21 included the dates for both an original and a revised NPR on the Schedule of Providers as well as audit adjustment reports related to both final determinations; however, after reviewing the remaining documents, the Board finds that the Provider has only actually appealed the dual eligible days issue from the revised NPR. Participant 21 only included the appeal request related to the revised NPR and it requested to transfer the dual eligible days issue from the appeal established from the March 13, 2006 revised NPR.

The Board finds that it does not have jurisdiction over Participant 21 because the revised NPR did not adjust dual eligible days. The Provider's audit adjustment report shows an adjustment to DSH for additional Medicaid days; the Provider did not submit any documentation to establish that dual eligible days were also adjusted. Therefore, Participant 21 is hereby dismissed because its appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

Participant 23, JPS Health Network, provider no. 45-0039, 9/30/2001

Participant 23 is appealing from both an original and a revised NPR that were incorporated into the same appeal. The Provider appealed the dual eligible days issue from both final determinations, however only the dual eligible days issue appealed from the revised NPR was transferred to this group. The Provider's transfer letter explained, "*Please note the Provider is transferring this issue from the appeal filed on September 28, 2006 of the Revised NPR dated April 13, 2006 – Audit Adjustments and 54 [sic]. The* ***Dual Eligible Days*** *component issue from the appeal of the Original NPR dated May 5, 2004 was previously transferred on July 25, 2006.*" This appeal, case number 07-0420G, was not established until November 6, 2006; therefore the dual eligible days issue from the original NPR must have been transferred into a different group,

which means that only the Provider's appeal of the revised NPR is in this group appeal.

The Board finds that it does not have jurisdiction over this Provider's revised NPR appeal because it did not specifically adjust dual eligible days. The Provider's audit adjustment report shows an adjustment to DSH; however it did not submit any additional documentation to establish that dual eligible days were adjusted as part of the reopening. Therefore, Participant 23 is hereby dismissed from this appeal.

Participant 32, Millcreek Community Hospital, provider no. 39-0198, 6/30/2000

Participant 32 included the dates for both an original and a revised NPR on the Schedule of Providers, as well as audit adjustment reports related to both final determinations; however, after reviewing all of the documents, the Board finds that the Provider has only actually appealed the dual eligible days issue from its revised NPR. Participant 32 only included the appeal request related to the revised NPR and it requested to transfer the dual eligible days issue from the appeal established from its January 13, 2006 revised NPR.

The Board finds that it does not have jurisdiction over Participant 32 because its revised NPR did not specifically adjust dual eligible days. The revised NPR indicates that the cost report was reopened in order to adjust DSH and the audit adjustment report states that DSH was adjusted in order to agree with the revised Medi-Cal inpatient days. Therefore, Participant 32 is hereby dismissed from this appeal.

Participant 54, Sutter Medical Center of Santa Rosa, provider no. 05-0291, 6/30/2000

Participant 54 included the dates for both an original and a revised NPR on the Schedule of Providers; however, after reviewing all of the documents, the Board finds that the Provider has only actually appealed the dual eligible days issue from its revised NPR. The Provider did not include an appeal request or audit adjustment report related to the original NPR appeal, which was a different case number than the revised NPR appeal. Participant 54 only included the appeal request related to the revised NPR and it requested to transfer the dual eligible days issue from the appeal established from its April 21, 2006 revised NPR (from case number 07-0203).

The Board finds that it does not have jurisdiction over Participant 54 because its revised NPR did not specifically adjust dual eligible days. The revised NPR audit adjustment report states that DSH was adjusted, but the Provider did not submit any additional documentation to establish that dual eligible days were specifically adjusted. Therefore, Participant 54 is hereby dismissed from this appeal.

Participant 60, Tucson Medical Center, provider no. 03-0006, 12/31/1999

Participant 60 included the dates for both an original and a revised NPR on the Schedule of Providers, as well as audit adjustment reports related to both final determinations; however, after reviewing all of the documents, the Board finds that the Provider has only actually appealed

the dual eligible days issue from its revised NPR. Furthermore, the Provider's appeal from its original NPR is a separate appeal, assigned case number 04-0284. Participant 60 only included the appeal request related to the revised NPR and it requested to transfer the dual eligible days issue from the appeal established from its April 28, 2006 revised NPR (case number 07-0069).

The Board finds that it does not have jurisdiction over Participant 60 because its revised NPR did not specifically adjust dual eligible days. The revised NPR audit adjustment report states that DSH was adjusted, but the Provider did not submit any additional documentation to establish that dual eligible days were specifically adjusted. Therefore, Participant 60 is hereby dismissed from this appeal.

Participant 61, Tucson Medical Center, provider no. 03-0006, 12/31/2003

Participant 61 included the dates for both an original and a revised NPR on the Schedule of Providers, as well as audit adjustment reports related to both final determinations; however, after reviewing all of the documents, the Board finds that the Provider has only actually appealed the dual eligible days issue from its revised NPR. Furthermore, the Provider's appeal from its original NPR is a separate appeal, assigned case number 04-2315. Participant 60 only included the appeal request related to the revised NPR and it requested to transfer the dual eligible days issue from the appeal established from its April 28, 2006 revised NPR (case number 07-0075).

The Board finds that it does not have jurisdiction over Participant 60 because its revised NPR did not specifically adjust dual eligible days. The revised NPR audit adjustment report states that DSH was adjusted, but the Provider did not submit any additional documentation to establish that dual eligible days were specifically adjusted. Therefore, Participant 60 is hereby dismissed from this appeal.

Participant 65, Wadley Regional Medical Center, provider no. 45-0200, 9/30/2001

The Board finds that it does not have jurisdiction over Participant 65 because it is appealing from a revised NPR that did not specifically adjust dual eligible days. The Provider submitted a page from its audit adjustment report that indicates an adjustment to DSH; however the Provider did not submit any additional documentation to establish that dual eligible days were adjusted as part of the reopening. Therefore, Participant 65 is hereby dismissed from this appeal.

Participant 66, Wadley Regional Medical Center, 45-0200, 9/30/2002

The Board finds that it does not have jurisdiction over Participant 66 because it is appealing from a revised NPR that did not specifically adjust dual eligible days. The Provider submitted a page from its audit adjustment report that indicates an adjustment to DSH; however the Provider did not submit any additional documentation to establish that dual eligible days were adjusted as part of the reopening. Therefore, Participant 66 is hereby dismissed from this appeal.

Participants that appeal from both original and revised NPRs

The following nine Providers in this group appeal that have appealed from both original and revised NPRs:

- 5. Community Medical Center, pn 39-0001, 6/30/2002;
- 11. El Centro Regional Medical Center, pn 05-0045, 6/30/2001;
- 12. El Centro Regional Medical Center, pn 05-0045, 6/30/2002;
- 35. Orthopaedic Hospital, pn 05-0256, 10/31/2002;
- 38. Pacific Hospital of Long Beach, pn 05-0277, 6/30/2002;
- 39. Palomar Medical Center, pn 05-0115, 6/30/1998;
- 40. Parkview Community Hospital, pn 05-0102, FYE 12/31/2000;
- 43. Providence Holy Cross Medical Center, pn 05-0278, 12/31/1996; and
- 46. Queen's Medical Center, pn 05-0278, 12/31/1996.

For those Providers that have appealed from both original and revised NPRs, the Board finds that it does not have jurisdiction over the revised NPR appeals as they did not have specific adjustments related to dual eligible days. However, these Providers will remain pending in this appeal because the Board has determined that the Providers have jurisdictionally valid appeals pending for the same fiscal year ends from the original NPRs.

Conclusion

In this decision, the Board has dismissed the following Participants as listed on the Schedule of Providers: 4, 9, 10, 13-16, 21, 23, 32, 54, 60-61, and 65-66. The Board has also dismissed the revised NPR appeals (but not the original NPR appeals) for the following Participants: 5, 11-12, 35, 38-40, 43, and 46.

Review of these determinations 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 this appeal.

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

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Refer to: 08-0071GC

CERTIFIED MAIL

DEC 03 2015

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Thomas P. Knight
President
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Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Darwin San Luis
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation
Sutter Health 1999 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-0071GC

Dear Mr. Knight and Mr. San Luis:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Sutter Health 1999 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Provider's ("CIRP")] Group's ("Sutter Health's") request for case bifurcation. The Board hereby grants Sutter Health's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues as set forth below.

Background

On October 16, 2007, the Board received Sutter Health's request to form a CIRP group comprised of two initial participants.[1] Subsequently, Sutter Health added three additional participants[2] to its CIRP group, and on July 27, 2010, the Board received Sutter Health's jurisdictional documentation for the participants within this appeal.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[3] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

[1] The initial participant appeals are Sutter Delta Medical Center's appeal (Provider No. 05-0523) for the fiscal year ending ("FYE") on December 31, 1999; and Summit Medical Center's appeal (Provider No. 05-0043) for FYE December 31, 1999.
[2] Sutter Health added Alta Bates Medical Center's appeal (Provider No. 05-0305) for FYE December 31, 1999; Memorial Hospital Modesto's appeal (Provider No. 05-0557) for FYE December 31, 1999; and Summit Medical Center's appeal (Provider No. 05-0043) for FYE February 28, 1999.
[3] Toyon is the representative for Sutter Health's appeal.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2001), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

The Board acknowledges that at the time that Sutter Health's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-0071GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[4] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The providers' Part C issue is now within newly formed PRRB Case No. 16-0271GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0271GC are included as enclosures along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 22, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0271GC
Standard Remand Letter for PRRB Case No. 08-0071GC

cc: Wilson Leong, Federal Specialized Services

[4] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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Refer to: 12-0444

DEC 03 2015

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Lucile Packard Children's Hospital
Jean Irwin
Manager, Revenue and Reimbursement
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Palo Alto, CA 94304

Noridian Healthcare Solutions, Inc.
Darwin San Luis
Appeals Coordinator – Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Jurisdictional Decision
Lucile Packard Children's Hospital
FYE: 8/31/2010
Provider No.: 05-3305
PRRB Case No.: 12-0444

Dear Ms. Irwin and Mr. San Luis,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal and determined that the appeal is premature. The jurisdictional decision of the Board is set forth below.

Background

The Medicare Contractor issued a Notice of Program Reimbursement (NPR) for FYE 8/31/2010 to the Provider on January 20, 2012. On July 16, 2012, the Provider filed a request for TEFRA Exception Relief with the Medicare Contractor. Two days later, on July 18, 2012, the Board received Lucile Packard Children's Hospital appeal request in which it appealed one issue: TEFRA Target Amount per Discharge and Related Medicare Days and Discharges.

Medicare Contractor's Position

The Medicare Contractor contends that it has not made a determination regarding the TEFRA Target Amount Exemption, therefore this issue is prematurely before the Board. 42 C.F.R. § 413.40(e) requires a hospital requesting an exemption to first make a request to the Medicare Contractor. The Medicare Contractor then refers the request to CMS with a recommendation. CMS must issue a decision within 180 days after receipt from completed application from the Medicare Contractor. The Medicare Contractor asserted that it had not made a determination with respect to the Provider's request at the time it filed its jurisdictional challenge with the Board.

Provider's Position

The Provider requested a TEFRA Exemption with the Medicare contractor on July 17, 2012. The Provider believes this issue is still resolvable with the current Intermediary. The Provider requests that the Board use 42 U.S.C. § 1395oo(a)(1) to order the new Medicare Contractor to calculate the TEFRA Exemption.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that this appeal is premature because the Medicare Contractor had not yet issued a final determination at the time the Provider filed its hearing request. 42 C.F.R. § 413.40(e) requires the Provider to request the TEFRA exception within 180 days of the date of the issuance of the NPR. The Medicare Contractor then submits a recommendation to CMS and CMS must issue a decision within 180 days of receipt of the recommendation. After the Medicare Contractor notifies the Provider of CMS's decision, the Provider has 180 days to appeal the decision directly to the PRRB. The Provider requested a hearing two days after requesting a TEFRA exception with the Medicare contractor. The request was premature because the Provider had not yet received the final determination of the TEFRA exception from the Medicare Contractor prior to requesting a hearing with the Board as required by 42 C.F.R. § 413.40(e). As the TEFRA Target Amount issue is the only issue in the appeal, case number 12-0444 is hereby dismissed.

Review of these determinations 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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Federal Specialized Services
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Refer to:

Certified Mail

DEC 08 2015

Naomi L. Oliva
Director - Client Services
Toyon Associates, Inc.
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Concord, CA 94520-2546

RE: **Expedited Judicial Review Decision**
15-1473GC Essentia Health FFY 2015 Two-Midnight Rule CIRP Group
15-1474GC St. Joseph Health System FFY 2015 Two-Midnight Rule CIRP Group
15-1475GC Susquehanna Health System FFY 2015 Two-Midnight Rule CIRP Group
15-1476GC John Muir System FFY 2015 Two-Midnight Rule CIRP Group
15-1477GC Sutter Health FFY 2015 Two-Midnight Rule CIRP Group
15-1478G Toyon FFY 2015 Two-Midnight Rule Group

Dear Ms. Oliva:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' October 30, 2015 request for expedited judicial review (EJR) (received November 9, 2015). The Board's decision is set forth below.

Background

Issue Under Appeal

The Providers note that in the final inpatient prospective payment system (IPPS) rule for Federal fiscal year (FFY) 2015 the Centers for Medicare & Medicaid Services (CMS) failed to eliminate the 0.2% reduction to IPPS payments to offset the expected increase in national inpatient reimbursement due to the implementation of the two-midnight policy. Based on this, the Providers filed these appeals to challenge the payment reduction in 2015 on the following grounds:

(1) The estimated increase in the IPPS expenditures of $220 million is unsupported and insufficiently calculated.

(2) CMS did not provide sufficient rationale for the use of exceptions adjustments authority under section 1886(d)(5)(I)(i) of the Act.

(3) CMS has not demonstrated that an anticipated shift in utilization between inpatient and outpatient coverage is a

unique situation demonstrating the need for the reduction in IPPS payment rates.

(4) The two-midnight policy is punitive and duplicative.[1]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because the Medicare review contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[4]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[5]

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[1] Providers' hearing requests establishing group appeals (various dates) at 2.
[2] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[6] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[7]

In the FFY 2014 IPPS proposed rule,[8] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[9]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

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[6] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.
[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. 50,908.
[10] *Id.*

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[11] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[12] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[14]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[15] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[16]

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[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.
[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18] In the final IPPS rule for 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 period.[19]

Providers' Position

The Providers contend that the CMS' actuarial analysis of an increase in the IPPS expenditures of $220 million, which lead to the implementation of the 0.2 percent reduction in IPPS payment, was insufficient given the small fraction of inpatient and outpatient claims analyzed. The Providers believe that the opposite conclusion should have been reached. They contend that the "IPPS payments will decrease and the OPPS will increase, which would necessitate an IPPS payment adjustment upward, not downward, in order to achieve budget neutrality."[20]

The Providers believe that CMS has not adequately demonstrated that there is a widespread issue regarding the delivery of hospital care as an inpatient versus an outpatient that justifies an overall adjustment to the IPPS rates. Also, the Providers contend that CMS has not demonstrated that the adjustment is authorized under CMS' exceptions and adjustments authority pursuant to section 1886(d)(5)(I)(i) of the Act.

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 79 Fed. Reg. 49,854,50,382-83 (Aug. 22, 2014).
[20] Providers' hearing requests establishing group appeals (various dates) at 2.

The Providers disagree with CMS' position that the two-midnight policy does not adjust IPPS rates for coverage decisions given that the policy is intended to make it more restrictive for a Provider to receive IPPS payment for same day and one day stays. The Providers contend that he 0.2 percent rate decrease is punitive and duplicative.

The Providers believe that EJR is appropriate because the Board has jurisdiction over the cases but lacke the authority to decide the legal question of whether the Secretary's adjustment to IPPS payments was appropriate.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board concludes that the Providers timely filed their requests for hearing from the issuance of the August 22, 2014 Federal Register[21] and the amount in controversy exceeds the $50,000 threshold necessary for each group appeal.[22] Consequently, the Board has determined that it has jurisdiction over Providers' appeals. Further, the Board finds that it lacks the authority to decide the legal question of whether the -0.2 percent payment adjustment to IPPS is appropriate. Therefore, EJR is appropriate for the issue under dispute in these cases.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers' are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount, 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 Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

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[21] *Washington Hospital Center v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ([A] year end cost report is not a report necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal) and *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

[22] *See* 42 C.F.R. § 405.1837(a)(3).

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Review of the jurisdictional determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedules of Providers

cc: Wilson C. Leong, Federal Specialized Services (w/Schedules of Providers)
Evaline Alcantara, Noridian Healthcare Solutions (w/Schedules of Providers)
Danene Hartley, National Government Services (w/Schedules of Providers)
Bruce Snyder, Novitas Solutions (w/Schedules of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL

DEC 08 2015

Berkshire Nursing Home, LLC
Lyudmila Vilchik
Controller
25 Bialystoker Place
New York, NY 10002 4008

RE: Berkshire Nursing Home, Provider No. 33-5083, FYE 12/31/2013
PRRB Case No. 15-1931

Dear Controller Vilchik:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal which you filed in March of 2015. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

The Provider filed an appeal on March 24, 2015. The Provider did not submit a statement of the issues with its appeal request.

On April 4, 2015, the Board established case number 15-1931 and issued an Acknowledgement and Critical Due Dates letter. On the same date, the Board sent a Request for Additional Information requesting the statement of issues, any applicable audit adjustment pages and a calculation demonstrating how the appeal meets the amount in controversy. The information was due within 30 days.

To date there has been no response to the Board's request for information.

Board Determination:

In the referenced case, the Provider is filing an appeal that does not meet the regulatory requirements. The Provider also failed to comply with the Board's request for information.

42 C.F.R § 405.1835(b)(2) specifically requires the Provider to provide

> An explanation . . . of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item . . . .

(ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
(iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.[1]

Board Rule 9 also addresses the acknowledgement of an appeal and issuance of critical due dates:

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

Because the appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, the Board dismisses the individual appeal. 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:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson
Jack Ahern, MBA

For the Board:

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877

cc: Kyle Browning, National Government Services
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[1] 42 C.F.R. § 405.1835(b)(2) (Oct. 2014)

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Refer to: 08-2635GC

CERTIFIED MAIL

DEC 09 2015

Toyon Associates, Inc.
Thomas P. Knight
President
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Darwin San Luis
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation
Hawaii Pacific Health 2004 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2635GC

Dear Mr. Knight and Mr. San Luis:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Hawaii Pacific Health 2004 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Provider's ("CIRP")] Group's ("Hawaii Pacific's") request for case bifurcation. The Board hereby grants Hawaii Pacific's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues as set forth below.

Background

On July 25, 2008, the Board received Hawaii Pacific's request to form a CIRP group comprised of two commonly-owned participants.[1] On December 31, 2012, the Board received Hawaii Pacific's jurisdictional documentation for these two participants.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[2] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the

[1] The two participants are Kapiolani Pali Momi Medical Center (Provider No. 12-0026) and Straub Hospital and Clinics (Provider No. 12-0022).
[2] Toyon is the representative for Hawaii Pacific's appeal.

date the notice of the intermediary's determination was mailed to the provider.

The Board acknowledges that at the time that Hawaii Pacific's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2635GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' HMO days issue is now within newly formed PRRB Case No. 16-0302GC GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0302GC are included as enclosures along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated December 21, 2012
Group Acknowledgment Letter for PRRB Case No. 16-0302GC
Standard Remand Letter for PRRB Case No. 08-2635GC

cc: Wilson Leong, Federal Specialized Services

[3] Both the regulation and Board Rule clearly state that a group appeal must contain only one issue.

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Refer to:

CERTIFIED MAIL DEC 09 2015

Michael K. McKay, President
McKay Consulting, Inc.
8590 Business Park Drive
Shreveport, LA 71105

Danene Hartley, Appeals Lead
Palmetto GBA c/o National Government Services
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
Duke University 2004 DSH Dual Eligible CIRP Group, Case No. 09-0587GC

Dear Mr. McKay and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the Representative's request for the bifurcation of Dual Eligible days and Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. Because the Part C days issue for the participants bifurcated from this group would not meet the $50,000 amount in controversy, the Part C days issue for Duke Health Raleigh Hospital, Duke University Hospital & Durham Regional Hospital will be consolidated with participants from other McKay groups that are also pursuing bifurcations. Each bifurcation will be addressed in a separate letter.

The Part C providers which the Board agrees to bifurcate will ultimately reside in case number 16-0314G, the McKay Consulting 1999 – Pre 10/1/2004 National Part C Days Group.[1] For those Providers appealing Part A Non-Covered and Exhausted Benefit days over which the Board finds jurisdiction, the Board will issue a remand pursuant to CMS Ruling 1498-R.

Background

The Representative's request for a group hearing, dated December 23, 2008, contained a lengthy group issue statement that included the following language:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[2]

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[1] An Acknowledgement Letter for the new consolidated Part C days group will be sent under separate cover once all of the related bifurcations are complete.
[2] 09-0587GC Group Request for Hearing at 2, December 23, 2008.

In the December 23, 2008 request, the Representative also identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

The preliminary Schedule of Providers attached to the Request for a Hearing, named one Provider: Duke Health Raleigh Hospital (34-0073) (Transfer from 08-1975).[3]

The following participants were then added to the group:

- Durham Regional Medical Center (34-0155) for FYE 6/30/2004 (Direct Add on 6/17/2009)
- Duke University Health System (34-0030) for FYE 6/30/2004 (Direct Add on 9/02/2010)

These three participants are on both the Dual Eligible days Schedule of Providers as well as the combined Part C Days Schedule.[4]

On June 3, 2013, the Representative submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[5] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[6] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[7]

Board Determination on Bifurcation

The Board has granted the bifurcation of the Dual Eligible days and Part C days issues for the three Providers requested. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[8] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed

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[3] *See id.* at Schedule A.
[4] In the Representative's August 30, 2013 Bifurcation Request, the Representative identifies various Part C Days groups that will have to be combined to meet the $50,000 group threshold amount in controversy.
[5] *See* Case Management Plan Letter, Jun. 3, 2013.
[6] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[7] *Id.* at 1.
[8] 42 C.F.R. § 405.1837(a)(2) (2003).

as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board acknowledges that at the time that Duke Health Raleigh Hospital's individual appeal, transfer request and the group appeal were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the provider's individual appeal and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

With regard to the remaining participants, Durham Regional Medical Center and Duke University Health System, both participants filed directly into the group from receipt of their respective Notices of Program Reimbursement. Therefore, the Board deems these participants to have appealed the group issue which included the Part C days component.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 09-0587GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[9] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The providers' Part C issue is now within newly formed PRRB Case No. 16-0314G. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal is included as an enclosure along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:

Charlotte Benson

Michael W. Harty
Chairman

[9] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

Enclosures: Standard Remand of Dual Eligible Days Pursuant to CMS Ruling 1498-R
Schedule of Providers

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosure)

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CERTIFIED MAIL

DEC 09 2015

Refer to:

John M. Maguire, Manager, Appeals
Tenet Healthcare Corporation
1445 Ross Avenue, Suite 1400
Dallas, TX 75202 2703

Byron Lamprecht
Wisconsin Physicians Services
Cost Report Appeals
P. O. Box 1604
Omaha, NE 68101

Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
Detroit Medical Center 2004 Dual Eligible CIRP Group, Case No. 09-0088GC

Dear Mr. Maguire and Mr. Lamprecht:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1)Pre 10/1/2004 Dual Eligible days (2) Post 9/30/2004 Dual Eligible days (3) Pre 10/1/2004 Part C days and (4) Post 9/30/2004 Part C days filed by McKay Consulting (McKay), the former representative for this group . The Board determined that, for providers deemed eligible, it will grant the bifurcation requests of the Pre 10/1/2004 and Post 9/30/2004 Dual Eligible days and the Pre 10/1/2004 and Post 9/30/2004 Part C days issues. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[1] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Because the Part C days issue for the participants bifurcated from this group would not meet the $50,000 amount in controversy, the two participants with a pre-10/1/2004 Part C days issue (Detroit Receiving Hospital and Sinai Grace Hospital) will be consolidated with participants from other McKay groups in a newly formed optional group to which we have assigned case number 16-0314G (McKay 1999-Pre 10/1/2004 Medicaid Fraction Part C Days Group). The participants with post 9/30/2004 Part C days issues (Detroit Receiving Hospital, Harper Hospital and Sinai Grace Hospital) will be combined with other participants from case numbers 09-1072GC and 09-1732GC, in a newly formed optional group to which we have assigned case number 16-0318G (McKay Post 9/30/2004 Medicaid Fraction Part C Days Group). Each respective group bifurcation will be addressed in a separate letter.

With regard to the Dual Eligible days issue, patient discharges before October 1, 2004 are subject to the Centers for Medicare & Medicaid Services (CMS) Ruling CMS 1498-R. Discharges on or after October 1, 2004 are not covered by the Ruling. Consequently, the Board is bifurcating and transferring the post-Ruling period to the 2005 group appeal for the same issue, (Detroit Medical

[1] 42 C.F.R. § 405.1837(a)(2) (2003).

Center 2005 Dual Eligible CIRP Group) case number 09-0089GC. The group name for case number 09-0089GC has been modified to reflect the inclusion of the period from 10/1/2004-12/31/2004. For those Providers appealing Dual Eligible days over which the Board finds jurisdiction, the Board will issue a remand pursuant to CMS Ruling 1498-R.

Background

McKay's request for a group hearing, dated October 14, 2008 (filed prior to the October 20, 2008 deadline for adding issues), contained a lengthy group issue statement that included the following language:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[2]

In the October 2008 hearing request, McKay also identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

The preliminary Schedule of Providers attached to the Request for a Hearing, named four Providers:

- Detroit Receiving Hospital (23-0273) (Transfer from 08-0330)[3]
- Harper Hospital (23-0104) (Direct Add)
- Sinai Grace Hospital (23-0024) (Transfer from 08-1980) and
- Rehabilitation Institute (23-3027)

When the final Schedule of Providers was submitted on December 23, 2009, Rehabilitation Institute was no longer included as a participant.

On June 3, 2013, the Representative submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[4] On August 30, 2013, the Board received the Schedule of Providers from McKay for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[5] McKay wrote that it determined that "...each of the group appeals...challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[6] However, not every provider was listed on both the Exhausted Benefits and Part C days' Schedules of Providers. Out of the three remaining participants in case number 09-0088GC, only Detroit Receiving Hospital and Sinai Grace Hospital are on both the Dual Eligible days Schedule of Providers as well as the combined Part C Days Schedule.[7,8]

---

[2] 09-0088GC Group Request for hearing at 2, October 14, 2008.
[3] See *id.* At Schedule A.
[4] *See* Case Management Plan Letter, Jun. 3, 2013.
[5] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[6] *Id.* at 1.
[7] In the Representative's August 30, 2013 Bifurcation Request, the Representative identifies various Part C Days groups that will have to be combined to meet the $50,000 group threshold amount in controversy.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Detroit Receiving Hospital and Sinai Grace Hospital filed individual appeals in 2007 and described general Dual Eligible days issues in their appeals. Both transferred the dual eligible days issue on October 15, 2008 in order to form the subject group appeal which explicitly defined the issue under appeal as including the Part C days component. Although the transfer of the Dual Eligible days issues occurred after the issuance of the August 2008 regulatory change, the transfers were filed prior to the period allowed for adding issues to pending appeals which expired October 20, 2008. Therefore, the Board agrees to allow the bifurcation of the (Pre 10/1/2004 and Post 09/30/2004) Part C days issues for these participants.

With regard to the remaining participant, Harper Hutzel Hospital, this participant filed directly into the group from receipt of its Notice of Program Reimbursement. Therefore, the Board deems this participant to have appealed the group issue which included the Part C days component, and grants the Post 9/30/2004 bifurcation for this participant.

Enclosed, please find a Standard Remand for the dual eligible days issue.

Board Members Participating:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: Standard Remand of Dual Eligible Days Pursuant to CMS Ruling 1498-R
Schedule of Providers

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosure)

[8] The Representative is not requesting that Harper Hospital be included in the pre 10/1/2004 Part C days group; only the post 9/30/2004 Part C days group. Harper Hospital should however remain in the pre-10/1/2004 and be included in the post 10/1/2004 (09-0089GC) dual eligible days groups.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-2097 **CERTIFIED MAIL** DEC 10 2015

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

RE: Request for Expedited Judicial Review
DCH Regional Medical Center
Provider No. 01-0092
Fiscal Year ("FY") September 30, 2014
PRRB Case No.: 14-2097

Dear Mr. Ravindran:

On November 13, 2015, the Provider Reimbursement Review Board ("PRRB" or "Board") received DCH Regional Medical Center's ("DCH's") request ("November 13, 2015 Request") for Expedited Judicial Review ("EJR") of DCH's uncompensated care determination issue within its FY September 30, 2014 request for hearing ("RFH"). As explained below, the Board has determined that it does not have jurisdiction to hear DCH's challenge to its uncompensated care determination and, therefore, cannot grant DCH's request for EJR of this issue.

Issue

Within its November 13, 2015 Request, DCH describes its issue in the following manner:

> Whether the provision in the Fiscal Year [2014 Inpatient Prospective Payment System [("IPPS")] Final Rule that, for purposes of the "Factor 3" uncompensated care determination under the new [Disproportionate Share Hospital ("DSH")] payment calculation, excludes, under certain circumstances, Medicaid and Supplemental Security Income [("SSI")] days of a hospital that merged into another hospital from the number of uncompensated care days of the surviving hospital to the merger, is procedurally invalid, arbitrary and capricious, and outside the statutory authority of the Centers for Medicare & Medicaid Services [("CMS")].

DCH's EJR Request

On January 28, 2014, the Board received DCH's timely filed RFH regarding the above-quoted issue (the only issue challenged within DCH's RFH). DCH filed its RFH in response to the

Secretary's 2014 IPPS Final Rule that implemented the new DSH payment regulations as published within the August 19, 2013 Federal Register Notice ("August 19, 2013 Final Rule").[1] In its original RFH, DCH does not include a request for EJR, but on November 13, 2015, the Board received DCH's EJR request for the sole issue within the appeal.

DCH is challenging a portion of the Secretary's policy, as published within the August 19, 2013 Final Rule, that implements Congress' 2010 revisions[2] to the DSH payment by amending "Section 1886(r) of the Social Security Act[("Act")]."[3] Specifically, DCH is challenging the "manner in which CMS decided to exclude Medicaid and SSI days from merged hospitals"[4] when determining "Factor 3."[5]

DCH explains that under the DSH revision mandates, a hospital's DSH payment consists of two components. The first component, representing 25% of the payment, is "calculated by determining the hospital's disproportionate patient percentage."[6] The second component, representing the other 75% of the DSH payment, is an uncompensated care payment "based in part on the hospital's Medicaid and [SSI] days from its 2010 or 2011 cost report (including the FY 2011 or FY 2010 SSI ratios, whichever represents the most recently available inputs prior to October 1, 2013)[,]" otherwise known as "Factor 3." DCH complains that in the case "where a hospital merged [with another hospital] in 2011 and is the surviving hospital under the merger, the only Medicaid and SSI days in 2011 that will be counted for purposes of the FY 2014 uncompensated care payment will be the days associated with the provider number of the surviving hospital."[7]

DCH acknowledges and quotes the following review preclusion within section 1886(r)(3) of the Act:

> (3) Limitations on review.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:
>
> (A) Any estimate of the Secretary[8] for purposes of determining the factors described in paragraph (2).
>
> (B) Any period selected by the Secretary for such purpose.

---

[1] Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status, 78 Fed. Reg. 50495 (Aug. 19, 2013).

[2] Referencing section 3133 of the Patient Protection and Affordable Care Act ("PPACA"), as amended by section 10316 of PPACA and section 1104 of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

[3] November 13, 2015 Request at 2.

[4] *Id.* at 3.

[5] The specifics of the DSH revision mandates are summarized *infra.*

[6] November 13, 2015 Request at 2.

[7] *Id.* at 3.

[8] "Secretary" refers to the Secretary of the Department of Health and Human Services.

DC[redacted]H argues at its appeal does not fall within the parameters of this preclusion pro[illegible]vi[illegible]sion bec[illegible]eal does not involve a challenge to CMS's computations and estimates, or t[illegible]he period 011) that CMS is using . . . for purposes of those computation and esti[illegible]mates." Des that it "is not claiming that CMS added [its] figures incorrectly or that [illegible]its estima 3 was off-kilter based on the data it used or that it should have used data [illegible]from a di period." Instead, DCH claims that it is "challenging the manner in whi[illegible]ch CMS exclude Medicaid and SSI days from merged hospitals as being proc[illegible]edurally and vely unlawful under the Administrative Procedure Act [("APA")]."[9]

DCH states that Board determined that it did not have jurisdiction over "essentially the same issue" in *Presbyterian Hospital*, PRRB Case No. 14-2092 . . .[,]" that case "was wrongly decided rgues that

> Where C as provided that there shall be no judicial or administrative review of cy's computation, the Courts have recognized a distinction between a of the agency's computation itself (no jurisdiction) and an appeal of cy's procedures or process for deciding how the computation should be risdiction).[10]

In support of its arg, DCH notes that "[t]here is a strong presumption in favor of judicial review of an admin action[ ]"[11] and that "[t]his presumption has been applied in cases in which there was a y preclusion of judicial review but there was no indication that the preclusion was inten prevent a challenge to the procedures by which the agency arrived at the policy or the com ons that [are] insulated from review."[12]

DCH also claims that are "a lon line of cases holding that although the Medicare statute precludes review of Medicare Geographic [Classification] Review Board (MGCRB) decisions, it does not lude challe es to the procedures underlying the decisions."[13] DCH states that these case not distinishable from the instant appeal . . . [because DCH] is challenging CMS's ru of general pplicability . . . by which [CMS] makes the Factor 3 determination for all ho als."[14]

In support of its EJR re est, DCH ims that "the Board does not have the authority to grant the relief requested by [CH]" bec DCH is requesting that a reviewing entity find that CMS' policy of excludin Medicaid SSI days of merged hospitals when calculating "Factor 3" is "procedurally invalid arbitrar pricious and outside [of CMS'] statutory authority . . ."[15]

Lastly, DCH states that if "the B concludes that it does not have jurisdiction [over this appeal, DCH] requests that the B cknowledge that it does not have the authority to decide

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[9] November 13, 2015 Request at 3.
[10] *Id.* at 2.
[11] *Id.* at 3.
[12] *Id.* at 4.
[13] *Id.*
[14] *Id.* at 6.
[15] *Id.*

the issue presented." DCH claims that if the Board acknowledges as much, this "would enable the Provider . . . to go immediately to court . . ." in the event that the Administrator reverses the Board's decision on jurisdiction or if it successfully appeals the agency's denial of jurisdiction in court. DCH claims that this is "the approach that the Board took in the rural floor budget neutrality adjustment cases . . ."[16]

Board's Decision

Relevant Statutory and Regulatory Provisions

EJR Request

Under the Medicare statute codified at 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 a provider's 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.

DSH Adjustment

Prior to the 2010 Congressional changes made to the Act, Medicare contractors calculated a qualifying hospital's[17] DSH payment adjustment by adding two fractions: the hospital's Medicare fraction and its Medicaid fraction ("Traditional DSH Adjustment").[18] The Medicare fraction represents the number of the hospital's inpatient days for patients entitled to Medicare Part A and SSI benefits.[19] The Medicaid fraction represents the number of the hospital's inpatient days for patients eligible for Medicaid but not Medicare Part A.[20]

Pursuant to Congress' mandates, the DSH adjustment was revised ("Amended DSH Adjustment") so that beginning in 2014, a qualifying hospital's DSH payment is based upon a combination of the hospital's Traditional DSH Adjustment and an estimate of the hospital's amount of uncompensated care that it provided to patients. Specifically, a hospital's Amended DSH Adjustment payment is determined using 25% of the hospital's Traditional DSH Adjustment and adding an "additional payment" equal to the hospital's share of "75 percent of what otherwise would have been paid as Medicare DSH payments . . . after the amount is reduced for changes in the percentage of individuals that are uninsured."[21]

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[16] *Id.* at 6-7.
[17] Under 42 U.S.C. § 1395ww(d)(5)(F)(i)(I), hospitals that serve a significantly disproportionate number of low-income patients receive an additional payment from Medicare. A hospital that receives such a payment is called a "disproportionate share hospital."
[18] 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[19] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[20] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).
[21] 78 Fed. Reg. 50505 (Aug. 19, 2013).

Congress directed the Secretary to calculate each hospital's "additional payment" by multiplying three factors: (1) an estimate of the remaining 75% of the nationwide DSH payments; (2) an estimate of the decline in the national uninsured rate for the FY as compared to the prior FY; and (3) the hospital's share of the total amount of uncompensated care.[22] With respect to the third factor—"Factor 3"—the codified version of the statute defines this factor in the following manner:

> (2) Additional payment
>
> . . .
>
> (C) Factor Three
>
> A factor equal to the percent, for each subsection (d) hospital,[23] that represents the quotient of—
>
> (i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and
>
> (ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).[24]

Also within the codified version of the statute, Congress limited administrative and judicial review of the Amended DSH Adjustment in the following manner:

> (3) Limitations on review
>
> There shall be no administrative or judicial review under section 1395ff of this title, section 1395oo of this title,[25] or otherwise of the following:
>
> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).
>
> (B) Any period selected by the Secretary for such purposes.[26]

In order to implement these Amended DSH Adjustment mandates, the Secretary published a proposed rule in May 2013[27] and, after receiving public comments, promulgated the final rule in

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[22] 42 U.S.C. § 1395ww(r)(2).
[23] A "subsection (d) hospital" is defined at 42 U.S.C. § 1395ww(d)(1)(B).
[24] 42 U.S.C. § 1395ww(r)(2)(C).
[25] 42 U.S.C. § 1395ff refers to beneficiary appeals, while 42 U.S.C. § 1395oo refers to appeals to the PRRB.
[26] 42 U.S.C. § 1395ww(r)(3).
[27] 78 Fed. Reg. 27486 (May 10, 2013).

August 2013.[28] The Secretary noted the following within the preamble to the August 19, 2013 Final Rule:

> [w]hile the statute instructs the Secretary to estimate the amounts of uncompensated care for a period 'based on appropriate data,' section 1886(r)(2)(C)(i) of the Act permits the Secretary to use alternative data 'in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured' for the numerator of Factor 3."

For the purposes of calculating "Factor 3" for FY 2014, the Secretary determined that CMS would use such "alternative data" and decided "that data on utilization for insured low-income patients can be a reasonable proxy for the treatment costs of uninsured patients."[29] The Secretary finalized the proposal "to use the utilization of insured low-income patients as defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 C.F.R. 412.106(b)(4) and 412.106(b)(2)(i), respectively to determine Factor 3."[30] The Secretary stated that "[t]he numerator of Factor 3 would be the estimated Medicaid and Medicare SSI patient days for the individual hospital based on its most recent 2010/2011 Medicare cost report data (including the most recently available data that may be used to update the SSI ratios)."[31] The Secretary concluded that such Medicare cost report data is "publicly available, subject to audit and used for payment purposes."[32]

DCH's Request

DCH's EJR request involves the following issue:

> [w]hether the provision in the [FY] 2014 [IPPS] Final Rule that, for purposes of "Factor 3" uncompensated care determination under the new DSH payment calculation, excludes, under certain circumstances, Medicaid and [SSI] days of a hospital that merged into another hospital from the number of uncompensated care days of the surviving hospital to the merger, is procedurally invalid, arbitrary and capricious, and outside the statutory authority of [CMS].[33]

As noted prior, while DCH acknowledges the preclusion provision contained within the statute, DCH argues that its appeal of Factor 3 does not involve a prohibited challenge to the Secretary's computations, estimates or choice of time periods used in the Factor 3 calculation. Rather, DCH states that its appeal involves "the *manner* in which CMS decided to exclude Medicaid and SSI days from merged hospitals as being procedurally and substantively unlawful under the [APA]."[34]

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[28] 78 Fed. Reg. 50495.
[29] *Id.* at 50636.
[30] *Id.*
[31] *Id.* at 50640.
[32] *Id.* at 50638.
[33] November 13, 2015 Request at 3.
[34] *Id.* (Emphasis added).

Within the preamble to the August 19, 2013 Final Rule, the Secretary set out the decision process used to determine the way in which CMS would calculate a hospital's share of uncompensated care within the Amended DSH Adjustment for FY 2014. As DCH states that it is challenging the manner in which the Secretary decided to exclude Medicaid and SSI days from merged hospitals, the Secretary's decision process is summarized below.

August 19, 2013 Final Rule Preamble Summary[35]

The Secretary stated that in order to implement the statutory requirements of Factor 3, it was necessary to (1) define uncompensated care in terms of the items to be included in the numerator (the hospital-specific portion) and the items to be included in the denominator (estimated uncompensated care for all hospitals estimated to receive DSH payments); (2) identify the data sources for the estimated compensated care amount; and (3) determine the computation's timing and manner.[36] Within the proposed rule, the Secretary stated that CMS would define the amount of uncompensated care for a hospital as the amount of uncompensated care *costs* of that hospital. The Secretary sought input from stakeholders and the public regarding which costs should be included in the definition of uncompensated care costs.[37] The Secretary also considered different "appropriate" data sources to provide the hospitals' information regarding these uncompensated care costs.

The Secretary "determined that the Medicare cost report Worksheet S-10 could potentially provide the most complete data for Medicare hospitals." Worksheet S-10 went into effect for cost reporting periods beginning on or after May 1, 2010, and is a relatively new data source that CMS had, up until that time, only used in a relatively restrictive way for specific payment purposes. Based on this fact, the Secretary noted that some providers felt that they were not sufficiently familiar with the document to provide "accurate and consistent data" and that there were "numerous inconsistencies in how uncompensated care is calculated and reported on Worksheet S-10 . . ." to use the document as a reliable data source. The Secretary, therefore, decided not to define uncompensated care costs in a way that required the use of Worksheet S-10 data, although it did state that it may choose to do so sometime in the future.

In considering other data sources for the Factor 3 computations, the Secretary stated that it was important to use "data that have been have been historically publicly available, subject to audit, and used for payment purposes." Therefore, consistent with the statute's statement that the Secretary may, when calculating Factor 3, use alternative data "in the case where the Secretary determines that alternative data is available and which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured[,]" the Secretary determined that, at least for FY 2014, "data on utilization for insured low-income patients can be a reasonable proxy for the treatment costs of uninsured patients." The Secretary further defined this as the inpatient days of Medicaid patients, as determined under 42 C.F.R. § 412.106(b)(4), plus the inpatient days of Medicare-SSI patients, as determined under 42 C.F.R. § 412.106(b)(2)(i).

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[35] 78 Fed. Reg. 50495.
[36] *Id.* at 50634.
[37] *Id.*

The Secretary determined that, based on this formula, a hospital's individual insured low-income days would represent the Factor 3 numerator while the sum of all insured low-income days for DSH-eligible hospitals would represent the Factor 3 denominator. The Secretary stated that, for FY 2014, "[t]he numerator of Factor 3 would be the estimated Medicaid and Medicare SSI patient days for the individual hospital based on its most recent 2010/2011 cost report data (including the most recently available data that may be used to update the SSI ratios)."[38]

Following publication of the proposed rule, the Secretary responded to a number of public comments regarding its Factor 3 calculation, with most supporting the Secretary's "proposal to not to employ the Worksheet S-10 data to determine uncompensated costs[,]" at least on an interim basis. One commenter, in particular, addressed the very issue being appealed here when it discussed the merger of two hospitals with two cost reports and two SSI ratios. The commenter requested that the Secretary "account for the merger and include both hospitals' data in the calculation of the Factor 3 amount." The Secretary responded by stating that "[a] hospital's Factor 3 is calculated based on the data" associated with its [CMS Certification Number ("CCN")] and that this approach is consistent with how CMS treats other IPPS payment factors. The Secretary also stated that "data reported on the Medicare hospital cost report under the CCN associated with the old provider agreement would not necessarily be used to determine hospital payments for the CCN associated with the surviving provider agreement." For those reasons, the Secretary stated that "in the case of a merger between two hospitals, Factor 3 will be calculated based on the low-income insured patient days (that is, Medicaid days and SSI days) under the surviving CCN based on the most recent available data for that CCN from the cost report for 2011 or 2010."[39]

Analysis

In the instant appeal, DCH states that, with respect to Factor 3, it "is challenging the manner in which CMS decided to exclude Medicaid and SSI days from merged hospitals as being procedurally and substantively unlawful under the Administrative Procedure Act."[40] However, no matter how DCH attempts to characterize its issue, the heart of its appeal is a challenge to the Secretary's determination of uncompensated care costs, i.e., Factor 3, for FY 2014.

The statute states that a hospital's Factor 3 will be represented by a quotient, the numerator of which is equal to "the amount of uncompensated care for such hospital for a period selected by the Secretary (as *estimated* by the Secretary, based on appropriate data . . .)[,]" and permits the Secretary to use alternative data, when available, which is a better proxy for a subsection (d) hospital's costs for treating the uninsured.[41] For FY 2014, the Secretary has determined that the closest proxy or *estimate*[42] of a hospital's uncompensated care costs is the use of alternative data in the form of a hospital's utilization of insured low-income patients—in this case, Medicaid or Medicare–SSI patients as reported on the hospital's 2010/2011 Medicare cost reports. The statute

[38] *Id.* at 50640.
[39] *Id.* at 50642.
[40] November 13, 2015 Request at 3.
[41] *Id.* at 50636 (emphasis added).
[42] *Id.* at 50638.

expressly prohibits "administrative and judicial review[43] of "any *estimate* of the Secretary for purposes of determining the factors described in paragraph (2)." As such, the statute specifically forbids administrative or judicial review of DCH's challenge in this appeal.

This analysis is consistent with the Board's jurisdictional decision in *New York-Presbyterian Hosp. v. BlueCross BlueShield Ass'n*, PRRB Case No. 14-2092 (September 15, 2014), a case in which a provider requested EJR of the Factor 3 merger policy at issue in the instant appeal. In that case, the provider challenged "the validity of the merger policy shift on grounds that it was improperly promulgated without proper notice and comment and is arbitrary and capricious and contrary to the law."[44] In that determination, the Board found that, under the statute codified at 42 U.S.C. § 1395ww(r)(3), it lacked jurisdiction "over the merger issue" and denied the provider's EJR request. The Board found "that the merger question involves the policy with respect to how the estimates for the amount of uncompensated care (Factor 3) are calculated . . . because it involves 'estimates for purposes of determining factors described in paragraph 2,' for which the statute precludes administrative review."[45]

The United States District Court for the District of Columbia came to the same conclusion in its memorandum opinion in *Florida Health Sciences Ctr., Inc. v. DHHS*, 89 F. Supp. 3d 121 (D.D.C. 2015) ("*Florida Health*"). In *Florida Health*, a hospital claimed that CMS' use of March 2013 updated data when calculating its "additional payment" under the Amended DSH Adjustment violated the APA and the Act. The hospital requested that, among other things, the Court find that the August 19, 2013 Final Rule's methodology for determining Factor 3 to be invalid. The Court, however, found in favor of the Secretary stating:

> Congress did not specifically prohibit review of the methodology used to calculate the "estimated" amount of hospitals' uncompensated care in factor three, and it did not expressly bar review of the "appropriate data" upon which the estimate would be based, but it did plainly and broadly prohibit any legal challenge to the estimate itself, by precluding administrative or judicial review "under section 1395ff of this title, section 1395oo of this title, or otherwise of . . . [a]ny estimate" or "[a]ny period" used by the Secretary for purposes of determining the factors that make up the additional payment. 42 U.S.C. § 1395ww(r)(3)(A)-(B). Because the Court finds that the complaint is, at its essence, a challenge to both an estimate and a period used by the Secretary for those very purposes, plaintiff's claims are not subject to judicial review.[46]

In the present case, DCH's use of the term "manner" is analogous with the Court's reference to "methodology" in *Florida Health* and the Court's analysis regarding the hospital's challenge to the Secretary's methodology appears to apply equally to DCH's challenge to the Secretary's "manner" of exclusion.

Alternatively, DCH requests that, in the event that the Board finds that it does not have

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[43] 42 U.S.C. § 1395ww(r)(3).
[44] *New York-Presbyterian Hosp.*, PRRB Case No. 14-2092 at 8.
[45] *Id.* at 10.
[46] 89 F. Supp. 3d at 132.

jurisdiction over this issue, the Board "acknowledge that it does not have the authority to decide the issue presented[ ]" as DCH claims this would enable DCH "to go immediately to court . . ." in the event that the Administrator reverses the Board's decision on jurisdiction or if it successfully appeals the Agency's denial of jurisdiction in court. Upon review, the Board agrees that if the Administrator reverses the Board's decision on jurisdiction or if DCH successfully appeals the Agency's denial of jurisdiction in court, the Board would grant DCH's request for EJR of this issue because the Board is bound by the Secretary's final rule and regulations and is without the authority to consider whether such regulations violate the language or intent of the statute or are otherwise outside the statutory authority.

Conclusion

The Board finds that DCH's uncompensated care determination issue involves a challenge to the Secretary's "estimates for purposes of determining factors described in paragraph (2)[,]"[47] and the statute clearly precludes administrative or judicial review of such estimates. In addition, under the regulations that implement the statute, 42 C.F.R. § 412.106(f)(2) precludes review of any estimate of the Secretary for the purpose of determining the factors in paragraph (g)(1), including the calculation of uncompensated care described within 42 C.F.R. § 412.106(g)(1)(iii).

As Board review of the specific matter at issue within DCH's request is barred, the Board does not have jurisdiction over this appeal. The Board cannot grant DCH's request for EJR since Board jurisdiction is a prerequisite to granting such a request. As this was DCH's sole issue within its RFH, the Board's decision hereby closes this case.

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:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Beth Wills, Cahaba GBA c/o National Government Services, Inc.
Wilson Leong, Federal Specialized Services

[47] 42 U.S.C. § 1395ww(r)(2).

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Refer to: 08-2862GC

CERTIFIED MAIL

DEC 15 2015

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RE: Request for Case Bifurcation and Jurisdictional Determination
UC Health System 2001 DSH Dual Eligible Days Group
PRRB Case No.: 08-2862GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the University of California ("UC") Health System 2001 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days Group's request to bifurcate the dual eligible days issue within this appeal. The Board hereby denies UC's bifurcation request and dismisses one of the participants within this group, as explained below.

Pertinent Facts

On September 5, 2008, the Board received UC's request to form a common issue related provider ("CIRP") group appeal comprised of five related participants. Within its request, UC describes its common issue in the following manner:

> Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments (DSH) accurately reflects the number of patient days furnished to patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part A benefits.

Subsequently, UC transferred a number of participants into its group appeal, but when the Board received UC's Schedule of Providers ("SOP") and Jurisdictional Documentation on December 31, 2012, only three participants remained within the group. The first two participants, UC Davis Medical Center (Provider No. 05-599) and UCSF Medical Center (Provider No. 05-0454), were included on UC's initial SOP that it submitted to the Board along with its September 5, 2008 group appeal request. The Board received a request to transfer the third participant, UC Irvine Medical Center (Provider No. 05-0348), into the instant group appeal on March 19, 2009.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[1] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

Board's Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2008), 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 ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination.

On May 23, 2008, the Secretary published updated regulatory provisions concerning PRRB appeals.[2] The May 23, 2008 Final Rule states that the new regulations were effective beginning August 21, 2008, and applicable to all appeals filed on or after this date.[3] Under these new regulations, a provider's request for hearing must contain an issue statement that describes each contested item with a certain degree of specificity. Specifically, a provider's hearing request must include "[a]n explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal . . ."[4] In addition, 42 C.F.R. § 405.1835(c) requires a provider to add an issue to its appeal "no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section[,]"[5] i.e., 240 days after the date of receipt by the provider of the Medicare contractor's (or Secretary's) determination. However, within the Final Rule, the Secretary specifically permitted a provider with an appeal pending before the Board prior to the effective date of the Final Rule to add issues to its pending appeal "by the expiration of the later of the following periods: . . . [s]ixty days after the expiration of the applicable 180-day period prescribed in . . . § 405.1835(a)(3) . . . or 60 days after the effective date of this rule."[6]

The Board also updated its rules to coincide with the publication of the May 23, 2008 Final Rule. With respect to the new regulatory provision that requires a provider to state its appeal issues with a certain level of specificity, the Board provided some further instruction for providers. Board Rule 8 concerns provider issues involving multiple components. Rule 8 states that in order "[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 . . ."[7]

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[1] Toyon is the participants' representative for this appeal.
[2] Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008).
[3] *Id.*
[4] 42 C.F.R. § 405.1835(b)(2).
[5] 73 Fed. Reg. at 30250.
[6] *Id.* at 30240.
[7] PRRB Rules at 6-7 (Aug. 21, 2008).

Jurisdiction for Participant 3

Based on the information contained within UC's December 31, 2012 Jurisdictional Documentation, Participant 3 did not include the dual eligible days issue within its original request for hearing dated January 21, 2005. In addition, UC did not include any documentation to show that Participant 3 requested to add the issue to its appeal prior to filing Participant 3's transfer request dated March 17, 2009.

As Participant 3's January 21, 2005 appeal request was pending on the effective date of the May 23, 2008 Final Rule, Participant 3 had until October 20, 2008 to add the dual eligible issue to its appeal. Based on UC's December 31, 2012 Jurisdictional Documentation, however, Participant 3 does not appear to have mentioned dual eligible days as an issue in its appeal until it filed its March 17, 2009 transfer request.

Based on the facts before the Board, the Board finds that Participant 3 did not include or timely add the dual eligible days issue to its individual appeal. Therefore, the Board has determined that it does not have jurisdiction over Participant 3's appeal of dual eligible days and hereby dismisses Participant 3 from the instant appeal.

Bifurcation Request

The Board notes that UC filed its September 5, 2008 CIRP group appeal request after the August 21, 2008 effective date of the Secretary's Final Rule. As such, the newly effective regulations mandate that within its request for hearing, UC include, for each specific item at issue, an explanation of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal. Board Rule 8 further requires UC to appeal each contested component of a multiple-component issue as a separate issue and to describe each issue as narrowly as possible.

In the instant appeal, the Board finds that UC's September 5, 2008 CIRP group appeal request contains an issue statement (quoted above) that describes its challenge to dual eligible days generally. The Board finds that this issue statement does not identify dual eligible Part C days with the requisite specificity, as required by the regulations, to allow the Board to assume jurisdiction over this issue. Accordingly, the Board hereby denies UC's request to bifurcate its dual eligible days issue.

Conclusion

The Board finds that there is only one issue in the instant appeal and denies UC's request to bifurcate its dual eligible days issue. The Board also finds that the remaining issue, participants' dual eligible Part A non-covered days issue, is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. However, since the Board finds that Participant 3, UC Irvine Medical Center (Provider No. 05-0348), failed to file a jurisdictionally valid appeal of its dual eligible days, Participant 3 is dismissed from the instant appeal and not included in the remand. The Board's Remand Letter for the instant appeal is included as an enclosure along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand Letter for PRRB Case No. 08-2862GC
Schedule of Providers dated December 21, 2012

cc: Wilson Leong, Federal Specialized Services

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Refer to: 07-0485GC

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Toyon Associates, Inc.
Thomas P. Knight
President
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Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation
UC 2000 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 07-0485GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to University of California ("UC") 2000 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. The Board hereby grants UC's request for case bifurcation of the dual eligible Part A non-covered and Part C days[1] issues as set forth below.

Background

On December 14, 2006, the Board received UC's request to form a CIRP group comprised of two initial participants.[2] On July 21, 2010, the Board received UC's updated Schedule of Providers and jurisdictional documentation for the CIRP group that now contained three participant appeals.[3]

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[4] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

---

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

[2] The initial participant appeals are UCSF Medical Center's appeal (Provider No. 05-0454) for the fiscal year ending ("FYE") on March 31, 2000; and UC Davis Medical Center's appeal (Provider No. 05-0599) for FYE June 30, 2000.

[3] On June 18, 2007, the Board received UC's request to add UCSF Medical Center's appeal (Provider No. 05-0454) for FYE June 30, 2000, to the instant CIRP group.

[4] Toyon is the representative for Sutter Health's appeal.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2006), 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 ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the Medicare contractor's determination was mailed to the provider.

The Board acknowledges that at the time that UC's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the participants' individual appeals and the CIRP group appeal described the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 07-0485GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[5] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The providers' Part C issue is now within newly formed PRRB Case No. 16-0361GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0361GC are included as enclosures along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers received on July 21, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0361GC
Standard Remand Letter for PRRB Case No. 07-0485GC

cc: Wilson Leong, Federal Specialized Services

[5] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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DEC 15 2015

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RE: Request for Case Bifurcation
NorthBay Health Group 2001 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 09-0384GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the NorthBay Health Group ("NorthBay") 2001 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request to bifurcate the dual eligible days issue within this appeal. The Board hereby denies NorthBay's bifurcation request as explained below.

Pertinent Facts

On December 8, 2008, the Board received NorthBay's request to form a CIRP group comprised of two related participants. Within its request, NorthBay describes its common issue in the following manner:

> Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments (DSH) accurately reflects the number of patient days furnished to patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part A benefits.
>
> We contend that the number of Medicaid eligible patient days used in the DSH calculation are understated due to exclusion of various categories of Medicaid eligible patients who enrolled in Medicare Part A but are not entitled to Medicare Part A benefits.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[1] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

Board's Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2008), 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 ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination.

On May 23, 2008, the Secretary published updated regulatory provisions concerning PRRB appeals.[2] The May 23, 2008 Final Rule states that the new regulations were effective beginning August 21, 2008, and applicable to all appeals filed on or after this date.[3] Under these new regulations, a provider's request for hearing must contain an issue statement that describes each contested item with a certain degree of specificity. Specifically, a provider's hearing request must include "[a]n explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal . . ."[4]

The Board also updated its rules to coincide with the publication of the May 23, 2008 Final Rule. Board Rule 8 concerns provider issues involving multiple components and states that in order "[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 . . ."[5]

Bifurcation Request

The Board notes that NorthBay filed its December 8, 2008 CIRP group appeal request after the August 21, 2008 effective date of the Secretary's Final Rule. As such, the newly effective regulations mandate that, within its request for hearing, NorthBay must include, for each specific item at issue, an explanation of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal. Board Rule 8 further requires NorthBay to appeal each contested component of a multiple-component issue as a separate issue and to describe each issue as narrowly as possible.

---

[1] Toyon is the participants' representative for this appeal.
[2] Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008) ("May 23, 2008 Final Rule").
[3] *Id.*
[4] 42 C.F.R. § 405.1835(b)(2).
[5] PRRB Rules at 6-7 (Aug. 21, 2008).

In the instant appeal, the Board finds that NorthBay's December 8, 2008 CIRP group appeal request contains an issue statement (quoted above) that describes its challenge to dual eligible days generally. The Board finds that this issue statement does not identify dual eligible Part C days with the requisite specificity, as required by the regulations, to allow the Board to assume jurisdiction over this issue. Accordingly, the Board hereby denies NorthBay's request to bifurcate its dual eligible days issue.

Conclusion

As explained prior, the Board finds that there is only one issue in the instant appeal and denies NorthBay's request to bifurcate its dual eligible days issue. The Board also finds that the remaining issue, participants' dual eligible Part A non-covered days issue, is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal is included as an enclosure along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand Letter for PRRB Case No. 09-0384GC
Schedule of Providers dated December 5, 2008

cc: Wilson Leong, Federal Specialized Services

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DEC 15 2015

Michael K. McKay, President
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Danene Hartley, Appeals Lead
Palmetto GBA c/o National Government Services
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Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
Duke University 2005 Dual Eligible CIRP Group, Case No. 09-2102GC

Dear Mr. McKay and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of the above-referenced appeal into four separate appeals: (1)Pre 10/1/2004 Dual Eligible days (2) Post 9/30/2004 Dual Eligible days (3) Pre 10/1/2004 Part C days and (4) Post 9/30/2004 Part C days filed by McKay Consulting (McKay). The Board determined that, for providers deemed eligible, it will grant the bifurcation requests of the Pre 10/1/2004 and Post 9/30/2004 Dual Eligible days and the Pre 10/1/2004 and Post 9/30/2004 Part C days issues. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Further, because the Part C days issues for the participants bifurcated from this group would not meet the $50,000 amount in controversy for either the pre 10/1/2004 nor the post 9/30/2004 periods, the Part C days issues for Duke Health Raleigh Hospital, Duke University Hospital & Durham Regional Hospital will be consolidated with participants from other McKay groups that are also pursuing bifurcations. Each group bifurcation will be addressed in a separate letter.

The Pre 10/1/2004 Part C providers which the Board agrees to bifurcate will ultimately reside in case number 16-0314G, the McKay Consulting Pre 10/01/2004 Medicaid Fraction Part C Days (Optional) Group.[1] The Post 9/30/2004 Part C providers which the Board agrees to bifurcate will reside in case number 16-0347GC, the Duke Post 9/30/2004 -2006 Medicare Part C Days CIRP Group. A copy of the Acknowledgement letter for this case is enclosed.

[1] An Acknowledgement Letter for the new consolidated Part C days group will be sent under separate cover once all of the related bifurcations are complete.

Background

The Representative's request for a group hearing, dated August 6, 2009, contained a lengthy group issue statement that included the following language:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[2]

In the August 6, 2009 request, the Representative also identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

The preliminary Schedule of Providers attached to the Request for a Hearing, named the following Provider:[3]

- Duke Health Raleigh Hospital (34-0073) (Direct Add)

The following participants were added on November 5, 2009 and September 7, 2010, respectively:

- Durham Regional Hospital (34-0155) (Direct Add)
- Duke University Health System (34-0030) (Direct Add)

Both Duke Health Raleigh and Duke University Hospital are listed as participants on the combined Pre-10/1/2004 Part C Days (optional group) Schedule as well as on the combined Duke 2005-2006 Part C Days (CIRP group) Schedule.[4]

Prior to the 2008 revisions of the Board's Rules, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[5] Here, the group appeal was filed a year after the 2008 revisions and described the "matter at issue" as Dual Eligible days and clearly includes the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days).

On June 3, 2013, the Representative submitted a Case Management Plan for the "McKay

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[2] 09-2102GC Group Request for Hearing at 2, August 6, 2009.
[3] *See id.* at Schedule A.
[4] In the Representative's August 30, 2013 Bifurcation Request, the Representative identifies various Part C Days groups that will have to be combined to meet the $50,000 group threshold amount in controversy for the pre 10/1/2004 and post 9/30/2004 periods.
[5] 42 C.F.R. § 405.1837(a)(2) (2003).

Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[6] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[7] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[8]

Board Determination on Bifurcation

The Board has granted the bifurcation of the Dual Eligible days for the three participants in the group and Part C days issues for Duke Health Raleigh Hospital and Duke University Hospital as requested. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[9] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board acknowledges that the three participants in case number 09-2102GC, Duke Health Raleigh Hospital, Durham Regional Medical Center and Duke University Health System, all filed directly into the group from receipt of their respective Notices of Program Reimbursement. Therefore, the Board deems these participants to have appealed the group issue which included the Part C days component.

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[6] *See* Case Management Plan Letter, Jun. 3, 2013.
[7] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[8] *Id.* at 1.
[9] 42 C.F.R. § 405.1837(a)(2) (2003).

Accordingly, the Board finds that there are four legally distinct issues pending within PRRB Case No. 09-2102GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[10] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals as follows:

- The pre 10/1/2004 Part C issue is now within newly formed PRRB Case No. 16-0314G for Duke Health Raleigh Hospital and Duke University Hospital.
- The post 9/30/2004 period for Duke Health Raleigh Hospital and Duke University Hospital is now within the newly formed PRRB Case No. 16-0347GC.[11]
- The providers' dual eligible Part A non-covered days issue for the period 7/1/2004-9/30/2004 will remain in case number 09-2102GC and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R.
- The providers' dual eligible Part A non-covered days issue for the period 10/1/2004- 6/30/2005 will be transferred to the Duke 2006 DSH Dual Eligible Days CIRP Group, case number 09-2120GC which will be renamed the Duke Post 9/30/2004 – 2006 DSH Dual Eligible Days CIRP Group.

As noted, the dual eligible Part A non-covered days issue for Duke Health Raleigh Hospital, Duke University Hospital and Durham Regional for the period 7/1/2004- 9/30/2004 is subject to remand pursuant to CMS Ruling 1498- R. The Board's Remand Letter for these providers is included as an enclosure along with this determination.

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 upon final disposition of the case on the merits.

Board Members Participating:
Clayton L. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:

Charlotte Benson for

Michael W. Harty
Chairman

Enclosures:
-Notice of Bifurcated Post 9/30/2004 Part C Days issue and Group Acknowledgement letter
-Standard Remand of Dual Eligible Days Pursuant to CMS Ruling 1498-R
-Schedule of Providers

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

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[10] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.
[11] The Board's Notice of Bifurcated Post 9/30/2004 Part C Days issue and Group Acknowledgement letter for the new CIRP group.

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Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
Duke University Dual Eligible DSH 2003 CIRP Group, Case No. 08-2866GC

Dear Mr. McKay and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the Representative's request for the bifurcation of Dual Eligible days and Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. Because the Part C days issue for the participants bifurcated from this group would not meet the $50,000 amount in controversy, the Part C days issue for Duke Health Raleigh Hospital, Duke University Hospital & Durham Regional Hospital will be consolidated with participants from other McKay Consulting, Inc. (McKay) groups that are also pursuing bifurcations. Each bifurcation will be addressed in a separate letter.

The Part C providers which the Board agrees to bifurcate will ultimately reside in Case No. 16-0314G, the McKay Consulting 1999 – Pre 10/1/2004 National Part C Days Group.[1] For those Providers appealing Part A Non-Covered and Exhausted Benefit days over which the Board finds jurisdiction, the Board will issue a remand pursuant to CMS Ruling 1498-R.

Background

The Representative's request for a group hearing, dated August 22, 2008, contained a lengthy group issue statement that included the following language:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[2]

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[1] An Acknowledgement Letter for the new consolidated Part C days group will be sent under separate cover once all of the related bifurcations are complete.

[2] 08-2866GC Group Request for Hearing at 2, August 22, 2008.

In the August 22, 2008 request, the Representative also identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

The Representative attached a preliminary Schedule of Providers to the Request for a Hearing, naming the following Providers:3

- Duke Health Raleigh Hospital (34-0073) (Transfer from 08-2031)
- Duke University Hospital (34-0030) (Direct Add)
- Durham Regional Hospital (34-0155) (Transfer from 08-1896)

Only Duke University Hospital & Durham Regional Hospital are listed as participants on the combined Part C Days Schedule.[4]

On June 3, 2013, the Representative submitted a Case Management Plan for the McKay appeals, including the instant case, which adopted new deadlines for the Schedule of Providers.[5] On August 30, 2013, the Board received the Schedule of Providers from McKay for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[6] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[7]

Board Determination on Bifurcation

The Board has granted the bifurcation of the Dual Eligible days and Part C days issues for the three Providers requested. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[8] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

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3 *See id.* at Schedule A.
4 In the Representative's August 30, 2013 Bifurcation Request, the Representative identifies various Part C Days groups that will have to be combined to meet the $50,000 group threshold amount in controversy. (See separate routing sheets for each case.)
5 *See* Case Management Plan Letter, Jun. 3, 2013.
6 *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
7 *Id.* at 1.
8 42 C.F.R. § 405.1837(a)(2) (2003).

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board acknowledges that at the time that Duke Health Raleigh Hospital's and Durham Regional Hospital's individual appeals and transfer requests were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' added the dual eligible days issue to their individual appeals using a broad issue statement and subsequently transferred to a CIRP group that encompassed both Part A non-covered days and Part C days.

With regard to the remaining participant, Duke University Hospital, this participant filed directly into the group from receipt of its respective Notice of Program Reimbursement. Therefore, the Board deems this participant to have appealed the group issue which included the Part C days component.

Accordingly, the Board finds that there are two legally distinct issues pending within PRRB Case No. 08-2866GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[9] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals for Durham Regional Hospital and Duke University Hospital.[10] The providers' Part C issue is now within newly formed PRRB Case No. 16-0314G. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal is included as an enclosure along with this determination.

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 upon final disposition of the appeal.

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[9] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

[10] Only Duke University Hospital and Durham Regional Hospital are included on the consolidated Part C days Schedule of Providers for the McKay 1999-Pre 10/1/2004 Medicaid Fraction Part C Days Group, Case No. 16-0314G.

Board Members Participating:
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:

Charlotte Benson

Michael W. Harty
Chairman

Enclosures: Standard Remand of Dual Eligible Days Pursuant to CMS Ruling 1498-R
Schedule of Providers

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosure)

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Refer to:

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DEC 16 2015

McKay Consulting, Inc.
Michael K. McKay, President
8590 Business Park Drive
Shreveport, LA 71105

National Government Services, Inc.
Danene Hartley, Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206 6474

Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
Hospital Sisters 2007 DE CIRP Group, Case No. 09-1072GC

Dear Mr. McKay and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into Dual Eligible days and Part C days filed by McKay Consulting (McKay). The Board determined that, for providers deemed eligible, it will grant the bifurcation requests of the Dual Eligible days and the Part C days issues. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[1] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Because the Part C days issue for the participants bifurcated from this group would not meet the $50,000 amount in controversy, the two participants (St. John's Hospital and St. Mary's Hospital) will be consolidated with participants from case numbers 09-0088GC and 09-1732GC in a newly formed optional Part C days group to which we have assigned case number 16-0318G (McKay Post 9/30/2004 Medicaid Fraction Part C Days Group). Each respective group bifurcation will be addressed in a separate letter.

Background

McKay's request for a group hearing, dated March 16, 2009, contained a lengthy group issue statement that included the following language:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should

[1] 42 C.F.R. § 405.1837(a)(2) (2003).

have been included in the calculations.[2]

In the March 16, 2009 hearing request, McKay also identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

The Representative attached a preliminary Schedule of Providers to the Request for a Hearing, naming the following Providers:3

- St. John Hospital (14-0053) (Direct Add)
- St. Mary's Hospital (14-0166) (Direct Add)

Prior to the 2008 revisions of the Board's Rules, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[4] Here, the group appeal was filed in March 2009, seven (7) months after the 2008 revisions and described the "matter at issue" as Dual Eligible days and clearly includes the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days).

On June 3, 2013, the Representative submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[5] On August 30, 2013, the Board received the Schedule of Providers from McKay for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[6] McKay wrote that it determined that "...each of the group appeals...challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[7] However, not every provider in every group was listed on both the Exhausted Benefits and Part C days' Schedules of Providers. In this case, both participants are listed on both the Dual Eligible days Schedule of Providers as well as the combined Part C Days Schedule.[8]

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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[2] 09-1072GC Group Request for hearing at 2, March 16, 2009.
3 *See id.* at Schedule A.
4 42 C.F.R. § 405.1837(a)(2) (2003).
[5] *See* Case Management Plan Letter, Jun. 3, 2013.
[6] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[7] *Id.* at 1.
[8] In the Representative's August 30, 2013 Bifurcation Request, the Representative identifies various Part C Days groups that will have to be combined to meet the $50,000 group threshold amount in controversy.

The two participants in this case, St. John Hospital and St. Mary's Hospital, both filed directly into the subject group appeal in 2009 thereby taking on the group issue statement which included the Part C days component. Therefore, the Board grants the bifurcation of the Dual Eligible days and Part C days for these participants.

Because the newly created Part C days group, case number 16-0318G, was formed with participants from three pending groups, the Board is deeming the new group complete. Enclosed, please find the Notice of Bifurcated Post 9/30/2004 Part C Days Group and Acknowledgement and Critical Due Dates letter. The Parties will receive a Notice of Hearing for case number 09-1072GC under separate cover.

Board Members Participating:
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:

Michael W. Harty
Chairman

Enclosure: Notice of Bifurcated Post 9/30/2004 Part C Days Group and Acknowledgement and Critical Due Dates letter

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
John M. Maguire, Manager, Tenet Healthcare Corporation (Rep for case 09-0088GC)
Byron Lamprecht, Wisconsin Physicians Services (MAC for case 09-0088GC)

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Shreveport, LA 71105

National Government Services, Inc.
Danene Hartley, Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206 6474

Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
Hospital Sisters 2006 DE CIRP Group, Case No. 09-1732GC

Dear Mr. McKay and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into Dual Eligible days and Part C days filed by McKay Consulting (McKay). The Board determined that, for providers deemed eligible, it will grant the bifurcation requests of the Dual Eligible days and the Part C days issues. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[1] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Because only one participant in this case, St. Mary's Hospital Decatur, is requesting bifurcation of the Part C days issue, it will be consolidated with participants from case numbers 09-0088GC and 09-1072GC in a newly formed optional Part C days group to which we have assigned case number 16-0318G (McKay Post 9/30/2004 Medicaid Fraction Part C Days Group). Each respective group bifurcation will be addressed in a separate letter.

Background

McKay's request for a group hearing, dated May 27, 2009, contained a lengthy group issue statement that included the following language:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[2]

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[1] 42 C.F.R. § 405.1837(a)(2) (2003).
[2] 09-1732GC Group Request for hearing at 2, May 28, 2009.

In the May 27, 2009 hearing request, McKay also identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

The Representative attached a preliminary Schedule of Providers to the Request for a Hearing, naming the following Providers:[3]

- St. John Hospital (14-0053) (transfer from case number 08-0170G)[4]
- St. Mary's Hospital (14-0166) (transfer from case number08-0170G)[5]

Both participants filed individual appeals prior to the August 2008 Board Rules. Both Providers described the dual eligible days issue using the following verbage:

> The Provider has identified ___ Medicare/Medicaid dual eligible days that have not been included in the Medicare proxy nor the Medicaid proxy. The Provider believes these days should be included in the Medicaid proxy.[6]

The Providers both transferred the Dual Eligible days issue to an optional group, case number 08-0170G, in May 2008 – prior to the issuance of the August 2008 regulation. Prior to the regulatory change providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. The group issue statement in case number 08-0170G described the Dual Eligible days issue as "Is the Intermediary's exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either whose Medicare Part A benefits were exhausted or who received Part C benefits correct?"

On June 3, 2013, the Representative submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[7] On August 30, 2013, the Board received the Schedule of Providers from McKay for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[8] McKay wrote that it determined that "...each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[9] However, not every provider in every group was listed on both the Exhausted Benefits and Part C days' Schedules of Providers. In this case, only St. Mary's Hospital Decatur is listed on both the Dual Eligible days Schedule of Providers as well as the combined Part C Days Schedule.[10]

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[3] *See id.* at Schedule A.
[4] Provider transferred issue from individual appeal 08-0855 to optional group 08-0170G prior to being transferred to this CIRP.
[5] Provider transferred issue from individual appeal 08-0894 to optional group 08-0170G prior to being transferred to this CIRP.
[6] *See* Schedule at 1B and 2B. # of days is 114 for Participant 1 and 191 for Participant 2.
[7] *See* Case Management Plan Letter, Jun. 3, 2013.
[8] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[9] *Id.* at 1.
[10] In the Representative's August 30, 2013 Bifurcation Request, the Representative identifies various Part C Days groups that will have to be combined to meet the $50,000 group threshold amount in controversy.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that St. Mary's Hospital Decatur filed its individual appeal which included the general Dual Eligible days issue and subsequently transferred the issue to an optional group (case number 08-0170G) in May 2008, prior to the issuance of the August 2008 regulatory change. The optional group issue statement described the Dual Eligible days issue and clearly included the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. The Provider then transferred the Dual Eligible days issue from the optional group to form this CIRP in May 2009. Although this CIRP group appeal was filed after the 2008 revisions, it seemingly, appealed multiple issues since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days).

Accordingly, the Board finds that there are two legally distinct issues pending within case number 09-1732GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[11] The Board is, therefore, bifurcating the Part C days issue which is now within the newly formed case number 16-0347GC. Because the newly created Part C days group was formed with participants from three pending groups, the Board is deeming the new group to be complete. A 'Notice of Bifurcated Post 9/30/2004 Part C Days Group and Acknowledgement and Critical Due Dates letter' was previously sent as an enclosure with the Board's earlier determination regarding the bifurcation of case number 09-1072GC.

The dual eligible Part A non-covered issue will remain in case number 09-1732GC, which will be scheduled for a hearing. The Notice of Hearing will be sent under separate cover.

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 upon final disposition of the case on the merits.

Board Members Participating:
Clayton L. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:

Michael W. Harty
Chairman

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
John M. Maguire, Manager, Tenet Healthcare Corporation (Rep for case number 09-0088GC)
Byron Lamprecht, Wisconsin Physicians Services (MAC for case number 09-0088GC)

[11] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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CERTIFIED MAIL

DEC 16 2015

Isaac Blumberg
Chief Operating Officer
Blumberg Ribner, Inc.
315 South Beverly Drive
Suite 505
Beverly Hills, CA 90212

RE: Provider 1, Alice Hyde Medical Center, Provider No. 33-0084, FYE 12/31/06, Provider 30, University Medical Center of Southern Nevada, Provider No. 29-0007, FYE 06/30/06, as participants in "Blumberg Ribner Independent Hospital 06 SSI Percentage Group" PRRB Case No.: 09-0918G

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 09-0918G. The Board finds that it lacks jurisdiction over the revised Notice of Program Reimbursement (NPR) for Provider 1, Alice Hyde Medical Center (provider number 33-0084, fiscal year end (FYE) December 31, 2006) and Provider 30, University Medical Center of Southern Nevada (provider number 29-0007, FYE June 30, 2006), as the Providers failed to provide evidence that the supplemental security income (SSI) percentage issue was specifically revised in their reopenings.

Background

Provider 1, Alice Hyde Medical Center, Provider No.33-0084

On March 21, 2008, the Medicare contractor issued a NPR to Alice Hyde Medical Center for the cost reporting period ending December 31, 2006. On April 15, 2008, the Medicare contractor issued a revised NPR to Alice Hyde Medical Center. The revised NPR stated that a revision was being made "due to tentative payment that was left off at desk review." On August 12, 2008, Alice Hyde Medical Center filed an appeal of the original and revised NPRs challenging the SSI percentage issue and other issues. The Board assigned case number 08-2690 to the appeal. On August 19, 2009, Alice Hyde Medical Center requested to transfer the SSI percentage issue from its individual appeal, case number 08-2690, to the current group appeal, case number 09-0918G.

Provider 30, University Medical Center of Southern Nevada, Provider No. 29-0007

On May 27, 2008, the Medicare contractor issued a NPR to University Medical Center of Southern Nevada for the cost reporting period ending June 30, 2006. On November 19, 2008, University Medical Center of Southern Nevada filed an appeal of the NPR

challenging the SSI percentage issue and other issues. The Board assigned case number 09-0337 to the appeal. On January 13, 2009, the Medicare contractor issued a revised NPR to University Medical Center of Southern Nevada. On July 27, 2009, University Medical Center of Southern Nevada filed an appeal of the revised NPR challenging the SSI percentage issue. The Board incorporated University Medical Center of Southern Nevada's appeal of the revised NPR into case number 09-0337. Also, on this date, University Medical Center of Southern Nevada requested to transfer the SSI percentage issue from its individual appeal, case number 09-0337, to the current group appeal, case number, 09-0918G.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) (2007) and 42 C.F.R. § 405.1835-405.1841 (2007), a Provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group) and the request for a hearing is received by the Board within 180 days of the date the notice of the Medicare contractor's determination was mailed to the provider.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2007) provides in relevant part:

> A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary . . . either on motion of such intermediary . . . or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889 (2007) states:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened . . . such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

In *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the court held that when a fiscal intermediary reopens its original determination regarding the amount of reimbursement that a Medicare provider is to receive and a provider appeals

this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations underlying the original NPR. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524, at *8 (D.D.C. Apr. 17, 2014), the court held that the Secretary's "issue-specific" interpretation of her NPR reopening regulations is reasonable and entitled to substantial deference.

In the instant case, Provider 1, Alice Hyde Medical Center and Provider 30, University Medical Center of Southern Nevada, are appealing from original and revised NPRs. For each of the Providers' appeals from the original NPR, the Board takes jurisdiction over the appeals pursuant to *Bethesda.*[1] For the appeals from the revised NPRs, the Providers did not include any audit adjustment reports for the revised NPRs nor supply any supporting documentation (such as the request for reopening, reopening notice, or the audit work papers) to determine the scope of the issues reviewed within the revised NPR process.[2] The Board finds that the record lacks evidence that the SSI percentage was specifically revised in the reopenings. Therefore, the Board finds that it lacks jurisdiction over Provider 1, Alice Hyde Medical Center (provider no. 33-0084, FYE 12/31/06) and Provider 30, University Medical Center of Southern Nevada (provider no. 29-0007, FYE 6/30/06) appeals from their revised NPRs and dismisses the Providers' revised NPR appeals from the case.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kyle Browning, National Government Services Inc.
Wilson C. Leong, Esq., Federal Specialized Services

[1] *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988).
[2] The Providers included audit adjustment reports from their original NPRs in their supporting documents and listed audit adjustments from their original NPRs on the Schedule of Providers.

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DEC 16 2015

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Shreveport, LA 71105

Danene Hartley, Appeals Lead
Palmetto GBA c/o National Government Services
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
Duke University 2006 DSH Dual Eligible CIRP Group, Case No. 09-2120GC

Dear Mr. McKay and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into Dual Eligible days and Part C days filed by McKay Consulting (McKay) for this group. The Board determined that, for providers deemed eligible, it will grant the bifurcation requests of the Dual Eligible days and Part C days issues. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Further, because the Part C days issues for the participants bifurcated from this group would not meet the $50,000 amount in controversy, the Part C day issue for Duke Health Raleigh Hospital, Duke University Hospital & Durham Regional Hospital will be consolidated with participants from another McKay group (case number 09-2102GC) that is also pursuing a bifurcation. Each group bifurcation will be addressed in a separate letter.

The Part C providers which the Board agrees to bifurcate will ultimately reside in case number 16-0347GC, the Duke Post 9/30/2004 -2006 Medicare Part C Days CIRP Group.[1]

Background

The Representative's request for a group hearing, dated August 6, 2009, contained a lengthy group issue statement that included the following language:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[2]

[1] A copy of the Acknowledgement letter for this case was enclosed with the letter detailing the bifurcation of case number 09-2102GC.

[2] 09-2120GC Group Request for Hearing at 2, August 7, 2009.

In the August 7, 2009 request, the Representative also identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

The Representative attached a preliminary Schedule of Providers to the August 7, 2009 Request for a Hearing, naming the following Provider:[3]

- Duke Health Raleigh Hospital (34-0073) (Direct Add)

The following participants were added on July 28, 2010 and September 7, 2010, respectively:

- Durham Regional Hospital (34-0155) (Direct Add)
- Duke University Health System (34-0030) (Direct Add)

Prior to the 2008 revisions of the Board's Rules, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[4] Here, the group appeal was filed a year after the 2008 revisions and described the "matter at issue" as Dual Eligible days and clearly includes the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days).

On June 3, 2013, the Representative submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[5] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[6] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[7]

Board Determination on Bifurcation

The Board has granted the bifurcation of the Dual Eligible and Part C days for the three participants in the group as requested. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

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3 *See id.* at Schedule A.
4 42 C.F.R. § 405.1837(a)(2) (2003).
5 *See* Case Management Plan Letter, Jun. 3, 2013.
6 *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
7 *Id.* at 1.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[8] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board acknowledges that the three participants in case number 09-2120GC, Duke Health Raleigh Hospital, Durham Regional Medical Center and Duke University Health System, all filed directly into the group from receipt of their respective Notices of Program Reimbursement. Therefore, the Board deems these participants to have appealed the group issue which included the Part C days component.

Accordingly, the Board finds that there are two legally distinct issues pending within PRRB Case No. 09-2120GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[9] The Board is, therefore, bifurcating the Part C days issue which is now within the newly formed PRRB Case No. 16-0347GC. The dual eligible Part A non-covered issue will remain in case number 09-2120GC, which will be scheduled for a hearing. The Notice of Hearing will be sent under separate cover.

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 upon final disposition of the case on the merits.

Board Members Participating:
Clayton L. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:

Michael W. Harty
Chairman

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

---

[8] 42 C.F.R. § 405.1837(a)(2) (2003).
[9] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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Refer to: 08-2426GC

CERTIFIED MAIL

DEC 17 2015

Toyon Associates, Inc.
Thomas P. Knight
President
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation
UC 1994 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2426GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the University of California ("UC") 1994 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. The Board hereby grants UC's request for case bifurcation of the dual eligible Part A non-covered and HMO days[1] issues as set forth below.

Background

On July 24, 2008, the Board received UC's request to form a CIRP group comprised of two common-related party participants[2] from the Toyon 1994 DSH Dual Eligible Days Group Appeal, PRRB Case No. 04-1725G. On July 21, 2010, the Board received UC's Schedule of Providers and Jurisdictional Documentation for the two participants within the instant appeal.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's") request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

[2] The two participants are Mt. Zion Medical Center (Provider No. 05-0033) and UCSF Medical Center (Provider No. 05-0454).

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (1998), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

The Board acknowledges that at the time that UC's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the participants' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and HMO days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2426GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' HMO days issue is now within newly formed PRRB Case No. 16-0367GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0367GC are included as enclosures along with this determination.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 19, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0367GC
Standard Remand Letter for PRRB Case No. 08-2426GC

cc: Wilson Leong, Federal Specialized Services

[3] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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DEC 17 2015

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Evaline Alcantara
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P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation and Jurisdictional Determination
UC 1992 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 10-0691GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the University of California ("UC") 1992 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. Upon review, the Board finds that it does not have jurisdiction over one of the two participants, UC Davis Medical Center (Provider No. 05-0599) ("UC Davis"), and hereby dismisses that participant from this appeal, as explained below. With respect to the other participant, Mt. Zion Medical Center (Provider No. 05-0033) ("Mt. Zion"), the Board is granting bifurcation of this participant's dual eligible days issue, transferring Mt. Zion's HMO days[1] issue into PRRB Case No. 16-0367GC and remanding Mt. Zion's dual eligible no Part A payment days issue in the instant appeal pursuant to the Centers for Medicare & Medicaid Services Ruling 1498-R ("CMS 1498-R").

Background

On February 1, 2010, the Board received UC's request to form a CIRP group with two of the initial common-related party participants[2] transferring from the Toyon 1992 DSH Dual Eligible Days Group, PRRB Case No. 04-1723G. On July 21, 2010, the Board received UC's Schedule of Providers and Jurisdictional Documentation for the two participants remaining within the instant appeal.

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[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

[2] The two participants are Mt. Zion Medical Center (Provider No. 05-0033) and UC Davis Medical Center (Provider No. 05-0599).

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's") request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

Board's Decision

Applicable Regulatory Provisions

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2009), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination.

A revised notice of program reimbursement ("RNPR") is considered a separate and distinct determination from which the provider may appeal. Under 42 C.F.R. § 405.1889 (1996)

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened . . . such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

Jurisdiction for UC Davis Medical Center

According to the information contained within UC's July 21, 2010 Schedule of Providers and Jurisdictional Documentation, UC Davis filed its appeal included within the instant CIRP group based on its December 19, 1996 RNPR. The December 19, 1996 RNPR states that the Medicare contractor issued a December 2, 1996 Notice of Reopening for UC Davis' fiscal year end June 30, 1992 cost report in order "[t]o amend the [DSH] Adjustment calculation, using the revised audited Administrative Days and MediCal Patient Days reflected in the MediCal Payment Summary Report as bases." Based on UC's July 21, 2010 Jurisdictional Documentation, UC Davis is able to show that the Medicare contractor adjusted DSH generally on its December 19, 1996 RNPR, but not that its dual eligible days were specifically adjusted.

In the United States District Court for the District of Columbia's decision in *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the Court held that when a fiscal intermediary[3] reopens it original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations underlying the original NPR. In the instant appeal, UC Davis has shown that the Medicare contractor adjusted UC Davis' DSH calculation within its December 19, 1996 RNPR but has not

[3] Fiscal intermediary is now referred to as "Medicare contractor."

demonstrated that its dual eligible days were "revisited on reopening." The Board finds, therefore, that it lacks the jurisdiction to hear UC Davis' appeal of this issue and hereby dismisses UC Davis from the instant appeal.

Request for Case Bifurcation

The Board acknowledges that at the time that UC's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that Mt. Zion Medical Center's individual appeal and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and HMO days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 10-0691GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[4] The Board is, therefore, bifurcating Mt. Zion Medical Center's dual eligible Part A non-covered and HMO days issues into separate appeals. Mt. Zion Medical Center's HMO issue is being transferred to the newly formed PRRB Case No. 16-0367GC. Mt. Zion Medical Center's dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0367GC are included as enclosures along with this determination.

As the Board has determined that UC Davis Medical Center (Provider No. 05-0599) failed to file a jurisdictionally valid appeal of the dual eligible days issue, UC Davis is excluded from the newly formed HMO days appeal and not included in the dual eligible Part A non-covered days issue remand for the instant appeal.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

[4] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 19, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0367GC
Standard Remand Letter for PRRB Case No. 10-0691GC

cc: Wilson Leong, Federal Specialized Services

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RE: Request for Case Bifurcation and Jurisdictional Determination
UC 1995 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2425GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the University of California ("UC") 1995 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. Upon review, the Board finds that it does not have jurisdiction over one of the two participants, UC Davis Medical Center (Provider No. 05-0599) ("UC Davis"), and hereby dismisses that participant from this appeal, as explained below. With respect to the other participant, Mt. Zion Medical Center (Provider No. 05-0033) ("Mt. Zion"), the Board is granting bifurcation of this participant's dual eligible days issue, transferring Mt. Zion's HMO days[1] issue into PRRB Case No. 16-0367GC and remanding Mt. Zion's dual eligible no Part A payment days issue in the instant appeal pursuant to the Centers for Medicare & Medicaid Services Ruling 1498-R ("CMS 1498-R").

Background

On July 24, 2008, the Board received UC's request to form a CIRP group comprised of two common-related party participants[2] from the Toyon 1995 DSH Dual Eligible Days Group Appeal, PRRB Case No. 04-1726G. On July 21, 2010, the Board received UC's Schedule of Providers and Jurisdictional Documentation for the two participants within the instant appeal.

---

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

[2] The two participants are Mt. Zion Medical Center (Provider No. 05-0033) and UC Davis Medical Center (Provider No. 05-0599).

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's") request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

Board's Decision

Applicable Regulatory Provisions

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2007), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

A revised notice of program reimbursement ("RNPR") is considered a separate and distinct determination from which the provider may appeal. Under 42 C.F.R. § 405.1889 (2007)

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened . . . such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

Jurisdiction for UC Davis Medical Center

According to the information contained within UC's July 21, 2010 Schedule of Providers and Jurisdictional Documentation, UC Davis filed its appeal included within the instant CIRP group based on its January 21, 2005 RNPR. The January 21, 2005 RNPR states that the Medicare contractor issued a February 12, 2004 Notice of Reopening for UC Davis' fiscal year end June 30, 1995 cost report in order "[t]o amend the DSH payments to apply the provision of HCFA Ruling 97-2 per Mandamus Action." HCFA Ruling 97-2 ("Ruling 97-2") required that CMS include, within the DSH adjustment calculation, 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 those inpatient hospital services.[3] Based on UC's July 21, 2010 Jurisdictional Documentation, UC Davis is able to show that its Medicaid eligible days were adjusted, per Ruling 97-2, on its January 21, 2005 RNPR, but not that its *dual* eligible days were specifically adjusted.

In the United States District Court for the District of Columbia's decision in *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the Court held that when a fiscal intermediary[4] reopens it original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations

[3] HCFA Ruling 97-2 (Feb. 1997).
[4] Fiscal intermediary is now referred to as "Medicare contractor."

underlying the original NPR. In the instant appeal, UC Davis has shown that the Medicare contractor adjusted UC Davis' Medicaid eligible days within its January 21, 2005 RNPR but has not demonstrated that its dual eligible days were "revisited on reopening." The Board finds, therefore, that it lacks the jurisdiction to hear UC Davis' appeal of this issue and hereby dismisses UC Davis from the instant appeal.

Request for Case Bifurcation

The Board acknowledges that at the time that UC's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that Mt. Zion Medical Center's individual appeal and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and HMO days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2425GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[5] The Board is, therefore, bifurcating Mt. Zion Medical Center's dual eligible Part A non-covered and HMO days issues into separate appeals. Mt. Zion Medical Center's HMO issue is being transferred to the newly formed PRRB Case No. 16-0367GC. Mt. Zion Medical Center's dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0367GC are included as enclosures along with this determination.

As the Board has determined that UC Davis Medical Center (Provider No. 05-0599) failed to file a jurisdictionally valid appeal of the dual eligible days issue, UC Davis is excluded from the newly formed HMO days appeal and not included in the dual eligible Part A non-covered days issue remand for the instant appeal.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

[5] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 19, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0367GC
Standard Remand Letter for PRRB Case No. 08-2425GC

cc: Wilson Leong, Federal Specialized Services

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DEC 21 2015

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Danene Hartley, Appeals Lead
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Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
Duke University Dual Eligible DSH 02 CIRP Group, Case No. 08-2864GC

Dear Mr. McKay and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the Representative's request for the bifurcation of Dual Eligible days and Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. Because the Part C days issue for the participants bifurcated from this group would not meet the $50,000 amount in controversy, the Part C days issue for Duke University Hospital and Durham Regional Hospital will be consolidated with participants from other McKay Consulting, Inc. (McKay) groups that are also pursuing bifurcations. Each bifurcation has been addressed in a separate letter.

The Part C providers which the Board agrees to bifurcate will ultimately reside in Case No. 16-0314G, the McKay Consulting 1999 – Pre 10/1/2004 National Part C Days Group.[1] For those Providers appealing Part A Non-Covered and Exhausted Benefit days over which the Board finds jurisdiction, the Board will issue a remand pursuant to CMS Ruling 1498-R.

Background

The Representative's request for a group hearing, dated August 22, 2008, contained a lengthy group issue statement that included the following language:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[2]

In the August 22, 2008 request, the Representative also identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

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[1] An Acknowledgement Letter for the new consolidated Part C days group will be sent under separate cover once all of the related bifurcations are complete.

[2] 08-2864GC Group Request for Hearing at 2, August 22, 2008.

The Representative attached a preliminary Schedule of Providers to the Request for a Hearing, naming the following Providers:[3]

- Duke University Hospital (34-0030) (Direct Add)
- Durham Regional Hospital (34-0155) (Transfer from 08-1898)

Both Duke University Hospital & Durham Regional Hospital are listed as participants on the combined Part C Days Schedule.[4]

On June 3, 2013, the Representative submitted a Case Management Plan for the McKay appeals, including the instant case, which adopted new deadlines for the Schedule of Providers.[5] On August 30, 2013, the Board received the Schedule of Providers from McKay for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[6] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[7]

Board Determination on Bifurcation

The Board has granted the bifurcation of the Dual Eligible days and Part C days issues for the two Providers as requested. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[8] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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[3] *See id.* at Schedule A.
[4] In the Representative's August 30, 2013 Bifurcation Request, the Representative identifies various Part C Days groups that will have to be combined to meet the $50,000 group threshold amount in controversy. (See separate routing sheets for each case.)
[5] *See* Case Management Plan Letter, Jun. 3, 2013.
[6] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[7] *Id.* at 1.
[8] 42 C.F.R. § 405.1837(a)(2) (2003).

The Board acknowledges that at the time that Durham Regional Hospital's individual appeal and transfer requests were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the provider appealed the dual eligible days issue in its individual appeal using a broad issue statement and subsequently transferred to a CIRP group that encompassed both Part A non-covered days and Part C days.

With regard to the remaining participant, Duke University Hospital, this participant filed directly into the group from receipt of its respective Notice of Program Reimbursement. Therefore, the Board deems this participant to have appealed the group issue which included the Part C days component.

Accordingly, the Board finds that there are two legally distinct issues pending within PRRB Case No. 08-2864GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[9] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals for Durham Regional Hospital and Duke University Hospital. The providers' Part C issue is now within newly formed PRRB Case No. 16-0314G. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal is included as an enclosure along with this determination.

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:
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:

Charlotte Benson

Charlotte F. Benson, CPA
Board Member

Enclosures: Standard Remand of Dual Eligible Days Pursuant to CMS Ruling 1498-R
Schedule of Providers

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosure)

[9] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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2520 Lord Baltimore Drive, Suite L
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Refer to:

CERTIFIED MAIL

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McKay Consulting, Inc.
8590 Business Park Drive
Shreveport, LA 71105

Judith E. Cummings, Accounting Manager
CGS Administrators
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
McKay 2003-2004 Dual Eligible Group, Case No. 12-0188G

Dear Mr. McKay and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the Representative's request for the bifurcation of Dual Eligible days and Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. Because the Part C days issue for the participants bifurcated from this group would not meet the $50,000 amount in controversy, the Part C days issue for participants for which the Board finds jurisdiction will ultimately reside in case number 16-0314G, the McKay Consulting 1999 – Pre 10/1/2004 National Part C Days Group.[1] For those Providers appealing Part A Non-Covered and Exhausted Benefit days over which the Board finds jurisdiction, the Board will issue a remand pursuant to CMS Ruling 1498-R.

Background

The Representative's request for a group hearing, dated January 30, 2012, contained a lengthy group issue statement that included the following language:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[2]

In the January 30. 2012 request, the Representative also identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days. .

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[1] An Acknowledgement Letter for the new consolidated Part C days group will be sent under separate cover once all of the related bifurcations are complete.

[2] 12-0188G Group Request for Hearing at 2, January 30, 2012.

The Representative attached a preliminary Schedule of Providers[3] to the Request for a Hearing, naming two participants:

- Hazelton Hospital (Provider no. 39-0185) FYE 12/31/2003 (Transfer from 05-1974) and
- Southern Ohio Medical Center (Provider no. 36-0008) FYE 6/30/2002 (Transfer from 05-1678).[4]

The Representative subsequently added two more participants to the group:

- Southern Ohio Medical Center (Provider no. 36-0008) FYE 6/30/2004 (Direct Add via Model Form E on November 12, 2012) and
- Trinity Health System (Provider no. 36-0211) FYE 12/31/2003 (Transfer from 06-0959 on January 28, 2013).

Of the three remaining participants in the group, only Southern Ohio Medical Center (FY 2004) and Trinity Health System are on both the Part A Days Schedule of Providers and the combined Part C Days Schedule.[5] Hazelton Hospital was excluded from the Part C Days Schedule of Providers.

On June 3, 2013, the Representative submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[6] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[7] McKay wrote that it determined that "...each of the group appeals...challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[8]

Board Determination on Bifurcation

The Board has granted the bifurcation of the Dual Eligible days and Part C days issues in the subject group. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

The regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[9] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible

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[3] Group Request for Hearing, January 30, 2012, at Schedule A.
[4] This participant was withdrawn from the group in a letter dated August 15, 2013.
[5] In the Representative's August 30, 2013 Bifurcation Request, the Representative identifies various Part C Days groups that will have to be combined to meet the $50,000 group threshold amount in controversy.
[6] *See* Case Management Plan Letter, Jun. 3, 2013.
[7] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[8] *Id.* at 1.
[9] 42 C.F.R. § 405.1837(a)(2) (2003).

days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Trinity Health System (12/31/2003):

The Board acknowledges that, at the time that Trinity Health System's individual appeal and the request to add the Dual Eligible days issue were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the provider's request to add the Dual Eligible days issue used a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 12-0188G in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13 for Trinity Health System.[10] The Board is, therefore, bifurcating the Dual Eligible and Part C days issues for this provider into separate group appeals. The provider's Part C issue is now within newly formed case number 16-0314G. The providers' Dual Eligible issue remains in the instant appeal.

Southern Ohio Medical Center (06/30/2004):

The Board notes that Southern Ohio Medical Center filed directly into the group from receipt of its revised Notice of Program Reimbursement (NPR). Thus, this Provider adopted the broad issue statement as it was raised in the group appeal and can also be considered to have raised both issues. However, the Board notes a jurisdictional impediment regarding the Part C days.

In accordance with 42 C.F.R. § 405.1889 (2008), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[11] The regulation provides:

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[10] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

[11] *See also, HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding that the Board's jurisdiction is

> (a) If a revision is made in a Secretary or intermediary 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.
>
> (b)(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.

There is evidence in the record to show 183 dual eligible Medicare Part A days were paid as part of the original NPR and disallowed in the revised NPR. Therefore, the provider has established the Board's jurisdiction over the Dual Eligible Medicare Part A days and the Provider can be remanded pursuant to CMS Ruling 1498-R.

However, there is no support to show an adjustment specific to Part C days. Therefore, the Board finds that there is no jurisdiction over the Part C days issue from Southern Ohio Medical Center's revised NPR and, thus, denies this provider's request to bifurcate the Part C days issue.

Hazelton General Hospital:

As noted earlier, this provider was excluded from the Part C days Schedule of Providers. Therefore, the Board considers this provider to have abandoned the Part C days issue.

Dual Eligible days Remand:

All three participants are subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal is included as an enclosure along with this determination.

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limited to the specific issues revisited on reopening); *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014) (holding that the "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered).

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:
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:

Charlotte Benson

Charlotte F. Benson, CPA
Board Member

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877
Standard Remand of Dual Eligible Days Pursuant to CMS Ruling 1498-R
Schedule of Providers

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

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Refer to: 07-0482GC

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DEC 21 2015

Toyon Associates, Inc.
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Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation and Jurisdictional Determination
St. Joseph Health System 2004 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 07-0482GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to St. Joseph Health System ("St. Joseph") 2004 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. The Board hereby grants St. Joseph's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues for all participants within this group except one, as explained below.

Brief Background

On December 14, 2006, the Board received St. Joseph's request to form a CIRP group based on the participants' DSH dual eligible days issue. On July 23, 2010, the Board received St. Joseph's "Updated Schedule of Providers and Jurisdictional Documentation" for the seven participants within the CIRP group. On May 31, 2011, the Board received St. Joseph's request to add Covenant Medical Center Lakeside (Provider No. 45-0040) ("Covenant") to the instant appeal as the eighth participant.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[1] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

[1] Toyon is the representative for St. Joseph's appeal.

Board's Decision

Applicable Regulatory Provisions

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Jurisdiction for Covenant

Additional Facts

On October 20, 2008, the Board received Covenant's request to add issues to its individual appeal of its fiscal year end June 30, 2004 cost report, PRRB Case No. 07-0859. The following three issues were included within the request:

> **Issue 4: Disproportionate Share Hospital Payment—Medicare Managed Care Part C Days**
>
> **Description of the Issue**
>
> Whether the Intermediary properly excluded Medicare Managed Care Part C Days from the DSH calculation . . . The Provider contends that the Intermediary failed to include patient days applicable to Medicare Managed Care Part C patients who were also eligible for Medicaid in the Medicaid fraction for Medicare DSH payment adjustment calculation purposes . . .
>
> **Issue 5: Disproportionate Share Hospital Payment—Dual Eligible Days**
>
> **Description of the Issue**
>
> Whether the Intermediary properly excluded Medicaid Dual Eligible days from the DSH calculation . . . The Provider contends that the Intermediary failed to include all Medi-Medi patient days (patients who are eligible for Medicaid and have days paid and/or covered by Medicare) in the Medicare DSH calculation. These days should have been included in the Medicaid percentage of the DSH calculation. . .
>
> **Issue 6: Disproportionate Share Hospital Payment—Exhausted Medicare Benefits Medicaid Dual Eligible Days**

Description of the Issue

> Whether the Intermediary properly excluded exhausted Medicare benefits Medicaid Dual Eligible days from the DSH calculation. . . The Provider contends that the Intermediary failed to include all Medi-Medi patient days for Medicare Part A patients, whose Medicare Part A benefits were exhausted, but who were still eligible for Medicaid, in the Medicaid percentage of the Medicare DSH calculation. These days should have been included in the Medicaid percentage of the DSH calculation. . .

As noted prior, on May 31, 2011, the Board received Covenant's request to transfer its "Disproportionate Share Hospital Payment—Dual Eligible Days" issue from its individual appeal to the instant CIRP group appeal.

On January 2, 2014, the Board received a copy of the signed Administrative Agreement ("Agreement") for Covenant's individual appeal, PRRB Case No. 07-0859. Within this Agreement, the parties report the resolution of the following issues:

> Issue 9: DSH-Medicare Managed Care/Part C Days . . . The Provider transferred this issue to PRRB Case No. 07-2388G on June 26, 2012.
>
> Issue 10: DSH-Dual Eligible Days . . . The Provider transferred this issue to PRRB Case No. 07-0482GC on May 26, 2011.
>
> Issue 10: DSH—Exhausted Medicare Benefits—Dual Eligible Days . . . The Provider transferred this issue to PRRB Case No. 07-0482GC on May 26, 2011.

Covenant's Dual Eligible Days Issue

According to Covenant's October 20, 2008 request to add issues to its individual appeal, Covenant added three separate dual eligible days issues, one of which was dual eligible Medicare Managed Care/Part C Days. Subsequently, Covenant reports, in its January 2, 2014 Agreement, that on June 26, 2012, it transferred its Medicare Managed Care/Part C Days issue into PRRB Case No. 07-2388G.

Based on these facts, the Board finds that Covenant separated out its dual eligible days issues prior to filing its request to transfer into the instant CIRP group appeal. Therefore, Covenant's dual eligible days issue transferred into the instant appeal consists of only dual eligible Part A non-covered days and does not include dual eligible Part C days. Accordingly, the Board concludes that St. Joseph's December 26, 2012 request for case bifurcation (as filed by its representative, Toyon), as written, does not apply to Covenant.

Decision Regarding Case Bifurcation

The Board acknowledges that at the time that St. Joseph's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible"

for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the participants' individual appeals and the group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that for all participants, except Covenant, there are two issues pending within PRRB Case No. 07-0482GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[2] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The participants' Part C issue is now within newly formed PRRB Case No. 16-0383GC. The participants' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0383GC are included as enclosures along with this determination.

As noted prior, the Board has determined that Covenant Medical Center Lakeside's (Provider No. 45-0040) dual eligible days issue contained within the instant appeal consists only of dual eligible Part A non-covered days. Therefore, at this time, Covenant is only included as a participant in the dual eligible Part A non-covered days issue remand for the instant appeal and not as a participant within the newly formed Part C days appeal because Covenant reports that its Part C days issue is currently within an optional group appeal, PRRB Case No. 07-2388G.[3]

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq. (dissenting as to Participant 7)
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

[2] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.
3 Under 42 C.F.R. § 405.1837(b)(1)(i) (2015), two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations or CMS Rulings that is common to the providers, that arises in cost reporting periods ending in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate must bring the appeal as a group appeal.

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated January 27, 2009
Group Acknowledgment Letter for PRRB Case No. 16-0383GC
Standard Remand Letter for PRRB Case No. 07-0482GC

cc: Wilson Leong, Federal Specialized Services

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Refer to: 07-0406GC

CERTIFIED MAIL

DEC 21 2015

Toyon Associates, Inc.
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Noridian Healthcare Solutions, LLC
Evaline Alcantara
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Fargo, ND 58108-6782

RE: Request for Case Bifurcation and Jurisdictional Determination
St. Joseph Health System 2003 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 07-0406GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to St. Joseph Health System ("St. Joseph") 2003 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. The Board hereby grants St. Joseph's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues for all participants within this group except one, as explained below.

Brief Background

On December 4, 2006, the Board received St. Joseph's request to form a CIRP group based on the participants' DSH dual eligible days issue. On July 23, 2010, the Board received St. Joseph's "Updated Schedule of Providers and Jurisdictional Documentation" for the five participants within the CIRP group. On May 31, 2011, the Board received St. Joseph's request to add Covenant Medical Center Lakeside (Provider No. 45-0040) ("Covenant") to the instant appeal as the sixth participant.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[1] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

[1] Toyon is the representative for St. Joseph's appeal.

Board's Decision

Applicable Regulatory Provisions

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Jurisdiction for Covenant

Additional Facts

On October 20, 2008, the Board received Covenant's request to add issues to its individual appeal of its fiscal year end June 30, 2003 cost report, PRRB Case No. 07-0428. The following three issues were included within the request:

> **Issue 4: Disproportionate Share Hospital Payment—Medicare Managed Care Part C Days**
>
> **Description of the Issue**
>
> Whether the Intermediary properly excluded Medicare Managed Care Part C Days from the DSH calculation . . . The Provider contends that the Intermediary failed to include patient days applicable to Medicare Managed Care Part C patients who were also eligible for Medicaid in the Medicaid fraction for Medicare DSH payment adjustment calculation purposes . . .
>
> **Issue 5: Disproportionate Share Hospital Payment—Dual Eligible Days**
>
> **Description of the Issue**
>
> Whether the Intermediary properly excluded Medicaid Dual Eligible days from the DSH calculation . . . The Provider contends that the Intermediary failed to include all Medi-Medi patient days (patients who are eligible for Medicaid and have days paid and/or covered by Medicare) in the Medicare DSH calculation. These days should have been included in the Medicaid percentage of the DSH calculation. . .
>
> **Issue 6: Disproportionate Share Hospital Payment—Exhausted Medicare Benefits Medicaid Dual Eligible Days**

Description of the Issue

> Whether the Intermediary properly excluded exhausted Medicare benefits Medicaid Dual Eligible days from the DSH calculation. . . The Provider contends that the Intermediary failed to include all Medi-Medi patient days for Medicare Part A patients, whose Medicare Part A benefits were exhausted, but who were still eligible for Medicaid, in the Medicaid percentage of the Medicare DSH calculation. These days should have been included in the Medicaid percentage of the DSH calculation. . .

As noted prior, on May 31, 2011, the Board received Covenant's request to transfer its "Disproportionate Share Hospital Payment—Dual Eligible Days" issue from its individual appeal to the instant CIRP group appeal.

On May 20, 2013, the Board received a copy of the signed Administrative Agreement ("Agreement") for Covenant's individual appeal, PRRB Case No. 07-0428. Within this Agreement, the parties report the resolution of the following issues:

> Issue 8: DSH-Medicare Managed Care—Part C Days . . . This issue was withdrawn by the Provider as indicated in its September 07, 2012 email.
>
> Issue 9: DSH-Dual Eligible Days . . . The Provider transferred this issue to PRRB Case No. 07-0406GC on May 25, 2011.
>
> Issue 10: DSH—Exhausted Medicare Benefits—Dual Eligible Days . . . The Provider transferred this issue to PRRB Case No. 07-0406GC on May 25, 2011.

Covenant's Dual Eligible Days Issue

According to Covenant's October 20, 2008 request to add issues to its individual appeal, Covenant added three separate dual eligible days issues, one of which was dual eligible Medicare Managed Care/Part C Days. Subsequently, as reported in its May 20, 2013 Agreement, Covenant states that it withdrew its Medicare Managed Care/Part C Days issue "as indicated in its September 07, 2012 email."

Based on these facts, the Board finds that Covenant separated out its dual eligible days issues prior to filing its request to transfer the issue into the instant CIRP group appeal. Therefore, Covenant's dual eligible days issue transferred into the instant appeal consists of only dual eligible Part A non-covered days and does not include dual eligible Part C days. Accordingly, the Board concludes that St. Joseph's December 26, 2012 request for case bifurcation (as filed by its representative, Toyon), as written, does not apply to Covenant.

Decision Regarding Case Bifurcation

The Board acknowledges that at the time that St. Joseph's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible"

for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the participants' individual appeals and the group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

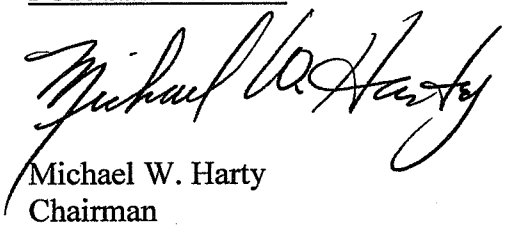
Accordingly, the Board finds that for all participants, except Covenant, there are two issues pending within PRRB Case No. 07-0406GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[2] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The participants' Part C issue is now within newly formed PRRB Case No. 16-0389GC. The participants' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0389GC are included as enclosures along with this determination.

As noted prior, the Board has determined that Covenant Medical Center Lakeside's (Provider No. 45-0040) dual eligible days issue contained within the instant appeal consists only of dual eligible Part A non-covered days. Therefore, Covenant is included as a participant in the dual eligible Part A non-covered days issue remand for the instant appeal but excluded as a participant within the newly formed Part C days appeal.

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated January 27, 2009
Group Acknowledgment Letter for PRRB Case No. 16-0389GC
Standard Remand Letter for PRRB Case No. 07-0406GC

cc: Wilson Leong, Federal Specialized Services

[2] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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Refer to: 09-1670GC

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National Government Services, Inc.
Danene Hartley, Appeals Lead
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P.O. Box 6474
Indianapolis, IN 46206 - 6474

RE: Essentia Health System 2005 DSH DE Days CIRP Group
Provider Nos: Various
FYE: 06/30/2005
PRRB Case No.: 09-1670GC

Dear Mr. Knight and Ms. Hartley:

The Provider Reimbursement Review Board (hereinafter "Board") has reviewed the jurisdictional documentation submitted in the above captioned case. The Board's jurisdiction decision is set forth below.

Background

In May of 2009, four Providers requested to establish a Common Issue-Related Party ("CIRP") group appeal for the following "Dual Eligible Days" issue:

> Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments (DSH) accurately reflects the number of patient days furnished to patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part B benefits.[3]

This CIRP group appeal for DSH Dual Eligible Days was assigned Case No. 09-1670GC. On February 25, 2015, the Providers notified the Board that the CIRP group was complete and that it contained two providers: SMDC Medical Center (Provider No. 24-0019) and St. Mary's Medical Center (Provider No. 24-0002).

[3] Providers "Establishment of CIRP Group Appeal" letter (May 8, 2009), Case No. 09-1670GC.

Provider No. 1, SMDC Medical Center, was transferred from Case No. 07-2233. This case was filed in June of 2007 with two issues: SSI Proxy and Medicaid Eligible Days. Issue No. 2 was described by the Provider as:

> Issue 2: Disproportionate Share & LIP Payment
>
> Medicaid Percentage (Eligible Days)
>
> The provider contends that the Fiscal Intermediary did not determine Medicare reimbursement for disproportionate share hospitals (DSH) in accordance with the statutory instructions at 42 U.S.C. 1395ww(d)(5)(c)(i). Specifically, the provider disagrees with the calculation of the second computation of the disproportionate share patient percentage, set forth at 42 C.F.R. 412.106(b)(4) of the Secretary's regulations. The Intermediary, contrary to the regulation, failed to include as Medicaid-Eligible Days services to all patients eligible for Medicaid, specifically patients eligible for Medicaid in Wisconsin and Michigan.
>
> Audit Adjustment #7 & #8
> Reimbursement Amount $30,572[4]

Provider No. 2, St. Mary's Medical Center, was transferred from Case No. 07-2235. This case was also filed in June of 2007, with two issues: SSI Proxy and Medicaid Eligible Days. Issue No. 2 was described by the Provider as:

> Issue 2: Disproportionate Share & LIP Payment
>
> Medicaid Percentage (Eligible Days)
>
> The provider contends that the Fiscal Intermediary did not determine Medicare reimbursement for disproportionate share hospitals (DSH) in accordance with the statutory instructions at 42 U.S.C. 1395ww(d)(5)(c)(i). Specifically, the provider disagrees with the calculation of the second computation of the disproportionate share patient percentage, set forth at 42 C.F.R. 412.106(b)(4) of the Secretary's regulations. The Intermediary, contrary to the regulation, failed to include as Medicaid-Eligible Days services to all patients eligible for Medicaid, specifically patients eligible for Medicaid in Wisconsin and Michigan.
>
> Audit Adjustment #32
> Reimbursement Amount $105,073[6]

For both participants, the Request to Transfer describes the issue that is being transferred as "Disproportionate Share Hospital (DSH) Dual Eligible Days" and references the adjustment numbers as raised in the Medicaid Percentage (Eligible Days) issue referenced above.[7]

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[4] Schedule of Providers (May 27, 2015), Tab 1B.
[6] Schedule of Providers (May 27, 2015), Tab 2B.

Medicare Contractor's Contentions

The Medicare Contractor contends that the only two Providers in this group were transferred from individual cases, and neither individual case contained a DSH Dual Eligible Days issue. The Medicare Contractor states the individual cases appealed DSH Medicaid Eligible Days which is different than DSH Dual Eligible Days. The Medicare Contractor asks the Board to dismiss the appeal in accordance with 42 C.F.R. § 405.1835 and PRRB Rule 16.1.

Providers' Contentions

The Providers contend that they properly and timely filed their individual appeals, and that DSH payments were adjusted for both Providers – specifically audit adjustments 7 and 8 for SMDC Medical Center (formerly Miller-Dwan Medical Center), and audit adjustments 31 and 32 for St. Mary's Medical Center.

The Providers assert that their individual appeals were filed prior to August 21, 2008, and that prior to this date, "it was a common and accepted practice by the Board for Providers to address multiple components of an issue as a single issue within their appeal request letter."[8] The further assert "[t]here was no known Board rule prior to August 21, 2008, that prohibited this practice."[9] The Providers proceed to explain that they find the issue of DSH Medicaid Eligible Days is a single issue in the Provider's appeals that contained the multiple components of DSH, Medicaid Eligible Days and Dual Eligible Days, within the adjustment of DSH Medicaid Eligible Days.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date the notice of the Medicare Contractor's determination was mailed to the provider.

The Board finds that it does not have jurisdiction over DSH Dual Eligible Days for either SMDC Medical Center or St. Mary's Medical Center in Case No. 09-1670GC because the Providers did not properly and timely appeal DSH Dual Eligible Days in their underlying individual appeals. Case Nos. 07-2233 and 07-2235 were filed with the Board in June of 2007 and at that time, the regulations required:

> Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position.

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[7] Schedule of Providers (May 27, 2015), Tabs 1G and 2G
[8] Providers' Response to MAC's Jurisdictional Challenge (August 26, 2015) at 2.
[9] *Id.*

> Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof. [10]

The PRRB Rules in 2007 elaborated on this regulatory requirement as follows:

> Your hearing request must contain an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending that the findings and conclusions are incorrect... You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not define the issue as "DSH." You must precisely identify the component of the DSH issue that is in dispute.[11]

The regulation governing a provider's ability to timely add issues to an appeal was amended in 2008. The amended regulation, contained in Federal Register's publication of the May 23, 2008 Final Rule and found at 42 C.F.R. § 405.1835(c)(3) (2008), became effective on August 21, 2008. The amended regulation states that a request to add an issue to an appeal is timely if the Board receives the request no later than 60 days after the expiration of the applicable 180-day period for filing the original hearing request. The following clarification also appeared in the May 23, 2008 Final Rule:

> [f]or appeals pending before ... the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of ... 60 days after the effective date of this rule.[12]

Thus, all providers with properly pending appeals before the Board as of August 21, 2008, had until October 20, 2008, to add issues, in writing, to their appeals.

The Providers did not raise DSH Dual Eligible Days issue in their initial appeal requests for Case Nos. 07-2233 and 07-2235, nor did they add the issue to these appeals before the regulatory deadline. The DSH *Medicaid Eligible* Days issue (Issue No. 2) challenged in both of the individual appeals lacked the specificity required by the regulations and the Board rules and cannot be construed to include the *Dual Eligible* Days issue the Provider now seeks. The first mention of the Dual Eligible Days issue for SMDC Medical Center and St. Mary's Medical Center was made in the Request for CIRP Group Appeal filed in May 2009,[14] which is seven months after the applicable deadline to add or clarify issues.

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[10] 42 C.F.R. 405.1841(a)(1) (2006).
[11] Provider Reimbursement Review Board Instructions, Part I § B.II.a (2002), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/Copy-2-of-Copy-2-of-PRRB_Instructions_March_03.pdf (last visited December 1, 2015).
[12] 73 Fed. Reg 30190, 30240 (May 23, 2008).
[14] *See* Providers "Establishment of CIRP Group Appeal" letter (May 8, 2009), Case No. 09-1670GC.

For the reasons stated above, the Board finds that the Dual Eligible Days issue was not properly or timely appealed by SMDC Medical Center or St. Mary's Medical Center, and therefore it lacks jurisdiction over these participants within the group appeal. The Board hereby dismisses SMDC Medical Center and St. Mary's Medical Center from Case No. 09-1670GC, and since these were the only participants in the group, the Board also close the case.

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

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 10-0661GC, 15-2025GC

DEC 22 2015

CERTIFIED MAIL

McKay Consulting, Inc.
Michael K. McKay
President
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RE: Northshore LIJ HS 2006 SSI CIRP Group; PRRB Case No. 10-0661GC
Northshore LIJ HS 2006 Post 1498R SSI CIRP Group; PRRB Case No. 15-2025GC

The Provider Reimbursement Review Board (Board) established the Northshore LIJ HS 2006 SSI CIRP Group, PRRB Case No. 10-0661GC, on February 25, 2010. The initial group participant appealed from a Notice of Program Reimbursement (NPR) dated prior to the issuance of CMS Ruling 1498-R (effective April 28, 2010). Additional providers were later added to this group; however, their NPRs were issued subsequent to CMS Ruling 1498-R. The Ruling affected the published Supplemental Security Income (SSI) percentages, so the issue in dispute for Providers that appealed NPRs dated prior to the Ruling are subject to remand to the Medicare Contractor for a recalculated SSI ratio. Participants that filed appeals with NPRs dated post-Ruling received the updated SSI ratios and are not subject to a remand. Therefore, the pre-Ruling SSI issue is different than the SSI issue being raised in the post-Ruling cases.

On April 9, 2015, the Board issued a determination and bifurcated Case No. 10-0661GC to separate the NPRs issued pre-Ruling and post-Ruling. The new group was assigned case number 15-2025GC. Four Providers (Provider Nos. 33-0195, 33-0372, 33-0043 and 33-0331) had filed appeals from post-Ruling NPRs and were transferred to the newly bifurcated group appeal. On April 14, 2015, the Board issued a Standard Remand of the SSI fraction under CMS Ruling 1498-R for the single remaining provider in Case No. 10-0661GC.

In response to the April 9, 2015 Board determination, the Board received correspondence and supporting documentation dated May 15, 2015 from the Providers' Representative contending that Forest Hills Hospital (Provider No. 33-0353) should have also been transferred to the newly bifurcated group appeal, Case No. 15-2025GC. The supporting documents attached to the Representative's request contained a copy of the April 9, 2013 filing adding Forest Hills Hospital to Case No. 10-0661GC. The NPR for Forest Hill Hospital is dated October 11, 2012, which is post-CMS Ruling 1498-R.

The Board finds that Forest Hills Hospital, Provider No. 33-0353, was inadvertently omitted from the bifurcation determination. The Board therefore confirms the transfer of Forest Hills Hospital into the bifurcated group appeal, Case No. 15-2025GC. As the remand of the pre-Ruling participant (Northshore Glen Cove, Provider No. 33-0180) was proper, Case Number 10-0661GC remains closed.

Board Members:
Michael W. Harty
Clayton J. Nix, Esquire
L. Sue Anderson, Esquire
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD:

Jack Ahern, MBA
Board Member

cc: Kyle Browning, Appeals Lead, National Government Services
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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Refer to: 06-1625GC

CERTIFIED MAIL

DEC 23 2015

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Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
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RE: Reconsideration Request and Jurisdictional Determination
Catholic Healthcare West ("CHW") 2002 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 06-1625GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to CHW 2002 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's ("CHW's") request that the Board reconsider its May 14, 2015 decision ("May 14, 2015 Decision" or "Decision") Within that Decision, the Board denied CHW's request to bifurcate the participants' dual eligible days issue within this CIRP group appeal. Upon reconsideration, the Board hereby grants CHW's request for case bifurcation of the dual eligible Part A non-covered and Part C[1] days issues within the instant appeal for all current group participants but one and reinstates two participants that were previously denied transfer into the appeal, as set forth below.

Background

On April 21, 2006, the Board received CHW's request to form a CIRP group appeal based on two participants' appeals of dual eligible days from their respective individual requests for hearing. On July 14, 2010, the Board received CHW's Schedule of Providers and Jurisdictional Documentation for 24 participants within the group. On February 24, 2012, the Board received Saint Mary's Regional Medical Center's (Provider No. 29-0009) ("Saint Mary's") Model Form D "Request to Transfer and Issue to a Group Appeal" ("Request"). Within its Request, Saint Mary's transferred its "DSH Dual Eligible Days" issue into the instant appeal. On June 20, 2012, the Board received CHW's updated Schedule of Providers and Jurisdictional Documentation in which CHW added Saint Mary's as Participant 25.

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[2] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

Within its May 14, 2015 Decision that denied CHW's request to bifurcate its dual eligible days issue, the Board determined that both the group appeal documentation and most of the participants' individual documentation did not establish that the participants "intended the Part C days to be an issue in the group appeal . . ." The Board also denied the transfer requests for two participants (Participants 7 and 17)[3] because the Board determined that, although Participants 7 and 17 "appealed the HMO days issue[,]" the dual eligible HMO days issue was not pending within the instant group appeal. Lastly, the Board dismissed Participant 22[4] from the instant appeal when it determined that it lacked jurisdiction over Participant 22's appeal. The Board concluded that as Participant 22 filed its appeal from a revised notice of program reimbursement "that did not specifically adjust dual eligible days[,]" under the terms of "42 C.F.R. § 405.1889, dual eligible days are beyond the scope of the appeal of [Participant 22]'s revised determination."

On July 13, 2015, the Board received CHW's "Request for Reconsideration of Denial of Bifurcation Request."

Board's Decision

Applicable Regulatory Provisions

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2005), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

On May 23, 2008, the Secretary published updated regulatory provisions concerning PRRB appeals.[5] The May 23, 2008 Final Rule states that the new regulations were effective beginning August 21, 2008, and applicable to all appeals filed on or after this date.[6] Under these new regulations, a provider's request for hearing must contain an issue statement that describes each contested item with a certain degree of specificity. Specifically, a provider's hearing request must include "[a]n explanation (for each specific item at issue . . .) of the provider's

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[2] Toyon is the representative for CHW's appeal.
[3] Participant 7 is Mercy Hospital Bakersfield (Provider No. 05-0295) and Participant 17 is St. Bernardine Medical Center (Provider No. 05-0129).
[4] Participant 22 is St. Rose Dominican Hospital—De Lima (Provider No. 29-0012).
[5] Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008) ("May 23, 2008 Final Rule" or "Final Rule").
[6] *Id.*

dissatisfaction with the contractor's or Secretary's determination under appeal . . ."[7]

The Board also updated its rules to coincide with the publication of the May 23, 2008 Final Rule. With respect to the new regulatory provision that requires a provider to state its appeal issues with a certain level of specificity, the Board provided some further instruction for providers. Board Rule 8 concerns provider issues involving multiple components. Rule 8 states that in order "[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 . . ."[8]

Request for Bifurcation

Upon reconsideration, the Board acknowledges that at the time that CHW's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that most of the participants' individual appeals added the dual eligible days issue prior to the May 23, 2008 Final Rule effective date by using a broad issue statement that encompassed both Part A non-covered days and HMO/Part C days. Accordingly, the Board finds that there are two issues pending within the instant appeal in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[9] The Board is, therefore, granting bifurcation for all of the participants' dual eligible days issues except Participant 22, who was dismissed previously within the May 14, 2015 Decision, and Participant 25, as explained below.

Jurisdiction for Participant 25

In a letter dated October 7, 2008, Saint Mary's added three issues to its individual appeal, PRRB Case No. 06-0890. Saint Mary's described the first issue, "Medicare/Medicaid Dual Eligible Patient Days," by stating that "the Provider contends that the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation."[10] On February 24, 2012, the Board received Saint Mary's request to transfer its dual eligible days issue into the instant appeal

The Board notes that Saint Mary's added its dual eligible days issue to its individual appeal after the August 21, 2008 effective date of the Final Rule that updated the PRRB regulations. These new regulations require a provider's request for hearing to provide, for each specific item at issue, an explanation for its dissatisfaction with contractor's or Secretary's determination under appeal. Board Rule 8 further requires a provider to appeal each contested component of a multiple-component issue as a separate issue and to describe each issue as narrowly as possible.

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[7] 42 C.F.R. § 405.1835(b)(2).
[8] PRRB Rules at 6-7 (Aug. 21, 2008).
[9] Both the regulation and Board Rule clearly state that a group appeal must contain only one issue.
[10] *See* CHW's June 20, 2012 Revised Schedule of Providers and Jurisdictional Documents at unnumbered page 13.

In the instant appeal, the Board finds that Saint Mary's described its challenge to dual eligible days generally and, in fact, does not mention HMO/Part C days at all. The Board concludes that this issue statement does not identify dual eligible Part C days with the requisite specificity, as required by the regulations for appeals pending as of, or filed on or after August 21, 2008, to allow the Board to assume jurisdiction over this issue. Accordingly, the Board hereby denies Saint Mary's request to bifurcate its dual eligible days issue.

Transfer Requests for Participants 7 and 17

Within its May 14, 2015 Decision, the Board denied Participants 7 and 17's requests to transfer into the instant appeal. As stated in the Decision, the Board determined that although Participants 7 and 17 "appealed the HMO days issue[,]" the dual eligible HMO days issue was not pending within the instant group appeal. However, as explained above, the Board has reconsidered its Decision and determined that two issues are pending within the instant appeal, one of which is dual eligible HMO/Part C days. As Participants 7 and 17 both included the dual eligible HMO days issue within their respective individual appeals, either within the original request or by transfer, they both belong within the instant group appeal.[11] The Board, therefore, has reconsidered its decision to deny the transfer requests for Participants 7 and 17 and hereby grants both of those requests.

Summary

As noted prior, the Board hereby finds that there are two issues pending within PRRB Case No. 06-1625GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[12] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' HMO/Part C days issue is now within newly formed PRRB Case No. 16-0410GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0410GC are included as enclosures along with this determination.

Within this reconsideration, the Board has determined that Saint Mary's Regional Medical Center's (Provider No. 29-0009)(Participant 25) dual eligible days issue contained within the instant appeal consists only of dual eligible Part A non-covered days. Therefore, Saint Mary's is included as a participant in the dual eligible Part A non-covered days issue remand for the instant appeal but excluded as a participant within the newly formed Part C days appeal. In addition, Mercy Hospital Bakersfield's (Provider No. 05-0295)(Participant 7) and St. Bernardine Medical Center's (Provider No. 05-0129)(Participant 17) transfer requests are hereby granted. Accordingly, these two participants are included within both the dual eligible Part A non-covered days issue remand for the instant appeal and the newly formed Part C days appeal, PRRB Case No. 16-0410.

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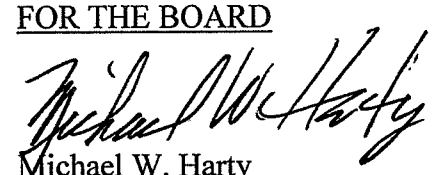
[11] *See* 42 C.F.R. § 405.1837(b)(1)(i).
[12] Both the regulation and Board Rule clearly state that a group appeal must contain only one issue.

Case No.: 06-1625GC

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 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated June 19, 2012
Group Acknowledgment Letter for PRRB Case No. 16-0410GC
Standard Remand Letter for PRRB Case No. 06-1625GC

cc: Wilson Leong, Federal Specialized Services