DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview Phone: 410-786-2671

Refer to: 07-1027G

CERTIFIED MAIL

JAN 05 2016

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 and Jurisdictional Determination
Toyon 2004 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 07-1027G

Dear Mr. Knight and Ms. Alcantara:

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

Background

On March 5, 2007, the Board received Toyon Associates, Inc. ("Toyon") request to form an optional group. On August 20, 2015, the Board received CHW's Schedule of Providers and Jurisdictional Documentation. In the same letter, Toyon also requests that, "the Dual Eligible Part C Day portion of this case be bifurcated from the Dual Eligible Part A Unpaid Day portion."[1] In addition, Toyon has requested bifurcation of the Low Income Patient ("LIP") dual eligible days issue for two Providers: Enloe Medical Center and San Joaquin General Hospital.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841, 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.

Request for Case Bifurcation of DSH Dual Eligible Part A Exhausted and Part C Days

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"

[1] Letter received by the Board on August 20, 2015.

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. 07-1667GC 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 HMO days issues into separate group appeals for some of the Providers in this appeal.[3]

The providers' Part C days issue is now within newly formed PRRB Case No. 16-0533G for the period ending 9/30/2004. 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 Letters for PRRB Case No. 16-0533G are included as enclosures along with this determination.

Providers Appealing from 12/31/2004 FYEs

Participants 1-3 and 6[4] are appealing from FYE 12/31/2004 final determinations. Both the exhausted Part A and Part C days are treated differently for periods ending before 10/1/2004 and after that date. Therefore, the Board hereby transfers the period from 10/1/2004 – 12/31/2004 to PRRB Case No. 07-2412G, Toyon 2005 DSH Dual Eligible Days CIRP Group and PRRB Case No. 11-0037G, Toyon 2005 DSH Dual Eligible Part C Days Group. The period from 1/1/2004 – 9/30/2004 will remain pending in this group for the Part A exhausted issue and in PRRB Case No. 16-0533G for the Part C days issue.

Request for Bifurcation of LIP Dual Eligible Days Issue

When Toyon requested bifurcation of the exhausted Part A and Part C issues, it also indicated that two Providers in the group have also appealed LIP dual eligible days: Participant 5, Enloe Medical Center (provider no. 05-0039, FYE 6/30/2004), and Participant 8, San Joaquin General Hospital (provider no. 05-0167, FYE 6/30/2004).

The Board hereby denies the requests for bifurcation of the LIP dual eligible days issues for Participants 5. Upon review of each of the Provider's jurisdictional documents, the Board finds that this Provider did not specifically appeal the LIP dual eligible days issue and did not request to transfer the issue to this group appeal. Therefore, the Board declines to bifurcate the LIP dual eligible days issue for Enloe Medical Center.

The Board finds that Participant 8 appealed both the DSH and LIP dual eligible days issues in its individual appeal. The Provider's appeal request pertained to both the hospital and the

---

[2] Both the regulation and Board Rule clearly state that a group appeal must contain only one issue.
[3] The Board hereby grants bifurcation of the DSH issues for Participants 1, 2, 4-11, 13, and 15-24.
[4] Community Hospital of the Monterey Peninsula (provider no. 05-0145); Dameron Hospital (provider no. 05-0122); Delano Regional Medical Center (provider no. 05-0608); and Memorial Hospital Modesto (provider no. 05-0167).

rehabilitation Provider, and the adjustments listed for the dual eligible days issue include the DSH and LIP Providers. As the DSH and LIP dual eligible days issues are separate issues, the Board hereby transfers the LIP dual eligible days issue back to the Provider's individual appeal, case number 08-1249, which remains open before the Board.

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 August 19, 2015
Group Acknowledgment Letters for PRRB Case No. 16-0533G
Standard Remand Letter for PRRB Case No. 07-1027G

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670
FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview
Phone: 410-786-2671

Refer to: 07-0096GC

CERTIFIED MAIL

JAN 05 2016

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: Reconsideration Request and Jurisdictional Determination
CHW 2003 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 07-0096GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the CHW 2003 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's ("CHW's") request that the Board reconsider its May 22, 2015 decision ("May 22, 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. The Board also dismissed Participant 13, St. Bernadine Medical Center, for lack of jurisdiction. Upon reconsideration, the Board hereby grants, in part, CHW's request for case bifurcation of the dual eligible Part A non-covered and Part C[1] days issues within the instant appeal. The Board hereby denies CHW's request to reconsider its decision to dismiss St. Bernadine Medical Center. The Board's decision is set forth below.

BACKGROUND

On October 20, 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 June 20, 2010, the Board received CHW's Revised Schedule of Providers and Jurisdictional Documentation for 24 participants within the group.

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

[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] Toyon is the representative for CHW's appeal.

days at issue."

Within its May 22, 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 Participant 4[3] because the Board determined that, although the Provider "appealed the HMO days issue[,]" the dual eligible HMO days issue was not pending within the instant group appeal. Lastly, the Board dismissed Participant 13[4] from the instant appeal when it determined that it lacked jurisdiction over the Provider's appeal. The Board concluded that as Participant 13 filed its appeal from a revised notice of program reimbursement ("NPR") "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 13]'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 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

---

[3] Mercy Hospital Bakersfield (provider no. 05-0295, FYE 6/30/2003).
[4] St. Bernadine Medical Center (provider no. 05-0129, FYE 6/30/2003).
[5] Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008) ("May 23, 2008 Final Rule" or "Final Rule").
[6] *Id.*
[7] 42 C.F.R. § 405.1835(b)(2).

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 Reconsideration of Denial of Bifurcation Request

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 13, who was dismissed previously within the May 22, 2015 Decision, and Participants 10 and 24, as explained below.

Transfer Request for Participant 4

Within its May 22, 2015 Decision, the Board denied Participant 4's request 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 Participant 4 included the dual eligible HMO days issue within its individual appeal and transferred the issue to this group, the Provider belongs within the instant group appeal.[10] The Board, therefore, has reconsidered its decision to deny the transfer requests for Participant 4 and hereby grants the request.

Denial of Bifurcation for Participants 10 and 24[11]

Participant 10 filed its individual appeal request on January 16, 2009 and requested to transfer the issue to this group appeal on February 13, 2009. Participant 24 did not include the dual eligible days issue in its individual appeal request and did not request to add the issue to its appeal until October 7, 2008. Participant 24 requested to transfer the issue to this group appeal on February 22, 2012.

All of these add and transfer requests came in after the August 21, 2008 effective date of the

---

[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* 42 C.F.R. § 405.1837(b)(1)(i).
[11] Northridge Hospital – Roscoe Campus (provider no. 05-0116, FYE 6/30/2003) and St. Mary's Regional Medical Center – Reno (provider no. 29-0009, FYE 12/31/2003).

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.

In the instant appeal, the Board finds that both Participants 10 and 24 described their challenge to dual eligible days generally and, in fact, do not mention HMO/Part C days at all. The Board concludes that this issue statements do 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 the requests to bifurcate the dual eligible days issue for Participants 10 and 24.

Request for Reconsideration of St. Bernadine Medical Center Dismissal

In its May 22, 2014 Decision Letter, the Board dismissed Participant 13, St. Bernadine Medical Center, from the instant appeal after determining that the Provider appealed from a revised NPR that did not specifically adjust dual eligible days as required by 42 C.F.R. § 405.1889 (2006). In its reconsideration request, the Provider argues that because Medicaid eligible days were adjusted for the first time in the revised NPR, the Board does have jurisdiction over St. Bernadine Medical Center. The Provider submitted its revised NPR and audit adjustment pages which do show an adjustment to Medicaid eligible days. However, the Provider did not submit anything to establish that dual eligible days specifically were adjusted as part of the reopening in order to satisfy the jurisdictional requirements of 42 C.F.R. § 42 C.F.R. §§ 405.1885, 405.1889 (2006). The Board hereby denies the Request for Reconsideration of St. Bernadine Medical Center's dismissal.

SUMMARY

As noted prior, the Board hereby finds that there are two issues pending within PRRB Case No. 07-0096GC 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. 16-0566GCGC. 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. 16-0566GC are included as enclosures along with this determination.

Within this reconsideration, the Board has determined that the dual eligible days issue for Participants 10 and 24 consists only of dual eligible Part A non-covered days. Therefore, Participant 10 (Northridge Hospital – Roscoe Campus) and Participant 24 (St. Mary's Regional Medical Center – Reno) are included as participants 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

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

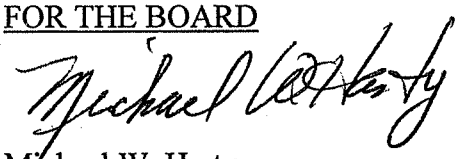
days appeal. In addition, Mercy Hospital Bakersfield's (Provider No. 05-0295)(Participant 4) transfer request is hereby granted. Accordingly, this Participant is included within both the dual eligible Part A non-covered days issue remand for the instant appeal and the newly formed Part C days appeal, PRRB Case No. 16-0566GC.

Finally, the Board denies CHW's Request for Reconsideration of St. Bernadine Medical Center's dismissal.

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. 16-0566GC
Standard Remand Letter for PRRB Case No. 07-0096GC

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244-2670
Phone: 410-786-2671 Fax: 410-786-5298

CERTIFIED MAIL

JAN 08 2016

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

RE: **St. Joseph's Medical Center**
Provider Number: 24-0075
FYE: 6/30/2007
Case Number: 13-2216

Dear Mr. Knight:

The Provider Reimbursement Review Board (Board) has begun a review of the above-referenced appeal. The pertinent facts and the Board's determination are set forth below.

On May 24, 2013, the Board received the Provider's appeal request in which the Provider appealed five issues from its December 4, 2012 Revised Notice of Program Reimbursement ("RNPR") for the fiscal year ending on June 30, 2007:

1. Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio issued March 16, 2012;
2. Inclusion of Medicare Dual Eligible Part C Days in the SSI Ratio issued March 16, 2012;
3. SSI Ratio Alignment to Provider's Cost Reporting Year
4. Accuracy of CMS Developed SSI Ratio issued March 16, 2012;
5. SSI MMA §951 Applicable to SSI Ratio issued March 16, 2012.

On January 8, 2014, the Board received the Provider's requests to transfer the following issues:

1. Medicare Dual Eligible Part A Days to Case No. 14-0022GC;
2. Medicare Dual Eligible Part C Days to Case No. 14-0023GC;
4. Accuracy of CMS Development SSI Ratio to Case No. 14-0024GC; and
5. SSI MMA §951 to Group Case No. 14-0020GC

The only issue remaining in this appeal is the SSI Ratio Alignment to Provider's Cost Reporting Year.

On February 21, 2014, the Board dismissed Case No. 13-2216 for the Provider's failure to file a PJSO or Preliminary Position Paper by the established due date.

On March 19, 2014, the Board received the Provider's request for reinstatement. In its letter, the Provider states they did submit a preliminary position paper to the Board; however, the Provider referenced the incorrect case number on the cover letter.

On May 2, 2014, the Board reinstated Case No. 13-2216 pursuant to the Provider's request.

Board's Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2002), 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.

SSI Ratio Alignment

In the Provider's appeal request, the SSI Ratio Alignment issue statement reads as follows:

> The Intermediary made adjustments to the Provider's reported Medicare DSH entitlement. The Provider contends the Intermediary's adjustments applied to the audited Medicare cost report resulted in an incorrect amount of DSH entitlement. The Provider is dissatisfied with the DSH payment because the MAC did not update all components of the DSH calculation in an effort to ensure DSH payments are properly stated.
>
> The DSH payment is developed from a combined SSI percentage (furnished by CMS and based upon a federal fiscal year) and Medicaid patient day percentage. The Provider contends the SSI percentage utilized in the development of the DSH payment is incorrectly stated because the SSI percentage does not align to the Provider's cost reporting year. *The Provider will consider requesting CMS realign the Provider's SSI percentage to the Provider's cost reporting year. Alternatively, the Provider may decide to use its own data for purposes of seeking a resolution to this issue.* The applicable regulation is 42 C.F.R. 412.106....

Since the Provider had not requested CMS realign the Provider's SSI percentage with the Provider's cost reporting year and no final determination related to realignment was made by the MAC[1] at the time of the appeal, the Board hereby denies jurisdiction over the SSI Ratio Alignment issue and dismisses it from this appeal. Since this issue is the only issue remaining in this appeal, the Board hereby closes this appeal and removes it from the docket.

---

[1] A Provider has a right to a Board hearing for specific issues covered by a final contractor determination. 42 C.F.R. 405.1835.

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

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670
Phone: 410-786-2671
FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview

16-0280

Refer to:

Certified Mail

JAN 11 2016

Emerson Hospital
Craig W. Cowan
Director, Patient Account Services
133 Old Road to Nine Acre Corner
Concord, MA 01742

Re: Emerson Hospital
Provider No. 22-0084
FYE 09/30/12
PRRB Case No. 16-0280
Jurisdictional Determination Concerning Provider's Appeal Request

Dear Mr. Cowan:

The Provider Reimbursement Review Board ("Board") is in receipt of the Provider's recent appeal request, which was assigned Case No. 16-0280. The background of the case and the decision of the Board are set forth below.

Background

On November 12, 2015, the Board received Emerson Hospital's appeal "to recover $42,293 denied findings from a[sic] overall total amount of $47,122 on our cost report for Part A and Part B claims." On December 1, 2015, the Board established the appeal and issued an electronic Acknowledgement and Critical Due Dates notification in accordance with Board Rule 9, which states:

> The Board will send an acknowledgement via e-mail indicating that the appeal request has been received and identifying the case number assigned. 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.

The appeal request was void of Model Form A, inclusion of information provided by Model Form A, or any required jurisdictional documents.

Decision of the Board

The Board finds that the Provider's appeal request is deficient because it failed to provide the final determination under appeal, an explanation of the specific issue(s) in dispute, or any documentary evidence to support the Provider's appeal request.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if the provider is dissatisfied with the determination of the Medicare Contractor, the amount in controversy is $10,000 or more for an individual appeal ($50,000 for a group), and the request for a hearing is filed within 180 days after the date of receipt by the provider of the Medicare Contractor determination.

If a provider's appeal request does not meet the requirements of 42 C.F.R. §§ 405.1835 (b)(1) - (b)(3), the Board may dismiss the appeal with prejudice, or take any other remedial action it considers appropriate. Paragraphs (b)(1) - (b)(3) state in part that the following must be included in the provider's request:

> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the contractor's or Secretary's determination under appeal.
>
> (2) An explanation (for each specific item at issue, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal....
>
> (3) A copy of the contractor or Secretary determination under appeal, and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.

Therefore, the Board hereby dismisses the Provider's appeal with prejudice due to insufficient information and documentation to support the regulatory requirements for filing an appeal at the Board and closes Case No. 16-0280.

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, Esquire
L. Sue Andersen, Esquire
Charlotte F. Benson, C.P.A.
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

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview **Phone: 410-786-2671**

Refer to: 08-2451GC

JAN 11 2016

CERTIFIED MAIL

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 Reconsideration–Daughters of Charity 2000 DSH Dual Eligible Days CIRP
Provider No.: Various
FYE: Various
PRRB Case No.: 08-2451GC

Dear Mr. Knight and Ms. Alcantara,

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the above-referenced appeal in response to the Daughters of Charity 2000 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Party ("CIRP")] Group's ("Charity's") July 23, 2015 "Request for Reconsideration of Denial of Bifurcation Request." Following its review, the Board is reopening the instant appeal, granting Charity's request to bifurcate the dual eligible days issue within this appeal and re-issuing the providers' remand, as explained below.

Background

Facts for PRRB Case No. 08-2451GC

On July 24, 2008, the Board received Charity's request to establish its 2000 DSH Dual Eligible Days CIRP Group based on two common-related providers identified within PRRB Case No. 04-1731G. On July 19, 2010, the Board received Charity's Schedule of Providers and jurisdictional documentation for the two participants within the appeal.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[1] request for, among other things, case bifurcation ("Request") in Charity's instant CIRP group appeal. 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."[2]

[1] Toyon is the representative for Charity's appeal.
[2] 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. 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. The Providers, however, have used the terms HMO days and Part C Days interchangeably for both time periods.

In response to the Request, the Board issued a June 3, 2015 Decision that denied Charity's request to bifurcate the providers' Part C days issue. The Board concluded that the providers did not "establish that [they] intended the HMO days to be an issue in [the] group appeal . . ."

On July 24, 2015, the Board received Charity's "Request for Reconsideration of Denial of Bifurcation Request."

On July 31, 2015, the Board issued a "Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R" letter for the instant appeal and closed the case.

Addition of Seton Medical Center's Appeal from PRRB Case No. 08-2450GC

In a May 22, 2015 decision, the Board denied Charity's request to bifurcate the dual eligible days issue for PRRB Case No. 08-2450GC, Daughters of Charity 1999 DSH Dual Eligible Days CIRP Group, because the providers did not "establish that [they] intended the HMO days to be an issue . . . in [the] group appeal . . ." Also within its May 22, 2015 decision, the Board determined that it did not have jurisdiction over O'Connor Hospital's appeal (Provider No. 05-0153) contained within the group because O'Connor Hospital filed its appeal from a revised notice of program reimbursement "that did not specifically adjust dual eligible days." Finally, the Board stated that it was transferring the fiscal year ending ("FYE") June 30, 1999 appeal for the sole remaining participant, Seton Medical Center (Provider No. 05-0289), to PRRB Case No. 08-2451GC and closing PRRB Case No. 08-2450GC.

On July 22, 2015, the Board received Charity's Reconsideration Request in which Charity is asking the Board to "reconsider and reverse its denial of the bifurcation request as it pertains to Seton Medical Center . . ."

On July 31, 2015, the Board issued a "Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R" letter for PRRB Case No. 08-2451GC, but Seton Medical Center's FYE June 30, 1999 appeal was not included within the Schedule of Providers for that remand.

Board's Decision

Statement of Authority

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.

Bifurcation Request

The Board acknowledges that at the time that 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 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/Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2451GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, reopening PRRB Case No. 08-2451GC in order to bifurcate the dual eligible Part A non-covered and HMO/Part C days issues into separate group appeals. The providers' Part C issue is now within newly formed PRRB Case No. 16-0596GC. However, as Seton Medical Center's FYE June 30, 1999 appeal includes both HMO and Part C days, the Board is further subdividing this provider's HMO and Part C days issues as follows. The portion of Seton Medical Center's FYE June 30, 1999 appeal covering the period in which the days at issue are considered HMO days—July 1, 1998, through December 31, 1998—will be transferred to PRRB Case No. 14-2046G, Toyon 1998 DSH HMO Days Group; the portion of the appeal covering the period in which the days at issue are considered Part C Days—January 1, 1999, through June 30, 1999—will be transferred the newly formed PRRB Case No. 16-0596GC.

The Board previously remanded the providers' dual eligible Part A non-covered days issue on July 31, 2015, but as the accompanying Schedule of Providers did not contain Seton Medical Center's FYE June 30, 1999 appeal, the Board is reissuing the remand with Seton Medical Center's appeal included. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0596GC are included as enclosures along with this determination. Following the Board's re-issue of the remand, PRRB Case No. 08-2451GC will once again be closed.

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

[3] 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
Two Schedules of Providers, both dated September 17, 2008
Group Acknowledgment Letter for PRRB Case No. 16-0596GC
Standard Remand Letter for PRRB Case No. 08-2451GC

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview Phone: 410-786-2671

Refer to: 08-2450GC

CERTIFIED MAIL

JAN 11 2016

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: Reconsideration Request
Daughters of Charity 1999 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2450GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Daughters of Charity [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Party's ("CIRP")] Group's ("Charity's") July 20, 2015 request that the Board reconsider its May 22, 2015 decision ("May 22, 2015 Decision") in which the Board denied Charity's request to bifurcate the providers' dual eligible days issue. Upon reconsideration, the Board hereby affirms its denial of Charity's request for bifurcation of the dual eligible Part A non-covered and HMO/Part C[1] days issues within the instant appeal because the sole remaining provider within this group has been transferred to a different CIRP group, PRRB Case No. 08-2451GC.

Background

On July 24, 2008, the Board received Charity's request to form a CIRP group based on two commonly-related providers identified in PRRB Case No. 06-1943G. The Board received Charity's Schedule of Providers and jurisdictional documentation for the newly formed CIRP group on July 19, 2010.

[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. As Charity has used the terms HMO days and Part C Days interchangeably for both time periods, the Board will simplify things by referring to the days collectively as "Part C days."

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[2] request for, among other things, case bifurcation ("Request") in Charity's instant CIRP group appeal. 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 response to the Request, the Board issued its May 22, 2015 Decision that denied Charity's request to bifurcate the providers' Part C days issue. The Board concluded that the providers did not "establish that [they] intended the HMO days to be an issue . . . in [the] group appeal . . ." Also within its May 22, 2015 Decision, the Board determined that it did not have jurisdiction over O'Connor Hospital's appeal (Participant 1, Provider No. 05-0153) contained within the group, because O'Connor Hospital filed its appeal from a revised notice of program reimbursement "that did not specifically adjust dual eligible days." Finally, the Board stated that it was transferring the sole remaining participant, Seton Medical Center (Provider No. 05-0289), to PRRB Case No. 08-2451GC and closing PRRB Case No. 08-2450GC.

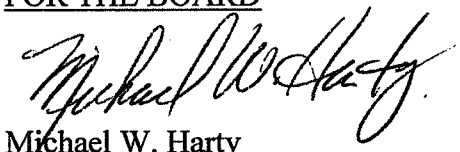
On July 22, 2015, the Board received Charity's "Request for Reconsideration of Denial of Bifurcation Request" dated July 20, 2015.

Board's Decision

The Board also received a "Request for Reconsideration of Denial of Bifurcation Request" for PRRB Case No. 08-2451GC on July 24, 2015. As the sole remaining participant within this CIRP group appeal was transferred to PRRB Case No. 08-2451GC on May 22, 2015, the Board will address Seton Medical Center's request for reconsideration along with the request it received for PRRB Case No. 08-2451GC. The Board, therefore, denies Charity's request to reconsider its May 22, 2015 Decision to deny bifurcation of the dual eligible days issue within the instant appeal and this appeal remains closed.

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

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview Phone: 410-786-2671

Refer to: 07-0364G

CERTIFIED MAIL

JAN 11 2016

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: Board's Own Motion Reconsideration of Request for Case Bifurcation
Toyon 2000 DSH Dual Eligible Days Group
PRRB Case No.: 07-0364G

Dear Mr. Knight and Ms. Alcantara:

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 2000 Disproportionate Share Hospital ("DSH") Dual Eligible Days Group. Although the Board initially denied Toyon's bifurcation request in its February 12, 2014 decision ("February 12, 2014 Decision"), upon its own motion reconsideration, the Board hereby grants Toyon's request to bifurcate the providers' dual eligible days issue, as explained below.

Background

On November 30, 2006, the Board received Toyon's group appeal request regarding DSH dual eligible days. Toyon's final Schedule of Providers, dated April 22, 2010, consists of four providers.

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 February 12, 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 Part C/HMO days issue was not raised in either the group appeal request or the providers' transfer requests . . ."[2]

On July 31, 2015, the Board issued a "Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R," and closed PRRB Case No. 07-0364G.

[1] Toyon is the providers' representative for this appeal.
[2] February 12, 2014 Decision at 3.

Board's Decision

Applicable Legal Authority

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.

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 group appeal request 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. 07-0364G in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, reopening PRRB Case No. 07-0364G and 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. 16-0608G. The Board remanded the providers' dual eligible Part A non-covered days issue, pursuant to CMS 1498-R, on July 31, 2015. As such, once the dual eligible Part C days issue is separated from the dual eligible Part A non-covered days issue, the instant appeal will once again be closed. The Board's Acknowledgment Letter for PRRB Case No. 16-0608G 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

Michael W. Harty
Chairman

[3] 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
Group Acknowledgment Letter for PRRB Case No. 16-0608G

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview Phone: 410-786-2671

Refer to: 08-2620GC

CERTIFIED MAIL

JAN 11 2016

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: Bifurcation Request and Jurisdictional Determination
Sutter Health 2002 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2620GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Sutter Health 2002 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Provider ("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[1] issues for all but two providers within this appeal, as explained below. In addition, the Board has created a separate appeal for Participant 1's low income patient ("LIP") dual eligible days fraction issue.

Background

On July 25, 2008, the Board received Sutter Health's request to form this CIRP group and on July 30, 2010, the Board received Sutter Health's jurisdictional documentation for the 13 participants now within this appeal.

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."

[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] 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 (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.

On May 23, 2008, the Secretary published updated regulatory provisions concerning PRRB appeals.[3] 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.[4] 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 . . ."[5]

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 . . ."[6]

Jurisdiction for Participant 3, California Pacific Medical Center (Provider No. 05-0047)

Sutter Health's July 30, 2010 Jurisdictional Documentation shows that Participant 3 filed a June 18, 2010 request for hearing based on its December 23, 2009 notice of program reimbursement. Within its request for hearing, Participant 3 included the following summary of its "Medicare DSH—Medicaid Dual Eligible Patient Days Issue":

> The Provider also contends that valid Medicare/Medicaid dual eligible patients that have exhausted their Part A benefits should be included in the numerator part of the DSH fraction calculation. Here, the controlling authorities require days furnished to patients eligible for Medicaid but not entitled to Medicare Part A or Part A benefits exhausted to be included in the Medicaid proxy.[7]

The Board notes that Participant 3 filed its June 18, 2010 request for hearing well 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, Participant 3 must include, for each

---

[3] Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008).
[4] *Id.*
[5] 42 C.F.R. § 405.1835(b)(2).
[6] PRRB Rules at 6-7 (Aug. 21, 2008).
[7] July 30, 2010 Jurisdictional Documents at Tab 3B.

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 Participant 3 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 Participant 3's June 18, 2010 request for hearing contains an issue statement 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 Participant 3's request to bifurcate its dual eligible days issue.

Jurisdiction for Participant 11, St. Luke's Hospital (Provider No. 05-0055)

Sutter Health's July 30, 2010 Jurisdictional Documentation shows that Participant 11 filed a request for hearing, dated March 2, 2006, based on its September 29, 2005 notice of program reimbursement. In an October 10, 2008 letter to the Board, Participant 11 requested to add the following dual eligible days issue to its appeal: "the Provider contends that the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation."

The Board notes that Participant 11 filed its October 10, 2008 add-issue 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, Participant 11 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 Participant 3 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 Participant 11's October 10, 2008 add-issue request contains an issue statement 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 Participant 11's request to bifurcate its dual eligible days issue.

LIP Issue for Participant 1, Alta Bates Medical Center (Provider No. 05-0305)

The Board notes that, within its February 4, 2010 request for hearing, Participant 1 entitles its dual eligible days issue as "Medicare [DSH] Payments/Low Income Payments (LIP)—Dual Eligible Days." Participant 1 goes on to explain its dissatisfaction with the way that the Medicare contractor treated its dual eligible days in both the DSH and the LIP calculations for its fiscal year end December 31, 2002 cost report.

The Board considers issues pertaining to the LIP calculation as separate from issues pertaining to the DSH calculation. As such, the Board is separating out Participant 1's LIP dual eligible days from the instant CIRP group appeal. Participant 1's LIP dual eligible days issue will now be within the newly formed PRRB Case No. 16-0565.

Bifurcation Request

With respect to the remaining participants, the Board acknowledges that at the time that Sutter Health's individual 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 remaining providers' included or added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and Part C days.

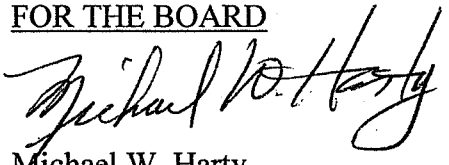
Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2620GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[8] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The providers' Part C days issue is now within newly formed PRRB Case No. 16-0531GC. 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, the Board's Acknowledgment Letter for PRRB Case No. 16-0531GC and the Board's Acknowledgment Letter for PRRB Case No. 16-0565 are all included as enclosures along with this determination.

As the Board has denied bifurcation for Participant 3, California Pacific Medical Center (Provider No. 05-0047), and Participant 11, St. Luke's Hospital (Provider No. 05-0055), these two providers are excluded from the newly formed Part C days appeal but 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

[8] 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 28, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0531GC
Group Acknowledgment Letter for PRRB Case No. 16-0565
Standard Remand Letter for PRRB Case No. 08-2620GC

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview Phone: 410-786-2671

Refer to: 08-2627GC

CERTIFIED MAIL JAN 11 2016

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 Reconsideration
Daughters of Charity 2001 DSH Dual Eligible Days CIRP
Provider No.: Various
FYE: Various
PRRB Case No.: 08-2627GC

Dear Mr. Knight and Ms. Alcantara,

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the above-referenced appeal in response to the Daughters of Charity 2001 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Party ("CIRP")] Group's ("Charity's") July 22, 2015 "Request for Reconsideration of Denial of Bifurcation Request." Following its review, the Board is reopening the instant CIRP group appeal and granting Charity's request to bifurcate the dual eligible days issue, as explained below.

Background

On July 25, 2008, the Board received Charity's request to establish its 2001 DSH Dual Eligible Days CIRP Group. On July 19, 2010, the Board received Charity's Schedule of Providers and jurisdictional documentation for the four providers within the appeal.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[1] request for, among other things, case bifurcation ("Request") in Charity's instant CIRP group appeal. 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."[2]

[1] Toyon is the representative for Charity's appeal.
[2] 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.

In response to the Request, the Board issued a May 22, 2015 Decision that denied Charity's request to bifurcate the providers' Part C days issue. The Board concluded that "there is no indication that the Providers intended the HMO days to be an issue in their various appeals or in case number 08-2627GC . . ." Within that same decision, the Board dismissed Seton Medical Center's (Provider No. 05-0289)("Seton") appeal for the fiscal year ending December 31, 2001, from the CIRP group because the Board determined that it did not have jurisdiction to consider Seton's dual eligible days issue that Seton appealed from its revised notice of program reimbursement.

On July 22, 2015, the Board received Charity's "Request for Reconsideration of Denial of Bifurcation Request."

On July 31, 2015, the Board issued a "Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R" letter for the instant appeal and closed the case.

Board's Decision

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 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 Charity's individual and group appeal 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' original optional group appeals described the dual eligible days issue using a broad issue statement that encompasses Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2627GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] As the Board previously remanded this appeal on July 31, 2015, and subsequently closed the case, the Board is hereby reopening PRRB Case No. 08-2627GC in order to grant Charity's dual eligible days issue bifurcation request. Accordingly, the Board is separating the providers' dual eligible Part A non-covered issue from the providers' Part C days issue for all providers remaining within the group. The providers' Part C days issue is now within newly formed PRRB Case No. 16-0586GC. As noted, the Board issued a July 31, 2015 remand of the providers' dual eligible Part A non-covered days issue, therefore, following the bifurcation of the dual eligible days issue, this case is once again closed. The Board's Acknowledgment Letter for PRRB Case No. 16-0586GC is included as an enclosure along with this determination.

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

As the Board previously determined that it does not have jurisdiction over Seton Medical Center's (Provider No. 05-0289) dual eligible days issue for the fiscal year ending December 31, 2001, this provider is excluded from the newly formed Part C days appeal and was 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

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Group Acknowledgment Letter for PRRB Case No. 16-0586GC

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Internet: www.cms.gov/PRRBReview
FAX: 410-786-5298
Phone: 410-786-2671

Refer to: 13-1315GC

JAN 11 2016

CERTIFIED MAIL

Maureen O'Brien Griffin
Hall, Render, Killian, Heath & Lyman, P.C.
Suite 2000, Box 82064
One American Square
Indianapolis, IN 46282

RE: PRRB Decision
Request for Expedited Judicial Review
ProMedica 2007 SSI Medicare Advantage Days CIRP Group
PRRB Case No. 13-1315GC

Dear Ms. Griffin:

The Provider Reimbursement Review Board's ("PRRB or Board") decision with respect to the above referenced request is set forth below.

Background

This group appeal involves Medicare Part C days (also called Medicare Advantage days, Medicare+Choice days, or M+C days in this memo) and their utilization in the Disproportionate Share Hospital ("DSH") payment calculation.

On March 29, 2013, the Providers filed a Mandatory CIRP (Common Issue Related Parties) appeal request with the Provider Reimbursement Review Board (Board). The Providers stated the issue in the request for appeal as:

> The MAC made adjustments to the Medicare cost reports, as identified on Model Form G, to the Medicare Fraction or SSI, of the Disproportionate Patient Percentage. The MAC used the Medicare Fraction as calculated by CMS. CMS acknowledged in the IPPS 2003 and 2004 proposed rules that MA days were not previously included in the Medicare Fraction. In July of 2007, CMS issued Transmittal 1311, which required hospitals to submit no-pay claims to their respective fiscal intermediaries of MA inpatient services from the 2006 and 2007 fiscal years. CMS used this data to ensure that MA days were included in the Medicare Fraction for 2006 forward. CMS relied on DSH regulation at 42 C.F.R. § 412.106, which includes

> MA days in the Medicare Fraction. However, the enabling statute for this regulation, 42 U.S.C. § 1395ww(d)(5)(F), does not mention the inclusion of MA days in the SSI Medicare fraction. The key legal argument will be that the regulation is invalid to the extent that it contradicts the enabling statute and was not properly promulgated...[1]

On July 2, 2013, the Providers' filed a "corrected Issue Statement" in this case. The Board reviewed the Providers' corrected Issue Statement, and determined that the Providers were requesting to add issues to this CIRP group appeal. The Board denied the Providers' request to add to the group issue in the appeal, stating "[a]s group appeals are limited to one legal issue, this adding of issues for the proper calculation of the Medicaid fraction (with Part C days) is a separate legal issue than that originally raised, which solely related to excluding the MA day[s] from the SSI [fraction]." [2]

On June 22, 2015, the Providers' filed a Request for Expedited Judicial Review (EJR). The Providers' described the issue in this appeal in the EJR request as:

> The common issue before the Board is the failure of the Medicare Administrative Contractor (MAC) and the Centers for Medicare & Medicaid Services (CMS) to properly determine the ratio of Supplemental Security Income (SSI) recipient patient days for patients who, for such days, were entitled to benefits under both Medicare Part A and SSI (excluding any State supplementation), to Medicare Part A patient days (the Medicare Proxy or Fraction) for the Participating Providers in their Disproportionate Share Hospital (DSH) eligibility determinations and payment calculations. The Participating Providers assert that the Medicare Proxy is improperly understated due to CMS's erroneous inclusion of inpatient days attributable to Medicare Advantage (MA) patients in both the numerator and the denominator of the DSH fraction and/or low income patient (LIP) fraction for Inpatient Rehabilitation Facilities (IRFs) and/or IRF units, as applicable. Providers also assert that any Medicare Advantage (MA or Medicare Part C) Days that are also Dual Eligible (DE) Days cannot be counted in the Medicare ratio for the same reasons as set forth above, primarily because the CMS regulation requiring such inclusion in the Medicare ratio is invalid, therefore these DE-MA Days must be counted in the Medicaid numerator.

The Board subsequently denied the Providers June, 2015 EJR request in a letter dated July 21, 2015. The Board reasoned that the issue in this group appeal does not include matters related to the DSH

---

[1] Providers' Group Appeal Request (Mar. 28, 2013), Tab 2 at 1.
[2] *See* Board letter to Providers' (Mar. 4, 2015) at 2.

Medicaid fraction (as stated in the Board's March 5, 2015 letter), and that the Board lacks the authority to issue a decision for SSI Medicare Days for LIP providers. The Board explained:

> An EJR request cannot be granted for an issue that was never appealed because the Board must have jurisdiction over an issue prior to granting an EJR.[3] Since there were no LIP providers identified as participants in this appeal, nor was the LIP issue included in the original hearing request, the Board lacks jurisdiction over this issue and hereby dismisses the LIP issue from the appeal…

On December 15, 2015, the Providers submitted a Revised Request for EJR. The Providers allege the Board is without the authority to implement the Court of Appeals decision in Allina Health Services v. Sebelius, 746 F.3d 1102 (D.C. Cir. 2014) ("Allina"), absent action by the Secretary or CMS in response to the Court's remand.

Statement of Facts

The DSH adjustment is made for certain hospitals that serve a significantly disproportionate number of low-income patients.[4] It is calculated based on a hospital's disproportionate patient percentage, which serves as a proxy for a hospital's utilization by low-income patients[5] and is defined as the sum of two fractions expressed as percentages.[6] These two DSH fractions are referred to as the "Medicare" fraction and the "Medicaid" fraction. The "Medicare" fraction is intended to include patient days for patients who were "entitled to benefits under part A" of the Medicare Act.[7] The "Medicaid" fraction is intended to include patient days for patients who were eligible for Medicaid, but who were not entitled to benefits under Medicare Part A.[8]

Under Medicare Part C plans, also currently referred to as Medicare Advantage plans,[9] Medicare pays private insurance companies to provide Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) coverage for these Medicare Part C recipients. The Part C recipients select and purchase their plan, also paying the private insurance companies for their coverage.[10] An individual that

---

[3] *See* 42 C.F.R. § 405.1842(a).
[4] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[5] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (F)(iv)-(v) and (F)(vii)-(xiii); 42 C.F.R. §§ 412.l06(c)(l) and (d).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[7] Section 1395ww(d)(5)(F)(vi)(I).
[8] Section 1395ww(d)(5)(F)(vi)(II).
[9] *See* https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/how-medicare-advantage-plans-work.html
[10] *Id.*

is entitled to benefits under Part A of the Medicare Act, and who is enrolled under Part B of the same, is eligible to enroll in a plan under Part C of the Medicare Act.[11]

In the past, CMS has changed its position regarding how Medicare Part C days should be included in the DSH payment calculation. In the FY 2004 Inpatient Prospective Payment System ("IPPS") Proposed Rule,[12] CMS clarified its position by proposing that the days should not be counted in the Medicare fraction of the DSH percentage. At that time, CMS also proposed to count these days in both the denominator and the numerator of the DSH Medicaid fraction.[13] Then, in the FY 2005 IPPS Final Rule, CMS changed its position stating

> [w]e are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction. As noted previously, if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[14]

The Rule was codified at 42 C.F.R. § 412.106(b)(2).

In Northeast Hospital Corp. v. Sebelius, 657 F.3d 1 (D.C. Cir. 2011), the Court of Appeals considered CMS' interpretation to count Medicare Part C days in both the numerator (if he/she is entitled to SSI) and in the denominator of the Medicare fraction, and to exclude the days from the numerator of the Medicaid fraction. The Court held that "the Secretary's decision to apply her present interpretation of the DSH statute to fiscal years 1999-2002 violates the rule against retroactive rulemaking." The Court added "[t]he Secretary's interpretation, as set forth in the 2004 rulemaking and resulting amendment to § 412.106, contradicts her former practice of excluding M+C days from the Medicare fraction."[15]

More recently, in Allina Health Services v. Sebelius, 746 F.3d 1102 (D.C. Cir. 2014) ("Allina"), the Court of Appeals upheld the lower court's decision vacating the portion of the 2005 IPPS Final Rule which clarified CMS was not adopting a policy to include the Part C days in the Medicaid fraction, and instead they were adopting a policy to include them in the Medicare fraction. The Court of Appeals

---

[11] 42 U.S.C. § 1395w-21(a)(3)(A).
[12] 68 Fed. Reg. 27154, 27208 (May 19, 2003).
[13] *Id.*
[14] 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004).
[15] Northeast Hospital Corp. v. Sebelius, 657 F.3d 1 (D.C. Cir. 2011) at 16-17.

reasoned that the Final Rule "was not a logical outgrowth of the proposed rule."[16] However, the Court of Appeals in Allina found error with the lower courts remedy "directing the Secretary how to calculate the hospitals' reimbursements, rather than just remanding after identifying the error."[17] Pursuant to the Court of Appeals remand under Allina, the Secretary of Health and Human Services issued a final administrative decision on December 1, 2015, finding that "...the Part C days at issue in this case [Allina] are to be counted in the Medicare fraction and should not be counted in the Medicaid fraction"[18] of the DSH payment calculation.

Providers Position

The Providers state in their most recent EJR request that the common issue before the Board is the failure of the Medicare Contractor and CMS to properly determine the ratio of SSI recipient patient days for patients who, for such days, were entitled to benefits under both Medicare Part A and SSI (excluding any State supplementation), to Medicare Part A patient days (the Medicare Proxy or Fraction) for the participating Providers in their DSH eligibility determinations and payment calculations. The Providers assert that the Medicare fraction is improperly understated due to CMS's erroneous inclusion of inpatient days attributable to Medicare Part C patients in both the numerator and the denominator of the DSH Medicare fraction. [19]

The Providers state the effect of this regulatory change was negative for most hospitals as many Medicare Part C patients are not also receiving SSI and/or Medicaid. The Providers explain that CMS change in policy added many days to the denominator of the Medicare fraction and did not add very many days to the numerator which had the effect of reducing the SSI percentage that results from the Medicare fraction. Under CMS's policy prior to the 2005 Final Rule, Medicare Part C days were mostly counted in the denominator of the Medicaid fraction and in the numerator if they were also Medicaid recipients. The Providers state this did not have the dilutive, negative effect that the FFY 2005 Final Rule had on most hospital's DSH reimbursement.[20]

Violation of the Administrative Procedures Act

The Providers argue that CMS's inclusion of Medicare Part C days violates the Administrative Procedures Act ("APA") which requires that agency rule making provide notice of "either the terms and

---

[16] Allina Health Services v. Sebelius, No. 13-5011 (D.C. Cir. Apr. 1, 2014) at 11.
[17] *Id.* at 15.
[18] CMS Decision of the Administrator (Dec. 1, 2015) at 25, on remand Allina Health Svcs. v. Sebelius, 746 F.3d. 1102, 1105 (D.C. Cir. 2014).
[19] Providers' Revised Request for EJR (Dec. 14, 2015) at 1-2.
[20] *Id.* at 4.

substance of the proposed rule" and "opportunity to participate in the rule-making process through submission of written data, views, or arguments" pursuant to 5 U.S.C. § 553(b) and (c). The Providers allege that CMS's about-face with respect to its treatment of Medicare Part C days in the DSH calculation deprived hospitals of a meaningful opportunity to provide comments to the completely new policy, and that it was arbitrary and capricious rule making. The Providers cite to both Allina Health Svcs. v. Sebelius, 904 F.Supp. 2d, 75 (D.D.C. 2012) and Allina Health Svcs. v. Sebelius, 746 F.3d. 1102, 1105 (D.C. Cir. 2014), stating these cases hold that the Secretary's 2004 about-face regarding Medicare Part C days violated the APA because she failed to acknowledge and/or explain her departure from past policy. The Providers also cite to Appalachian Power Co. v. EPA, 251 F.3d 1026 (D.C. Cir. 2001), stating federal courts have held that agency rulemaking devoid of detail in proposed methodologies and lacking a defense for the methodology used are arbitrary and capricious.

Providers EJR Request

The Providers state that, pursuant to 42 C.F.R. § 405.1842(f)(1), EJR is appropriate when: 1) the Board has jurisdiction on the matter and issue, and 2) the Board lacks the legal authority to decide the specific legal question. The Providers state there are no pending jurisdictional challenges. They also believe the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the Administrative Procedures Act and is bound by CMS policy until the Secretary instructs the Board otherwise.

The Providers assert that the Board has granted EJR when a legal challenge related to the APA is raised, citing to Clarian West Medical Center v. WPS, PRRB Case No. 12-0269 (EJR granted January 3, 2014) and Hunterdon/Somerset 2001 Wage Index Group, PRRB Decision 2004-D13 (April 14, 2004). The Providers also generally refer to EJR requests granted by the Board in cases that led to the Allina decisions. The Providers claim the Board lacks the authority to implement the effect of the Allina Court decision on other Providers until the Secretary instructs to do so, and it has already granted EJR in the similar PRRB Case Nos. 14-3736G and 14-3813G on August 13, 2014.

The Providers conclude that the only recourse at this point is to proceed to federal court and request the same treatment that the Allina Providers received as the Board is unable to provide such relief absent specific agency direction.

Decision

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), require the Board to grant expedited judicial review 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.

Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a), 42 C.F.R. § 405.1837 and 42 C.F.R. § 405.1835(a), a provider has a right to a Board hearing for specific items claimed for a cost reporting period covered by a final determination if it has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, 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 it has jurisdiction to conduct a hearing on the specific matter at issue for all five Providers in this appeal. These five Providers have requested a hearing within 180 days after receipt of their final determinations, and the $50,000 amount in controversy requirement for a group appeal has been met. Additionally, all five Providers have preserved their right to claim dissatisfaction with the amount of Medicare payment for the specific issue under appeal by demonstrating a cost report adjustment to their DSH SSI fraction.

Board Finding Regarding Authority

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers' allege "the regulation is invalid to the extent that it contradicts the enabling statute and was not properly promulgated"[21] and they "seek relief pursuant to the recent Court of Appeals decision in *Allina Health Services v. Sebelius*."[22] The Board finds it lacks the authority to examine this legal question as it pertains to the five Providers in this appeal.

Conclusion

With regards to the Providers' request for EJR, the Board finds that:

1) it has jurisdiction over the specific matter at issue, and the Providers are entitled to a hearing before the Board;

---

[21] *Supra* note 1.
[22] *Supra* note 19, at 1.

2) based upon the Providers' assertion regarding the invalidity of the DSH payment regulation at 42 C.F.R. §§ 412.106, there are no findings of fact for resolution by the Board;

3) it is bound by Title XVIII of the Social Security Act and the regulations issued thereunder; and

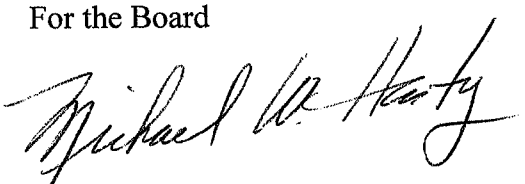
4) it is without the authority to decide the legal question of whether the DSH regulation is valid.

Accordingly, the Board finds that the DSH SSI Medicare Fraction Part C days issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and grants the Providers request for EJR for all five Providers in Case no. 13-1315GC.

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:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA (not participating)

For the Board



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877,
Schedule of Providers

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

CERTIFIED MAIL

JAN 15 2016

Daniel Hettich
King & Spalding
1700 Pennsylvania Avenue, NW
Suite 200
Washington, D.C. 20006-4706

RE: K&S 2011 SCH HSR Budget Neutrality Group
Provider Nos.: Various
FYEs: Various 2011
PRRB Case No.: 14-4180G
Request for Reconsideration of the Board's Jurisdictional Decision

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed your November 12, 2015 correspondence requesting that the Board reconsider its November 5, 2015 jurisdictional decision in regards to Portneuf Medical Center (Provider No. 13-0028), Hays Medical Center (Provider No. 17-0013) and Northwestern Medical Center Inc. (Provider No. 47-0024)[1] wherein the Board found that it lacked jurisdiction over the Providers because they failed to protest the application of the cumulative budget neutrality adjustment to the fiscal year under appeal and denied the Providers' Request for Expedited Judicial Review (EJR). The Board's decision with respect to your Request for Reconsideration is set forth below.

Background

On November 5, 2015, the Board found that it lacked jurisdiction over all of the Providers in case number 14-4180G because they failed to protest the application of the cumulative budget neutrality adjustment to the fiscal year under appeal as required by 42 C.F.R. § 405.1835(a)(1)(ii). As jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board denied the Providers' Request for EJR and closed the case.

Providers' Position

The Providers maintain they have provided additional support further proving that the protested amounts removed by the Medicare Contractor in the audit adjustments included with their Schedule of Providers encompassed the issue under appeal.[2] The Providers

[1] The Providers indicate that the remaining Provider, Newman Regional Health (Provider No. 17-0001, FYE 12/31/11), is not requesting a reconsideration of the Board's decision because it did not protest the issue on its as-filed cost report.
[2] Providers' Request to Reconsider the Board's Jurisdictional Decision at 1.

contend the facts are undisputable that the Board does, in fact, have jurisdiction over this issue based on the Providers' protest of the issue and the Medicare Contractor's removal of those protested items. The Providers assert they each appealed from an audit adjustment removing their protested amounts and adjusting their hospital specific payments. The Providers maintain given that the Board found that it lacked jurisdiction based on insufficient proof that the Providers' protest items removed during audit encompassed the base-year hospital specific rate (HSR) issue, and in light of the fact that the Providers have supplied additional proof further substantiating that fact here, the Providers strongly urge the Board to reconsider its determination.[3]

Decision of the Board

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 a hearing is filed within 180 days of the NPR.[4]

The Board reverses its prior November 5, 2015 decision in case number 14-4180G in regards to Portneuf Medical Center (Provider No. 13-0028), Hays Medical Center (Provider No. 17-0013) and Northwestern Medical Center Inc. (Provider No. 47-0024). The Board grants jurisdiction over these Providers, reopens case number 14-4180G and reinstates the Providers into case number 14-4180G as each Provider provided adequate support that they protested the application of the cumulative budget neutrality adjustment to the fiscal year under appeal as required by 42 C.F.R. § 405.1835(a)(1)(ii) and met the other jurisdictional requirements. The Board will address the denial of the Providers' Request for EJR in the November 5, 2015 decision 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.

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), 42 C.F.R. §§ 405.1875 and 405.1877

cc: Bryon Lamprecht, Wisconsin Physicians Service
Wilson C. Leong, Esq., Federal Specialized Services

---

[3] *Id.* at 3.
[4] 42 U.S.C. § 1395oo(a)(2014) and 42 C.F.R. §§ 405.1835-1840(2014).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

JAN 15 2016

Certified Mail

Daniel J. Hettich, Esq.
King & Spalding
1700 Pennsylvania Avenue, NW
Suite 200
Washington, D.C. 20006-4706

RE: K&S 2011 SCH HSR Budget Neutrality Group
Provider Nos.: Various
FYEs: Various 2011
PRRB Case No. 14-4180G
Revised Expedited Judicial Review Determination

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed your November 12, 2015 correspondence requesting that the Board reconsider its November 5, 2015 jurisdictional decision in regards to Portneuf Medical Center (Provider No. 13-0028), Hays Medical Center (Provider No. 17-0013) and Northwestern Medical Center Inc. (Provider No. 47-0024)[1] wherein the Board found that it lacked jurisdiction over the Providers because they failed to protest the application of the cumulative budget neutrality adjustment to the fiscal year under appeal and denied the Providers' Request for Expedited Judicial Review (EJR). The Board's *revised decision* with respect to the Providers' October 10, 2015 Joint Request for Determination as to Whether EJR is Appropriate is set forth below.[2]

Issue Under Appeal

Whether it is appropriate to apply a cumulative budget-neutrality factor to the base year hospital specific rate (HSR) for sole community hospitals (SCHs).[3]

Background: Sole Community Hospital (SCH) Rebasing

A SCH is a hospital that is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries by reason of its distance from other hospitals (i.e. more than 35 miles), travel conditions, or similar factors.[4] Section 122 of the Medicare Improvements for Patients and

[1] The Providers indicate that the remaining Provider, Newman Regional Health (Provider No. 17-0001, FYE 12/31/11), is not requesting a reconsideration of the Board's decision because it did not protest the issue on its as-filed cost report.
[2] The Board granted the Providers' Request for Reconsideration under separate cover. The Board found that it has jurisdiction over the Providers and reinstated the Providers into case number 14-4180G.
[3] Providers' October 10, 2015 Request for Expedited Judicial Review at 1.
[4] *See* 42 U.S.C. § 1395ww(d)(5)(D)(iii).

Providers Act of 2008 (Pub. L. No. 110-275) provided an option for SCHs to rebase their HSR including data from their fiscal year (FY) 2006 cost reports if this resulted in a payment increase. In cases where no payment increase resulted from using the HSR, the provider continued to be paid the higher of their FY 1982, FY 1987 or FY 1996 rate.[5]

The August 27, 2009 Federal Register, which published the final inpatient prospective payment system (IPPS) rule for 2010, explained that effective with cost reporting periods beginning prior to January 1, 2009, 42 U.S.C. § 1395ww(d)(5)(D)(i) provided that SCHs would be paid based on one of four statutorily specified rates which yielded the greatest aggregate payments. In this case, that was the updated HSR based on the FY 2006 costs per discharge.[6, 7] The CMS Medicare Claims Processing Manual[8] instruction issued October 3, 2008 directed Medicare Contractors (formerly known as "Intermediaries") to apply the 2007 budget neutrality factor to providers' 2006 cost report data. Later, in the August 27, 2009 Federal Register, the Secretary expanded the fiscal years' budget neutrality adjustments applied to the SCH reimbursement to include the aggregate FYs 1993-2007 adjustments. She explained that the "instructions for implementing both the FY 1996 and FY 2006 SCH rebasing provisions direct the fiscal intermediary . . . to apply cumulative budget neutrality adjustment factors to account for diagnosis related group (DRG) changes *since FY 1993* in determining a SCH's [HSR] based on . . . FYE 2006 cost data."[9] These instructions had been furnished in a Joint Signature Memorandum (JSM), JSM/TDL-09052 issued on November 17, 2008.

Providers' Position

The Providers contend that the policy adopted by the Centers for Medicare and Medicaid Services (CMS) in the federal fiscal year (FFY) 2010 IPPS final rule requiring a reduction to a SCH's base year HSR to account for budget neutrality adjustments that preceded the base year, leads to a miscalculation of their respective base year HSRs and is contrary to CMS' own regulation.[10] The Providers assert that the regulations governing payments to SCHs require specific steps to calculate a hospital's HSR, and do not account for the application of a cumulative budget neutrality adjustment.[11] The Providers believe that while 42 C.F.R. § 412.78 is silent with respect to the application of the prior years' budget neutrality facts to rebase the HSR, the Secretary adopted a definitive policy in the 2010 IPPS rule to apply prior years' cumulative budget neutrality adjustments to the 2006 HSR.[12]

---

[5] 42 U.S.C. § 1395ww(d)(5)(D)(i) was amended by section 6003(e) of Pub. L. No. 101-239 (OBRA 1989) and section 1395ww(b)(3)(I) (as added by section 405 of Pub. L. No. 106-113 (BBRA 1999) and further amended by section 213 of Pub. L. No. 106-554 (BIPA 2000) provides that SCHs are paid based on whichever of four statutorily specified rates yields the greatest aggregate payment to the hospital for the cost reporting period. 74 Fed. Reg. 43,754, 43,894 (Aug. 27, 2009).

[6] Providers' September 5, 2014 Hearing Request, Tab 2.

[7] 74 Fed. Reg. 43,754, 43,894 (Aug. 27, 2009).

[8] CMS Manual (CMS Pub. 100-04), Transmittal 1610 (Change Request 6189).

[9] 74 Fed. Reg. at 43,895.

[10] Providers' October 10, 2015 EJR Request at 1.

[11] *Id.* at 2 referencing 42 C.F.R. § 412.78.

[12] *Id.* at 3 referencing 74 Fed. Reg. at 43,895-97.

The Providers point out that the Board is bound by the Secretary's policy set forth in the Federal Register with respect to the cumulative budget neutrality adjustment. Consequently, the Board lacks the authority to grant the relief sought, and the Providers assert EJR is appropriate.[13]

Decision of the Board

The Board has reviewed the Providers' Requests for Hearing and Joint Request for Determination as to Whether EJR is Appropriate. The regulation at 42 C.F.R. § 405.1842(c) 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). With respect to jurisdiction, the Board concludes that the above referenced Providers timely filed their Requests for Hearing and the amount in controversy exceeds the $50,000 threshold necessary for group appeals.[15] The Providers provided adequate support that they protested the application of the cumulative budget neutrality adjustment to the fiscal year under appeal as required by 42 C.F.R. § 405-1835(a)(1)(ii). Consequently, the Board has determined that it has jurisdiction over the appeals. This issue involves a challenge to the validity of 42 C.F.R. §§ 412.77(j) and 412.78(j)[16] and a rate published in the Federal Register and its implementation in the Notice of Program Reimbursements (NPRs).[17] The Board is bound by these regulations. Further, the Board finds that it lacks the authority to decide the legal question of whether the application of the cumulative budget neutrality adjustment to the Providers' base year hospital specific rates is proper; therefore, EJR is appropriate for the issue under dispute in this case.

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 application of the cumulative budget neutrality adjustment, there are no findings of fact for resolution by the Board; and

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

Accordingly, the Board finds that the application of the cumulative budget neutrality issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review for the issue and the subject year. The Providers on the Schedule of Providers

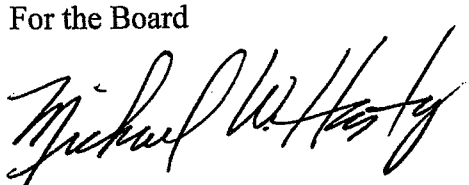
---

[13] *Id.* at 7.
[15] *See* 42 C.F.R. §§ 405.1835(a)(2), 405.1837(a)(3) and 412.79(g).
[16] The regulations at §§ 412.77(j) and 412.78(j) state that in regards to "*Maintaining budget neutrality*" CMS makes an adjustment to the hospital-specific rate to ensure that changes to the DRG classifications and recalibrations of the DRG relative weights are made in a manner so that aggregate payments to section 1886(d) hospitals are not affected.
[17] Case number 14-4180G was filed from NPRs and the application of the budget neutrality adjustment was included on each Provider's cost report as a protested amount as required by 42 C.F.R. § 405.1835(a)(1)(ii).

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.

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)(1), Schedule of Providers for Case Number 14-4180G

cc: Byron Lamprecht, Wisconsin Physicians Service
Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview Phone: 410-786-2671

Refer to: 06-0014G

CERTIFIED MAIL JAN 21 2016

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: Board's Own Motion Reconsideration of Request for Case Bifurcation
Toyon 2002 DSH Dual Eligible Days Group
PRRB Case No.: 06-0014G

Dear Mr. Knight and Ms. Alcantara:

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 January 16, 2014 decision ("January 16, 2014 Decision" or "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 October 7, 2005, the Board received Toyon's group appeal request regarding DSH dual eligible days. The group was initially comprised of three providers but following its multiple transfer requests, Toyon's final Schedule of Providers, dated April 28, 2010, consists of seven providers listed on the Schedule as participants 1-4, 6, 7, and 9.

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 January 16, 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]

[1] Toyon is the providers' representative for this appeal.
[2] January 16, 2014 Decision at 3.

Toyon submitted a Request for Reconsideration of the Board's initial denial of its request for bifurcation. The Board denied the request for reconsideration. This appeal was remanded to the Medicare Contractor on July 1, 2015 pursuant to CMS Ruling 1498-R and the appeal was closed.

Board's Decision

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.

Although the Board initially denied Toyon's request for case bifurcation, and denied the request for reconsideration, the Board has decided to grant reconsideration of the bifurcation denial on its own motion. 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. 06-0014G 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 Board hereby reopens case number 06-0014G in order to bifurcate the Part C Days issue from this appeal. The Providers' Part C issue is now within PRRB Case No. 16-0465G, which was established by the Board on December 28, 2015.[4] The Providers' dual eligible Part A non-covered days issue has already been remanded to the Medicare Contractor pursuant to CMS Ruling 1498-R on July 1, 2015. As the Part C days issue has been transferred to case number 16-0465G and the dual eligible days issue in this appeal has been remanded, case number 06-0014G is hereby closed.

In the Group Acknowledgment letter issued for case number 16-0465G, Toyon has been instructed to submit an updated Schedule of Providers to the Board and Medicare Contractor. This Schedule is to also include the Providers from case number 06-0014G.

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.

---

[3] Both the regulation and Board Rule clearly state that a group appeal must only contain one issue.
[4] Case number 16-0465G (Toyon 2002 DSH Part C Days Group)was established when the Part C days issue was bifurcated from case number 07-2238G (Toyon DSH Dual Eligible Days Group #2).

Case No.: 06-0014G

Board Members
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 April 28, 2010

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview Phone: 410-786-2671

Refer to: 06-2011G

CERTIFIED MAIL JAN 21 2016

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: Board's Own Motion Reconsideration of Request for Case Bifurcation
Toyon 2001 DSH Dual Eligible Days Group
PRRB Case No.: 06-2011G

Dear Mr. Knight and Ms. Alcantara:

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 2001 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days Group. Although the Board initially denied Toyon's bifurcation request in its February 12, 2014 decision ("February 12, 2014 Decision" or "Decision"), upon its own motion reconsideration, the Board hereby grants Toyon's request.

Background

On July 24, 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 26, 2010, consists of seven providers listed on the Schedule as providers 1-3 and 11-14.

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 February 12, 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]

This appeal was remanded to the Medicare Contractor pursuant to CMS Ruling 1498-R and closed on July 1, 2015.

[1] Toyon is the Providers' representative for this appeal.
[2] February 12, 2014 Decision at 3.

Board's Decision

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.

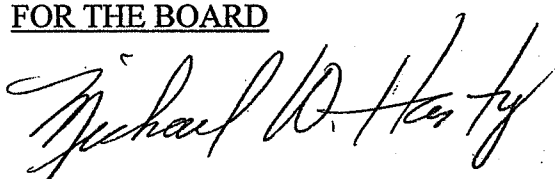
Although the Board initially denied Toyon's request for case bifurcation, upon reconsideration, the Board acknowledges that at the time that the providers' individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare 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. 06-2011G 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 Board hereby reopens case number 06-2011G in order to bifurcate the Part C Days issue from this appeal. The Providers' Part C issue is now within newly formed PRRB Case No. 16-0612G. The Providers' dual eligible Part A non-covered days issue has already been remanded under the Centers for Medicare and Medicaid Services' Ruling 1498-R on July 1, 2015. As the Part C days issue has been transferred to case number 16-0612G and the dual eligible days issue in this appeal has been remanded, case number 06-2011G is hereby closed. The Board's Acknowledgment Letter for PRRB Case No. 16-0612G 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.

Board Members:
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 April 26, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0612G
cc: Wilson Leong, Federal Specialized Services

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