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

Refer to:

10-1153GC

APR 01 2016

CERTIFIED MAIL

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

Kyle Browning
National Government Services, Inc.
Manager
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206 6474

Re: Catholic Health System NY 1999 Dual Eligible CIRP Group
PRRB Case No. 10-1153GC

Duane Morris/McKay Consulting DSH DE Days Bifurcation to
(1) Part A Non-Covered/Exhausted Benefits Days and
(2) Part C Days

Dear Mr. McKay and Mr. Browning:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The background of the case and the Board's determination are set forth below.

Background

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible ("DE") days into (1) Exhausted Benefits days and (2) Part C days. The Board determined that, for Providers deemed eligible, it will grant the bifurcation request. The Part C days issue will be adjudicated in Case No. 16-1313GC, the Catholic Health System NY 1999 Part C Days CIRP. Enclosed, please find the Group Acknowledgement letter for the new case. If the Board grants jurisdiction over Providers appealing Part A Non-Covered and Exhausted Benefit days, those Providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal, established on July 13, 2010, framed the group issue as follows:

> This group appeal concerns the determination of the Providers' Medicare disproportionate share adjustment ("DSH") payments

> under the prospective payment system ("PPS") for inpatient hospital services for the Providers. The common issue relates to the treatment of patient days for individuals considered as 'eligible' for both Medicare Part A and Medicaid in determining the Providers' disproportionate patient percentages for purposes of the Medicare DSH adjustment. Such individuals are commonly referred to as 'dual eligible' patients. The common issue for the group is whether the Providers' [Medicare Contractors] correctly excluded from the Providers' Medicaid percentages all days of care that were rendered to dual eligible patients.[1]

The initial appeal request included two providers, Mercy Hospital (Prov. No. 33-0279) and Sisters of Charity Hospital (Prov. No. 33-0078), both for fiscal year end 12/31/1999.[2]

Elaborating on the Dual Eligible ("DE") days issue in its issue description, McKay wrote:

> The fourth category of days . . . for which [DE] patients were not entitled to have payment made under Medicare Part A involved days for which the patient received benefits under Medicare Part C ("Part C days"). These days were also not covered days under Medicare Part A.[3]

On January 19, 2012, the lead Medicare Administrative Contractor, National Government Services ("NGS"), sent in its Jurisdictional Review along with a copy of McKay's Schedule of Providers for the two Providers who established the group. NGS stated that the Providers appealed the following issue: whether the Medicare/Medicaid dual eligible days were properly included in the DSH calculation.[4] NGS further stated that, based on its review, it believed there were no jurisdictional impediments related to the two Providers.[5]

McKay submitted its Case Management Plan on May 31, 2013, which changed the date that the DE Schedule of Providers was due to September 1, 2013.[6] On August 30, 2013, McKay requested bifurcation of the DE days issue into DE and Part C days. It wrote:

> McKay Consulting has conducted a review of its dual eligible day group appeals and has determined that each of the group appeals listed behind Tab A challenges the exclusion of both non-covered and Medicare [P]art C dual eligible patients from the numerator of the DSH Medicaid fraction. While we contend that these groups were properly established with a singular dual eligible days issue, we now request that the Board bifurcate each of these groups into

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[1] McKay Hearing Request Tab 2 at 1, Jul. 13, 2010.
[2] *Id.* at Tab 1.
[3] *Id.* at Tab 2 at 2-3.
[4] NGS Jurisdictional Review Letter at 1, Jan. 19, 2012.
[5] *Id.*
[6] *See* McKay Case Management Plan Letter, May 31, 2013.

> two groups, with one group including dual eligible Medicare [P]art A non-covered days and the other group including Medicare [P]art C dual eligible days.[7]

McKay further stated that this request was made in light of CMS Ruling 1498-R, which subjects DE non-covered days to remand, but not Part C days.[8] The Schedules of Providers for both DE and Part C days were also submitted on August 30, 2013. The only two Providers on both the Part C and DE Schedules of Providers are the original two Providers used to establish this appeal, Mercy Hospital of Buffalo and Sisters of Charity Hospital.

Board Determination on Bifurcation

Prior to the 2008 regulatory change which limited the ability to add issues to an open appeal, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Although the two providers in this case requesting bifurcation of the Part C days issue did not originally raise the sub-issue of Part C days in their original individual appeals (all of which were filed prior to the 2008 Rule change), the requests to transfer the Dual Eligible days issue to optional group appeals also occurred prior to the 2008 regulation change. Seemingly, the groups appealed multiple issues, since the groups' definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). Therefore, the Board deems the "transfer" of the "Dual Eligible days component" a transfer of Dual Eligible Exhausted Benefits days and an "add/transfer" of the Dual Eligible Part C days issue. The Board finds that the optional group appeals to which the providers initially transferred explicitly defined the issue under appeal as including the Part C days component and hereby grants the bifurcation of Dual Eligible days and Part C Days issues.

Board Determination on Jurisdiction

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

(1) Dual Eligible [Discharges Prior to 10/1/2004]

CMS Ruling 1498-R explains that, under the revised DE days policy, any patient entitled to Part A is included in the DSH Medicare fraction, regardless of whether the patient's stay was covered or the patient's Part A benefits were exhausted.[9] The Ruling discusses the related appeals:

> For cost reports with discharges before October 1, 2004, hospitals have filed [Board] appeals seeking inclusion in the [disproportionate patient percentage] DPP of inpatient days where

[7] McKay Bifurcation Letter at 1, Aug. 30, 2013.
[8] *Id.*
[9] *See id.*

> the patient was entitled to Medicare Part A but the inpatient hospital stay was not covered under Part A. For example, some hospitals have appealed the exclusion from the DPP of inpatient hospital days of patients (whether dual eligible or entitled only to Medicare) whose Part A hospital benefits were exhausted.[10]

Here, the appealed DE days are for discharges prior to 10/01/2004. CMS describes that these appeals will be resolved by CMS and the Medicare Administrative Contractors.[11] A properly pending appeal means that the "applicable jurisdictional and procedural requirements for appeal" are satisfied.[12] The Board determines that jurisdictional requirements have been met for Mercy Hospital of Buffalo and Sisters of Charity Hospital.

Enclosed, please find the Board's Standard Remand of the Dual Eligible Days issue. Since there are no remaining participants to be adjudicated, case number 10-1153GC is hereby closed.

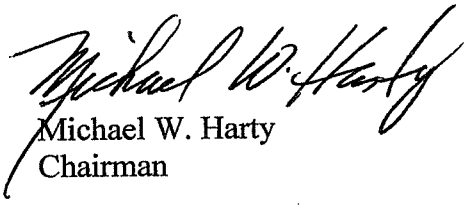
(2) Part C Days [Discharges Prior to 10/1/2004]

The Board accepts jurisdiction over Part C days because the Participants' transfers to the optional group appeals occurred prior to the 2008 change in regulation. Since the Participants requested a transfer of Part C days prior to 2008, the Board considers each transfer request an "add/transfer" of the Part C days issue. In the instant case, the Board grants the bifurcation of Part C days prior to 10/01/2004 to continue in a new case (Case No. 16-1313GC)

Review of this jurisdictional determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 1877.

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

For the Board:



Michael W. Harty
Chairman

Enclosures: Group Acknowledgement
Standard Remand of Dual Eligible Days Issue
Schedule of Providers

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

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[10] *Id.* at 8-9.
[11] *Id.* at 10.
[12] *Id.*

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Refer to:
09-0089GC

APR 01 2016

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

Re: Detroit Medical Center Post 9/30/2004 & 2005 Dual Eligible CIRP Group
Case No. 09-0089GC
Duane Morris/McKay Consulting DSH DE Days Bifurcation to Part A Non-Covered/Exhausted Benefits Days and Part C Days

Dear Mr. McKay and Mr. Lamprecht:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The background of the case and the Board's determination are set forth below.

Background

The instant group appeal, established in October 2008, framed the issue as follows:

> . . . CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[1]

The Representative identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

[1] 09-0089GC Group Request for Hearing at 2, October 14, 2008.

The Representative established the group with one Provider:
Detroit Receiving Hospital (23-0273) FYE 12/31/2005 (transfer from 08-2886) [2]

Subsequently, the following participants were added:
Detroit Receiving Hospital (23-0273) FYE 12/31/2006 (direct add filed on 2/13/2009)
Harper Hutzel Hospital (23-0104) FYE 12/31/2005(direct add filed on 3/16/2009)
Sinai Grace Hospital (23-0024) FYE 12/31/2006 (direct add filed on 3/16/2009)
Sinai Grace Hospital (23-0024) FYE 12/31/2005 (transfer from 09-0783 on 6/23/2009)
Harper Hospital (23-0104) FYE 12/31/2006 (direct add filed on 12/4/2009)

On June 3, 2013, the Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[3] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[4] McKay wrote that it determined that " . . . each of the group appeals . . . challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[5]

By letter dated December 9, 2015, the Board bifurcated the post Ruling period for the three participants in Case No. 09-0088GC (Detroit Medical Center 2004 Dual Eligible CIRP group) and consolidated them into the subject group. [6]

Board Determination

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

Prior to the 2008 revisions of the Board's Rules, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[7] Here, the CIRP group appeal was filed after the 2008 revisions and described the "matter at issue" as Dual Eligible days and clearly includes the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the

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[2] *See id.* at Schedule A.
[3] *See* Case Management Plan Letter, Jun. 3, 2013.
[4] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[5] *Id.* at 1.
[6] The Board previously found jurisdiction over the post 9/30/2004 period in case number 09-0088G for Detroit Receiving Hospital, Harper Hospital and Sinai Grace Hospital. Therefore, jurisdiction will not be addressed again for these participants in this letter.
[7] 42 C.F.R. § 405.1837(a)(2) (2003).

group appealed multiple issues since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days).

Four of the participants in this group case: Detroit Receiving Hospital (FYE 2006), Harper Hutzel Hospital (FYE 2005), Sinai Grace Hospital (FYE 2006) and Harper Hospital (FYE 2006), filed directly from final determinations to the Dual Eligible Days group. As noted, the group issue statement described the "matter at issue" as Dual Eligible days and clearly included the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the Board concludes that it will grant the bifurcation of Dual Eligible days and Part C days for these four participants. The Part C days issue will be adjudicated in Case No. 16-1253GC, the Detroit Medical Center 2005 - 2006 Part C Days CIRP. Enclosed, please find the Board's Notice of Bifurcated Group Acknowledgement.

With regard to Detroit Receiving Hospital (FYE 12/31/2005), in its initial appeal request dated September 15, 2008, the Provider appealed 660 Medicaid eligible days that were dual eligible. Upon review of the documentation for this Provider behind Tab 1E of the 2005/2006 Part C days Schedule of Providers and Tab 1E of the 2005/2006 Dual Eligible days Schedule of Providers, the Provider is now requesting 758 days. Based on the available documentation, the Board is unable to determine whether the original 660 days removed by the Medicare Contractor and appealed by the Provider included the 3 Part C days it is now requesting. Consequently, the Board denies the bifurcation of the Part C days issue for this participant.

Finally, with regard to Sinai Grace Hospital (FYE 2005), the Provider filed its individual appeal on January 26, 2009 (after the August 2008 Rule Change) and described the issue in dispute as:

> . . . the allowable disproportionate share percentage is understated due to the Intermediaries failure to include 2,050 dual eligible days. These days are not included in the SSI % and should therefore be added to the Medicaid days.

Sinai Grace Hospital then transferred the dual eligible days issue for FYE 2005 to the subject group on June 23, 2009. Because the individual appeal issue statement did not specifically break out the Part C days issue and the individual appeal was filed after the 2008 Rule change, the Board denies the request to bifurcate the Part C days issue for this Provider.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the case on the merits.

The Dual Eligible days group, case number 09-0089GC, will be scheduled for a hearing date. The Parties will receive a Notice of Hearing and Critical Due Dates letter under separate cover.

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

For the Board:

Board Member

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877
Group Acknowledgement for Case No. 16-1253GC

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

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Refer to:

14-3866

APR 04 2016

CERTIFIED MAIL

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Corinna Goron, President
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

Novitas Solutions, Inc.
Bill Tisdale
Director JH, Provider Audit & Reimburs.
Union Trust Bldg.
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Dallas Medical Center
Provider No: 45-0379
FYE: 12/31/2010
PRRB Case No.: 14-3866

Dear Ms. Goron and Mr. Tisdale,

Dallas Medical Center (hereinafter "DMC") has appealed the amount of Medicare reimbursement as determined by the Medicare contractor, Novitas Solutions, Inc. The Medicare Contractor has challenged jurisdiction over Issue No. 2 in this appeal which alleges error with the Supplemental Security Income ("SSI") percentage used in the Disproportionate Share Hospital ("DSH") payment calculation.

The Provider Reimbursement Review Board ("Board") concludes that it has jurisdiction over Issue no. 2, hereinafter referred to as the "Provider Specific SSI Issue." However, the Board also concludes that Issue no. 2 is the same as Issue no. 1, hereinafter referred to as the "SSI Baystate Issue," which was transferred to Case No. 14-2928GC.

Background:

Two issues in the appeal allege the Medicare Contractor applied an incorrect SSI percentage to the DSH adjustment payment. These two issues were added to the appeal on October 6, 2014.

DMC describes Issue no. 1 as the "Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI")" issue, and Issue no. 2 as the "Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific)" issue.[1]

After adding the issues, DMC filed a Model Form D – Request to Transfer Issue to a Group Appeal regarding the SSI Baystate Issue, requesting the Issue to be transferred to group Case No. 14-2928GC. The issue in group Case No. 14-2928GC is identical to the SSI Baystate Issue in this appeal, and is stated as whether the Secretary properly calculated the Provider's DSH/SSI percentage.[2] The issues in both this appeal and the transfer/group appeal allege that the SSI percentage calculated by CMS and used by the Medicare Contractor does not address all of the deficiencies identified in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008).[3]

No transfer request has been filed regarding Issue no. 2, the Provider Specific SSI Issue, and DMC has filed a letter with the Board (dated March 1, 2015) indicating that it is the only remaining issue in the appeal. The Medicare contractor has filed a jurisdictional challenge regarding this last remaining issue.

Medicare Contractor's Position

The Medicare Contractor asserts that the Hospital Specific SSI Issue in this appeal is duplicative of the SSI Baystate Issue which has been transferred to a group appeal. The Medicare Contractor asserts that both Issues appeal the same audit adjustments, refer to MedPAR data and present similar arguments. The Medicare Contractor claims there is no distinction between the issues. The Medicare Contractor concludes that there is a jurisdictional impediment with regards to Issue No. 2, the sole remaining issue in this appeal, as it is duplicative and prohibited by PRRB Rule 4.5 which states "[a] Provider may not appeal an issue from a final determination in

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[1] Case No. 14-3866, Request to Add Issue(s) to an Individual Appeal (October 2, 2014), Tab 1 at 4-5.
[2] Case No. 14-2928G, Model Form B – Group Appeal Request (March 11, 2014), Tab 2; Case No. 14-3866, Request to Add Issue(s) to an Individual Appeal (October 2, 2014), Tab 1 at 4.
[3] *Id.*

more than one appeal." The Medicare Contractor requests that the Board dismiss Issue No. 2 for lack of jurisdiction and close the appeal.[4]

DMC's Position

None.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

The Board concludes regarding Issue No. 2, the Provider Specific SSI Issue, that it has jurisdiction over this issue as there was an adjustment to the SSI percentage (Adj. 12), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also concludes that Issue No. 2 is duplicative of Issue No. 1, the SSI Baystate Issue that was transferred to 14-2928GC. The basis of both Issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data to determine if the SSI percentage is accurate. The Board hereby dismisses Issue No. 2 from this appeal as it is duplicative, and it now resides in Case No. 14-2928GC.

[4] Medicare Contractor's Jurisdictional Challenge (June 4, 2015).

Case No. 14-3866 is now closed as there are no remaining issues. Review of this decision may be available under 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) and 42 C.F.R. §§ 405.1875 and 405.1877

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

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Refer to: 11-0594 & 12-0189

APR 08 2016

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Jaycee Lin
Essential Consulting, LLC
2720 Joaquin Drive
Burbank, CA 91504

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

RE: Jurisdictional Decision
Children's Hospital of Los Angeles
FYE: 6/30/2009 & 6/30/2010
Provider No.: 05-3302
PRRB Case No.: 11-0594 & 12-0189

Dear Ms. Lin and Ms. Alcantara,

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

Background

PRRB Case No. 11-0594

The Medicare Contractor issued a Notice of Program Reimbursement ("NPR") for FYE 6/30/2009 to the Provider on November 10, 2010. On April 28, 2011, the Provider filed a request for TEFRA Exception Relief with the Medicare Contractor. Just days later, on May 2, 2011, the Board received Children's Hospital of Los Angeles' appeal request in which it appealed one issue: TEFRA Target Amount per Discharge.

PRRB Case No. 12-0189

The Medicare Contractor issued an NPR for FYE 6/30/2010 to the Provider on August 12, 2011. On February 6, 2012, the Provider filed a request for TEFRA Exception Relief with the Medicare Contractor. Just days later, on February 9, 2012, the Board received Children's Hospital of Los Angeles' appeal request in which it appealed one issue: TEFRA Target Amount per Discharge.

Medicare Contractor's Position

The Medicare Contractor has made the same argument in both case numbers addressed in

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

Providers' Position

The Provider contends that for both FYEs addressed in this decision, that its TEFRA Target Amount per discharge is understated. The Provider argues that it should be entirely exempted from the application of the TEFRA limit because its base year, FYE 2/28/1983, includes inadequate activity on which to base a reimbursement rate for the future, especially a FYE 30 years later. Therefore, the Provider requests that a new base year be assigned that is more representative of the current FYEs under appeal.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2010), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that the appeals are premature because the Medicare Contractor had not yet issued a final determination at the time the Provider filed its hearing requests. 42 C.F.R. § 413.40(e) requires the Provider to request the TEFRA exception within 180 days of the date of the issuance of the NPR. The Medicare Contractor then submits a recommendation to CMS and CMS must issue a decision within 180 days of receipt of the recommendation. After the Medicare Contractor notifies the Provider of CMS's decision, the Provider has 180 days to appeal the decision directly to the PRRB. For both FYEs, the Provider requested a hearing within a few days of requesting a TEFRA exception with the Medicare contractor. The hearing requests are premature because the Provider had not yet received the final determinations of the TEFRA exceptions from the Medicare Contractor prior to requesting a hearing with the Board as required by 42 C.F.R. § 413.40(e). As the TEFRA Target Amount issue is the only issue in the appeals, case numbers 11-0594 and 12-0189 are hereby dismissed.

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

Board Members
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

cc: Wilson C. Leong, Esq., CPA, FSS

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CERTIFIED MAIL

APR 08 2016

Hall, Render, Killian, Heath & Lyman
Keith D. Barber, Esq.
500 North Meridian Street
Suite 400
Indianapolis, IN 46204

RE: Ascension Health 2005-2006 DSH Medicare Part B Exhausted Days CIRP
Case No. 09-0668GC

Dear Mr. Barber:

The Provider Reimbursement Review Board (the Board) recently began a review of the above captioned group appeal which has been pending since 2009. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Ascension Health 2005-2006 DSH Medicare Part B Exhausted Days group appeal was filed on January 16, 2009 with one Provider (St. Mary's Hospital) appealing FYEs 6/30/2005 and 6/30/2006. The Board accepted the Representative's proposed group name, the Ascension Health Medicare Part B Exhausted Days Group, and established case number 09-0668GC.

On June 9, 2009 the Representative filed a Request to Join/Direct Add (Direct Add) for St. Joseph's Hospital for FYE 6/30/2007.

On January 10, 2011, the Representative filed additional Requests to Transfer St. Mary's Hospital for FYEs 6/30/2001 through 6/30/2004 and St. Joseph's Hospital for 6/30/2002 and 6/30/2004.

Board Determination:

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

PRRB Rule 12.2 states that "Providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. However, groups may

submit a written request to include more than one calendar year to meet the $50,000 amount in controversy."

The Board notes that the Providers in this group appeal are members of the Ascension Health chain. As noted, the Board generally discourages allowing more than one FYE per group. In this case, the Board finds that denial of the previously filed Direct Adds and Transfers would result in a one Provider group covering multiple FYEs.

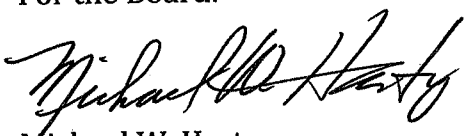
Further, the Board notes that the issue in this group, although initially characterized as Medicare Part B Exhausted Days, is actually Dual Eligible Part A Exhausted days, which is subject to CMS Ruling 1498-R for cost reporting periods through 9/30/2004. Because the participating providers in the subject group (both the original and added) span this time frame, the Board agrees to grant the Representative's earlier requests to allow multiple fiscal years to be included in the group.

The Board is, however, forming a separate multi-year group to account for the post-Ruling periods. Consequently, the group name for case number 09-0668GC has been changed to the Ascension 2001-9/30/2004 DSH Medicare Part A Exhausted Days Group.[1] The Board has created a new group, to which it has assigned case number 16-1002GC, to cover the period from 10/1/2004 through 2007. Enclosed please find a Group Acknowledgement (Common Issue Related Party CIRP/Mandatory Group) for the new group.

The Board is requiring that you file a Schedule of Providers and the associated jurisdictional documentation for both groups within 60 days of the date of this letter. Failure to submit this documentation in a timely manner will result in dismissal of case numbers 09-0668GC and 16-1002GC. The Board will review the documentation submitted in case number 09-0668GC and will issue a determination regarding the applicability of CMS Ruling 1498-R and case number 16-1002GC will be scheduled for a hearing date.

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

Enclosure: Group Acknowledgement (Common Issue Related Party CIRP/Mandatory Group) for case no. 16-1002GC

cc: James R. Ward, Noridian Healthcare Solutions, LLC (w/enclosure)
Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosure)

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[1] The period from 7/1/2004-9/30/2004 for St. Mary's (the original group participant) will remain in this group and the period from 10/1/2004-6/30/2005 will be handled in case number 16-1002GC.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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2520 Lord Baltimore Drive, Suite L
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FAX: 410-786-5298
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Refer to: 10-1008

APR 08 2016

CERTIFIED MAIL

Jaycee Lin
Essential Consulting, LLC
2720 Joaquin Drive
Burbank, CA 91504

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

RE: Jurisdictional Decision
Children's Hospital of Los Angeles
FYE: 6/30/2008
Provider No.: 05-3302
PRRB Case No.: 10-1008

Dear Ms. Lin and Ms. Alcantara,

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

Background

The Medicare Contractor issued a Notice of Program Reimbursement ("NPR") for FYE 6/30/2008 to the Provider on October 27, 2009. On April 18, 2010, the Provider filed a request for TEFRA Exception Relief with the Medicare Contractor. Just days later, on April 26, 2010, the Board received Children's Hospital of Los Angeles' appeal request in which it appealed two issues: Settlement Data and the TEFRA Target Amount per Discharge.

Board's Decision

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

The Board finds that this appeal is premature because the Medicare Contractor had not yet issued a final determination at the time the Provider filed its hearing request. 42 C.F.R. § 413.40(e) requires the Provider to request the TEFRA exception within 180 days of the date of the issuance of the NPR. The Medicare Contractor then submits a recommendation to CMS and CMS must issue a decision within 180 days of receipt of the recommendation. After the Medicare Contractor

notifies the Provider of CMS's decision, the Provider has 180 days to appeal the decision directly to the PRRB. The Provider requested a hearing within just a few days of requesting a TEFRA exception with the Medicare Contractor. The TEFRA Target Amount issue is premature because the Provider had not yet received the final determinations of the TEFRA exceptions from the Medicare Contractor prior to requesting a hearing with the Board as required by 42 C.F.R. § 413.40(e). The Board finds that it does not have jurisdiction over the TEFRA Target Amount issue and dismisses it from this appeal.

The Board also finds that it does not have jurisdiction over the other issue that remains pending in this appeal: the settlement data issue. The Provider explains this issue as, "The Provider agrees with the aforementioned audit adjustment, as the Intermediary included in a patient's service of unusual high cost of Novo 7 drug, except that the Provider believes the cost of this drug should not be subject to the TEFRA target amount limit, as this was an atypical exception rendered to one unique Medicare patient." The Board concludes that because the settlement data issue is tied to the TEFRA Target Amount issue, over which the Board does not have jurisdiction, the Board consequently does not have jurisdiction over the settlement data issue and dismisses it from this appeal.

As the TEFRA Target Amount and settlement data issues are the only issues in the appeal, case number 10-1008 is hereby dismissed.

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

Board Members
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

cc: Wilson C. Leong, Esq., CPA, FSS

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Refer to:

CERTIFIED MAIL APR 11 2016

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

Kyle Browning, Manager
National Government Services, Inc
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcation**
McKay 2004 - 2006 DSH Dual Eligible Group, Case No. 09-1730G
McKay 2006 DE Optional Group, Case No. 11-0572G
McKay Post 09/30/2004 - 2007 DSH Dual Eligible Days Group, Case No. 11-0754G
McKay 1999-Pre 10/1/2004 Medicaid Fraction Part C Days Group, Case No. 16-0314G

Dear Mr. McKay and Mr. Browning:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeals regarding the Representative's request for the bifurcation of Dual Eligible days and Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request.

Because there is only one participant in the McKay 2006 DSH Dual Eligible Optional Group, Case No. 11-0572G, with discharges prior to 10/1/2004, that participant is being considered with the pre 10/1/2004 participants in case 09-1730G.[1] For those Providers appealing Part A Non-Covered and Exhausted Benefit days over which the Board finds jurisdiction, the Board will issue a remand pursuant to CMS Ruling 1498-R.

Pertinent Facts Regarding Bifurcation of Case 09-1730G:

This case was formed on 5/29/2009 as a result of the Representative's 5/27/2009 request to remove participants with FYEs 12/31/2004 and later from an earlier group, Case No. 08-0170G, the McKay 2003/2004 DSH Dual Eligible Group. The Representative's original request for a group hearing in Case No. 08-0170G, dated December 30, 2007, contained a group issue statement that included the following language:

> Is the Intermediary's exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either

[1] The Board's determination with regard to the bifurcation of the remaining participants in Case No. 11-0572G will be issued under separate cover.

Is the Intermediary's exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either whose Medicare Part A benefits were exhausted or who received Part C benefits correct?[2]

The Representative attached a Schedule of Providers to be transferred to the new group, identifying the participants with FYEs after 10/1/2004 which included the following:

Provider No.	Provider	FYE	Orig. Case
34-0070	Alamance Regional Medical Center	12/31/2005	08-1880
33-0235	Auburn Memorial Hospital	12/31/2004	08-0265
33-0235	Auburn Memorial Hospital	12/31/2005	08-0753
33-0229	Brooks Memorial Hospital	12/31/2005	08-0370
39-0168	Butler Memorial Hospital	06/30/2006	08-1235
33-0250	Champlain Valley Physicians Hospital	12/31/2005	08-0734
36-0096	East Liverpool City Hospital	12/31/2005	08-0256
13-0049	Kootenai Medical Center	12/31/2005	08-1526
23-0021	Lake Mercy Memorial Med Center	9/30/2005	08-0262
14-0148	Memorial Medical Center	9/30/2005	08-0435
01-0113	Mobile Infirmary Medical Center	3/31/2005	07-1948
01-0113	Mobile Infirmary Medical Center	3/31/2006	08-1188
33-0276	Nathan Littauer Hospital	12/31/2005	08-0172
33-0226	Park Ridge Hospital	12/31/2004	08-0094
13-0028	Portneuf Medical Center	9/30/2005	08-0073
33-0215	Rome Memorial Hospital	12/31/2005	08-0179
36-0008	Southern Ohio Medical Center	6/30/2006	08-1527
33-0066	St. Clare Schenectady	12/31/2004	08-1525
33-0108	St. Joseph Hospital	12/31/2004	07-2506
27-0049	St. Vincent Hospital & Healthcare	5/31/2006	08-2223
39-0042	The Washington Hospital	6/30/2006	08-12383

Although not included on the initial Schedule of Participants to be transferred from Case No. 08-0170G, Laughlin Medical Center (44-0025) for FYE 6/30/2006 was included in Case No. 08-0170G as of December 31, 2007 and should have been included on the initial Schedule.[4]

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[2] Case No. 08-0170G Group Request for Hearing at 1, October 30, 2007. (The issue statement followed the Providers that were split from Case No. 08-0170G into Case No. 09-1730G.)

[3] *See id.* at Schedule A.

[4] *See* Direct Add dated December 27, 2007 (received December 31, 2007).

Although the Group Acknowledgement letter emailed to the Parties on May 29, 2009 advised that Case No. 09-1730G was being created ". . . by removing providers with ***FYEs after 10/1/2004*** from Case No. 08-0170G. . ." the Representative included participants that have portions of a FYE prior to 10/1/2004 (Providers with 12/31/2004, 6/30/2005 and 3/31/2005 FYEs) in the new group. Consequently, those participants that have a portion of a FYE prior to 10/1/2004 must now be further bifurcated from the post 09/30/2004 Dual Eligible Days issue (in order to be remanded) and for the post 09/30/2004 Part C Days issue (which will be scheduled for hearing). None of the participants with FYEs after 9/30/2004 remained in Case No. 08-0170G (which was recently remanded on 2/26/2016).

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

Board Determination on Bifurcation

The Board acknowledges that at the time the majority of participants' individual appeals, transfer requests and the group appeal were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days, therefore, necessitating the Board to bifurcate these issues.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 09-1730GC 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 and is handling them in the following group appeals:

Issue	Case No.
Dual Eligible Discharges Before 10/1/2004	09-1730G
Part C Discharges Before 10/1/2004	16-0314G[9]
Dual Eligible Discharges After 9/30/2004	11-0754G
Part C Discharges After 9/30/2004	16-0318G[10]

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[5] *See* Case Management Plan Letter, Jun. 3, 2013.
[6] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[7] *Id.* at 1.
[8] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.
[9] Case No. 16-0314G was previously established by bifurcating participants from 09-0088GC, 09-0587GC, 09-2102GC, 08-2866GC, 12-0188G and 09-1733GC in December 2015.

The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the original group appeal (Case No. 08-0170G) was filed. Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[11] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Therefore, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

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

(1) Dual Eligible [Discharges Prior to 10/1/2004]

CMS Ruling 1498-R explains that, under the revised Dual Eligible days policy, any patient entitled to Part A is included in the DSH Medicare fraction, regardless of whether the patient's stay was covered or the patient's Part A benefits were exhausted.[12] The Ruling discusses the related appeals:

> For cost reports with discharges before October 1, 2004, hospitals have filed [Board] appeals seeking inclusion in the [disproportionate patient percentage] DPP of inpatient days where the patient was entitled to Medicare Part A but the inpatient hospital stay was not covered under Part A. For example, some hospitals have appealed the exclusion from the DPP of inpatient hospital days of patients (whether dual eligible or entitled only to Medicare) whose Part A hospital benefits were exhausted.[13]

Here, the appealed Dual Eligible days are for discharges prior to 10/01/2004. CMS describes that these appeals will be resolved by CMS and the Medicare Contractors.[14] A properly pending appeal means that the "applicable jurisdictional and procedural requirements for appeal" are

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[10] Case No. 16-0318G was previously established by combining bifurcated participants from 09-0088GC, 09-1072GC & 09-1732GC in December 2015.
[11] 42 C.F.R. § 405.1837(a)(2) (2003).
[12] *See id.*
[13] *Id.* at 8-9.
[14] *Id.* at 10.

satisfied.[15] The Board determines that jurisdictional requirements have been met for all 7 participants on the August 30, 2013 Schedule of Providers for Dual Eligible Discharges prior to 10/1/2004 in Case No. 09-1730G. These Participants have a valid portion of their fiscal years to which CMS Ruling 1498-R applies. Enclosed, please find the Board's Standard Remand of the Dual Eligible Days issue.

(2) Part C Days [Discharges Prior to 10/1/2004]

The Board accepts jurisdiction over the 7 Participants listed on the August 30, 2013 Schedule of Providers for Part C Discharges prior to 10/1/2004.

The Board finds that all Participants either filed individual appeals which included the Dual Eligible Days issue prior to the August 2008 Rule change or they specifically appealed or added the Part C days issue. In the instant group case, the Board grants the bifurcation of Part C days prior to 10/01/2004 to continue in Case No. 16-0314G.

(3) Dual Eligible & Part C [Discharges After 09/30/2004]

The Board finds that the individual appeals for the following participants and the original optional group appeal were filed prior to the August 2008 Rule change and included the Dual Eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days:

Ptcp.	Provider Name/FYE
1	Alamance Regional Medical Center (12/31/2005)
3	Auburn Memorial Hospital (10/1/2004 - 12/31/2004)
4	Auburn Memorial Hospital (12/31/2005)
5	Brooks Memorial Hospital (12/31/2005)
6	Butler Memorial Hospital (6/30/2006)
7	Champlain Valley Physicians Hospital Medical Center (12/31/2005)
8	East Liverpool City Hospital (12/31/2005)
10	Kootenai Medical Center (12/31/2005)
11	Lakeland Regional Medical Center (9/30/2005)
14	Memorial Medical Center (9/30/2005)
17	Nathan Littauer Hospital (12/31/2005)
18	Portneuf Medical Center (9/30/2005)
19	Rome Memorial Hospital (12/31/2005)
20	Southern Ohio Medical Center (6/30/2006)
21	St. Clare Schnectady (10/1/2004 - 12/31/2004)
22	St. Joseph Hospital Elmira (12/31/2004)
23	St. Vincent Hospital & Healthcare (5/31/2006)
24	The Unity Hospital of Rochester (10/1/2004 - 12/31/2004)
25	The Washington Hospital (6/30/2006)

Albany Medical Center (12/31/2005)-participant #2 and Kaleida Health (10/1/2004-

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[15] *Id.*

12/31/2004) participant # 9, both filed individual appeals after the August 2008 Rule change, but included the Part C days issue in their issue descriptions. Mobile Infirmary Medical Center (3/31/2005 & 3/31/2006) – participant #s 15 and 16 both filed individual appeals prior to the 2008 Rule Change but neither included the Dual Eligible Days issue. Both, however, added the Dual Eligible Days issue with the Part C days sub-issue by the October 20, 2008 deadline for adding issues.

With regard to the remaining participant #s 12 & 13, Laughlin Medical Center (6/30/2006 and 6/30/2007), both participants filed directly into the group from receipt of their respective Notices of Program Reimbursement. Therefore, the Board deems these participants to have appealed the group issue which included the Part C days component.

Consequently, the Board finds that all 25 participants with discharges after 10/1/2004 properly appealed the Part C days issue. Therefore, the Board hereby transfers the Part C days issue for the 25 participants to Case No. 11-0754G. [16] The Dual Eligible days issue will be scheduled for a hearing date. The Parties will receive a Notice of Hearing under separate cover in Case No. 11-0754G.

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: Standard Remand of Dual Eligible Days Pursuant to CMS Ruling 1498-R
Schedule of Providers
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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

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[16] The Board's determination regarding the bifurcation of Case No. 11-0754G will be issued under separate cover.

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Refer to: 08-2622GC

APR 13 2016

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Noridian Healthcare Solutions, LLC
Evaline Alcantara
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P.O. Box 6782
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RE: Bifurcation Decision
Sutter Health 2001 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2622GC

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 2001 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Party] ("CIRP") Group's Request for Case Bifurcation. The Board hereby grants in part and denies in part, Toyon's request for bifurcation of the dual eligible Part A non-covered and HMO/Part C[1] days issues. The decision of the Board with regard to jurisdiction and the bifurcation request is set forth below.

BACKGROUND

FORMATION OF GROUP

This appeal was established when several CIRP Providers were identified in optional group appeals: PRRB Case Nos. 04-1732G (Toyon 2001 DSH Dual Eligible Days Group) and 06-2011G (Toyon 2001 DSH Dual Eligible Days Group #2). This CIRP Group was also consolidated with a duplicate filing, PRRB Case No. 09-1962GC (Sutter Health 2001 DSH Dual Eligible Days CIRP Group) in October 2010.

On December 26, 2012, the Board received Toyon request for, among other things, case bifurcation ("Request") in the instant optional 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."

[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."

JURISDICTION

Participant 11, Sutter Medical Center Santa Rosa (provider no. 05-0291, FYE 12/31/2001), filed its individual appeal request with the Board on February 16, 2006, but did not raise either the dual eligible Part A exhausted or Part C days issues. The Provider did not raise the issue until its *November 11, 2010* request to transfer the dual eligible days issue from its individual appeal to this group.

BOARD'S DECISION

JURISDICTIONAL DETERMINATION

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 a hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

The Board finds that it does not have jurisdiction over Participant 11 because the Provider did not appeal or timely add the dual eligible days issue to its individual appeal prior to requesting to transfer the issue to this group. The regulation governing a provider's ability to timely add issues to an appeal was amended in 2008. The amended regulation, contained in Federal Register's publication of the May 23, 2008 Final Rule and found at 42 C.F.R. § 405.1835(c)(3) (2008), became effective on August 21, 2008. The amended regulation states that a request to add an issue to an appeal is timely if the Board receives the request no later than 60 days after the expiration of the applicable 180-day period for filing the original hearing request. The following clarification also appeared in the May 23, 2008 Final Rule:

> [f]or appeals pending before ... the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of ... 60 days after the effective date of this rule.[2]

Thus, Participant 11 had until October 20, 2008, to add the dual eligible Part A exhausted and Part C days issues, in writing, to its individual appeal. However, the Provider did not raise the dual eligible days issue until its November 11, 2010 transfer letter, which was submitted after the deadline to add issues to pending appeals. The Board therefore finds that it does not have jurisdiction over Participant 11, Sutter Medical Center Santa Rosa (provider no. 05-0291, FYE 12/31/2001) and hereby dismisses the Provider from this appeal.

BIFURCATION DETERMINATION

The Board hereby denies bifurcation of the issues for Participant 7, Sutter Auburn Faith Hospital (provider no. 05-0498, FYE 12/31/2001). This Provider filed its individual appeal request with

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[2] 73 Fed. Reg 30190, 30240 (May 23, 2008).

the Board on November 11, 2005 and did not request to add the dual eligible days issue to its appeal until October 15, 2008. This add request did not specifically identify Part C days, and neither did the Provider's request to transfer the issue to a group appeal. The amended regulations discussed above also state that 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 . . ."[3]

The Board also updated its rules to coincide with the publication of the May 23, 2008 Final Rule. Board Rule 8 concerns provider issues involving multiple components and states that in order "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible.[4] The Board finds that Sutter Auburn Faith Hospital's add and transfer requests do not meet the specificity requirements for the Part C days issue as outlined in the regulations and Board rules, therefore the Board hereby denies bifurcation of the issues for Participant 7.

The Board grants bifurcation of the issues for the remaining Participants that have jurisdictionally valid appeals: Participants 1-6, 8-10, and 12. The Board finds that that at the time the group appeal, individual appeals, and transfer requests were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the group appeal request, and the Providers' individual appeal and transfer requests used a broad issue statement that encompassed both Part A non-covered days and Part C days. Therefore, the Board grants bifurcation of the issues for this Provider.

Based on these factors, the Board finds that there are two issues pending in case number 08-2622GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[5] Therefore, the Board bifurcates the dual eligible exhausted Part A and Part C days issues into separate group appeals. The Providers' Part C issue (apart from Participant 11, which the Board has dismissed and Participant 7, for which the Board has denied bifurcation of the issues) is now in case number 16-1375GC, Sutter Health 2001 DSH Part C Days CIRP Group. The remaining Providers in Case No. 08-2622GC are subject to CMS Ruling 1498-R, and you will receive notification of remand of those providers under separate cover.

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

---

[3] 42 C.F.R. § 405.1835(b)(2).
[4] PRRB Rules at 6-7 (Aug. 21, 2008).
[5] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
CMS Ruling 1498-R Remand Letter for Case No. 08-2622GC
Acknowledgement and Critical Due Dates Notice for case number 16-1375GC

cc: Wilson Leong, Federal Specialized Services

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APR 18 2016

Jason M. Healy, Esq.
The Law Offices of Jason M. Healy, PLLC
1750 Tysons Blvd.
Suite 1500
McLean, VA 22012

RE: Post Acute Specialty Hospital of Hammond
Provider No. 19-2036
FFY 2016
PRRB Case No. 16-0037

Dear Mr. Healy:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's March 19, 2016 request for expedited judicial review (EJR) (received March 21, 2016). The decision of the Board with respect to the request for EJR is set forth below.

Issue Under Dispute

Whether the Centers for Medicare & Medicaid Services (CMS) failed to properly calculate or adjust the wage index for [the Provider] under the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for [Federal] Fiscal Year [FFY] 2016.[1]

Background

LTCH Wage Index Calculations

With each decennial census, the Office of Management and Budget (OMB) issues new labor market area delineations based on the census data. The new standards issued as a result of the 2010 Decennial were published on February 28, 2013 in OMB Bulletin 13-01. This publication announced revisions to the Metropolitan Statistical Areas (MSA), Micropolitan Statistical Areas, and Combined Statistical Areas and provided guidance for the uses of these new labor markets.[2] As a result of this announcement, there are new core based statistical areas[3] (CBSAs), urban counties that have become rural, rural counties that become urban, and existing CBSAs that have been split. After reviewing the new designations, the Secretary adopted the new OMB delineations and the corresponding changes to the wage index based on those delineations in the

[1] Provider's October 6, 2015 Individual Appeal Request, Tab 3 at 1.
[2] 79 Fed. Reg. 49,854, 49,951 (Aug. 22, 2014).
[3] CBSAs consist of the county or counties, or equivalent entities, associated with at least one core (urbanized area or urban cluster) of a population of at least 10,000. Also included are adjacent counties having a high degree of social and economic integration with the core, as measured through community ties with counties associated with the core. *See* http://www.census.gov/geo/reference/gtc/gtc_cbsa.html (last visited March 31, 2016).

FFY 2015 LTCH PPS final rules. This resulted in geographic reclassifications based on these changes for hospitals throughout the country.[4]

Subsequent to the review of the new designations, the Secretary acknowledged that some LTCHs' reimbursement would be negatively impacted. To mitigate this effect, a transitional wage index would be implemented for one year (FFY 2015). This transitional wage index was a 50/50 blended area wage index which consisted of 50 percent of the 2014 wage index and 50 percent of the 2015 wage index.[5] This transition policy was not extended to FFY 2016.[6] The wage index values for LTCH PPS are calculated using wage data of inpatient prospective payment system hospitals (IPPS) (acute care hospitals).[7] Hospitals that are designated rural are included in each State's rural wage index. Hospitals located in other areas have wage indices based on an average hourly wage based on the hospitals in their MSA.[8]

The Provider in this Case

The Provider is located in Tangiphoa Parish County, LA. Prior to the implementation of the new geographic designations in FFY 2015, the Provider had been designated a rural provider. The Provider's reimbursement was based on the state-wide average that included 35 rural hospitals. Under the new geographical designations, the Provider is considered an urban provider. This urban area includes one acute care hospital and the Provider. The new wage index was based on the only IPPS hospital in the geographical area.[9] The Provider's wage index of 0.9452 was reduced to 0.8167 as a result of this change. This was approximately a 14% reduction in reimbursement.[10]

The Request for EJR

The Provider believes that the decline in its reimbursement is partly attributable to a decrease in wages for the geographical area to which it is now assigned (really a change from rural to urban). The move to urban status reduced the provider pool used to compute the wage index because the urban area contains only a single IPPS hospital.[11] The single IPPS provider, North Oaks Medical Center, was reclassified to a different CBSA (New Orleans-Metairie, LA MSA). The North Oaks wage index for FFY 2016 is based upon its reclassified CBSA.[12]

The Provider is challenging the FFY 2016 LTCH PPS wage index in the final rule and correction notice for violations of the Administrative Procedures Act (APA).[13] The Provider contends that

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[4] 79 Fed. Reg. at 50,181.
[5] *Id.* at 50,183-84.
[6] Provider's March 19, 2015 EJR Request at 3.
[7] 79 Fed. Reg. at 50,182.
[8] *Id.* at 49,952.
[9] Provider's EJR Request at 2.
[10] *Id.* at 3-4.
[11] *Id.* at 4.
[12] *Id.* at 2-3.
[13] *Id.* at 17.

the Secretary failed to adjust the method it used to apply the wage index published in the August 17, 2015 Federal Register, which is the date of the final IPPS rule for FFY 2016. The Provider is not challenging its own wage data, but rather the wage index policy that failed to account for significant year-to-year variability in the wage index for hospitals in revised CBSAs that contain few other hospitals.[14]

The Provider asserts that the Secretary promulgated the wage index without sufficient notice to allow an opportunity for the public to submit meaningful comments, thus violating procedural requirements under the APA. Specifically, the Provider believes that the Secretary violated sections 553 and 706 of the APA by failing to adequately notify affected parties of the significance of its decision to retain in 2016 the revised labor market delineations that were adopted in the FY 2015 final rule. This, the Provider contends, prevented the Provider and other hospitals from submitting meaningful comments before the rule was finalized. Without sufficient information from the Secretary of the potential for significant variability in the wage index for hospitals located in revised CBSAs consisting of only a few hospitals, the Provider could not understand the significance of the new CBSA after the first year of implementation. In addition, the public could not provide meaningful comments on this aspect of the FFY 2016 LTCH PPS proposed rule. The Provider points out that it is a well-established principle that the legitimacy of a Federal regulation may be called into question when the public is denied the ability to submit meaningful comments.[15]

The Provider believes that in order to provide meaningful comments on the proposed wage index for 2016, it needed sufficient notice of the data, analyses, and modeling that was performed - or should have been performed - to develop the wage index and evaluate the need for policies to address significant variability in new CBSAs with only a small number of hospitals. The Provider contends that CMS did not adequately explain the economic impact of its adoption of the new CBSA classifications after the first year of implementation. In particular, the Provider claims the Secretary neglected to disclose the extraordinary volatility these classifications would inject into geographical markets with a drastic reduction in the size of the provider pool, even where the wage index may have increased during the first year of implementation.[16] The Provider believes the FFY 2016 LTCH PPS wage index is arbitrary and capricious because the Secretary violated the APA by changing its wage index without providing a reasoned explanation for subjecting the Provider to the wide fluctuations inherent in a new wage index methodology.[17]

Decision of the Board

The Board concludes that EJR is appropriate for the issue of whether the Provider's wage index was properly calculated under the LTCH PPS for the FFY 2016. Once the Board finds that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a), the regulation

[14] *Id.* at 20.
[15] *Id.* at 20-21.
[16] *Id.* at 23-24.
[17] *Id.* at 28.

at 42 C.F.R. § 405.1842(c)(1) permits the Board to determine whether it lacks the authority to decide the legal question at issue. With respect to jurisdiction, the Board concludes that the Provider timely filed its requests for hearing and the amount in controversy in this case exceeds the $10,000 threshold for an individual appeal.[18] Consequently, the Board has determined that it has jurisdiction over the appeal. Further, the Board finds that it lacks the authority to decide the legal question of whether the regulation, the Provider's wage index was properly calculated under LTCH PPS; 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 Provider is entitled to a hearing before the Board;
2) based upon the Provider's assertions regarding the calculation of the wage index, 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 wage index calculation for this LTCH properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. The Board will be issuing a decision under separate cover addressing the other issues under appeal in these cases.

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

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosure: 42 U.S.C. § 1395oo(f)(1)

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

[18] *See* 42 C.F.R. § 405.1835(a) (2005).

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Refer to:

APR 19 2016

CERTIFIED MAIL

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

Kyle Browning, Manager
National Government Services, Inc.
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
McKay 2006 DSH Dual Eligible Group, Case No. 11-0572G

Dear Mr. McKay and Mr. Browning:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the Representative's request for the bifurcation of Dual Eligible days and Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request.

Because one of the participants in this group, Hurley Medical Center for FYE 6/30/2005, involves a partial period (7/1/2004 - 9/30/2004) prior 10/1/2004, the pre-10/1/2004 period was combined with participants from Case No. 09-1730G for the Dual Eligible days issue and Case No. 16-0314G for the Part C Days issue.[1]

Background

This group, filed on March 28, 2011, contained a lengthy group issue statement that included the following language:

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

The Representative identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

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[1] A remand for the Dual Eligible Days issue for the period in question will be issued under Case No. 09-1730G.

[2] 11-0572G Group Request for Hearing at 2, March 25, 2011.

The Representative attached a preliminary Schedule of Providers identifying the following participants:

- Albany Medical Center (51-0022) FYE 12/31/2006 (transfer from 10-1083)
- Hurley Medical Center (23-0132) FYE 6/30/2006 (transfer from 11-0154)

Subsequently, the following participants were added/transferred to the group:

- Highland Hospital of Rochester (33-0164) FYE 12/31/1994 (transfer from 11-0049 filed on 5/27/2011) which the Board denied on June 17, 2011.
- Hurley Medical Center (23-0132) FYE 6/30/2005 (transfer from 11-0141 filed on 6/10/2011)[3]
- Hurley Medical Center (23-0132) FYE 6/30/2007 (transfer from 11-0114 filed on 8/24/2011)
- Hershey Medical Center (39-0256) FYE 6/30/2006 (direct add filed on 10/14/2011)[4]
- Hershey Medical Center (39-0256) FYE 6/30/2007 (direct add filed on 12/8/2011)[5]
- Cheyenne Regional Medical Center (53-0014) FYE 6/30/2006 (transfer from 11-0665 filed on 1/9/2012)[6]

Pertinent Facts Regarding Participants Appealing Revised NPRs:

Two of the participants in Case No. 11-0572G appealed from revised NPRs.

Cheyenne Regional Medical Center (Participant 2) for FYE 2006: As part of the reopening, the Provider identified 868 days paid by Part A days that had been previously included in the DSH payment (they were included in the original NPR). The Medicare Contractor removed them in the revised NPR.

Hershey Medical Center (Participant 3) for FYE 2006: The Provider requested 2243 days in its Reopening Request. The Medicare Contractor sampled 167 days. 8 of those days were found to have Part A (Dual Eligible) so they were removed

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[3] As noted, this participant has a partial period (7/1/2004-9/30/2004) that is subject to CMS Ruling 1498-R and is, therefore, requesting to be combined with the pre-10/1/2004 participants in 09-1730G (and 16-0314G).

[4] Hershey Medical Center (FYE 6/30/2006) withdrew from the group by letter dated 09/28/2012.

[5] The MAC has filed a jurisdictional objection over the appeal of dual eligible days issue from revised NPR for this participant.

[6] The MAC has filed a jurisdictional objection over the appeal of dual eligible days issue from revised NPR for this participant.

(A total of 66 were removed due to sampling extrapolation). See Exhibit 3 D, page 5. This Provider filed directly from its revised NPR into the group appeal.

Pertinent Facts Regarding Participants Filing from Original NPRs:

The remaining participants filed individual appeals from original NPRs after the August 2008 Rule change. All appealed Dual Eligible days and either mentioned the Part C days as a sub-issue or appealed Part C days as a separate issue.

On June 3, 2013, the Representative submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[7] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[8] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[9]

Board Determination on Jurisdiction

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

Revised NPR Appeals

In accordance with 42 C.F.R. § 405.1889 (2008), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[10] The regulation provides:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835,

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[7] *See* Case Management Plan Letter, Jun. 3, 2013.
[8] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.
[9] *Id.* at 1.
[10] *See also, HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding that the Board's jurisdiction is limited to the specific issues revisited on reopening); *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014) (holding that the "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered).

§ 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

(b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Cheyenne Regional Medical System (06/30/2006):

The Board grants jurisdiction over the 671 Dual Eligible days adjusted in the revised NPR, but finds no evidence of an adjustment to the Part C days. Therefore, the Board denies jurisdiction over, and the bifurcation of, the Part C days issue for this Provider.

Hershey Medical Center (06/30/2006):

The Board notes that Hershey Medical Center filed directly into the group from receipt of its revised Notice of Program Reimbursement (NPR). Although the Provider adopted the broad issue statement as it was raised in the group appeal and is considered to have raised both issues, the Board notes a jurisdictional impediment as there is not enough evidence to support an adjustment to either Dual Eligible Exhausted Part A days or Dual Eligible Part C days in the revised NPR. Therefore, the Board denies jurisdiction over this Provider for both Dual Eligible days issues.

Board Determination on Bifurcation

The Board grants the bifurcation of the Dual Eligible days and Part C days issues for the remaining participants in Case No. 11-0572G. The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

The regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[11] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. The Board finds that there are two issues pending within Case No. 11-0572G in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[12] The Board is, therefore, bifurcating the Dual Eligible and Part C days issues into separate group appeals. The Part C Discharges will be handled within Case No. 16-0318G –

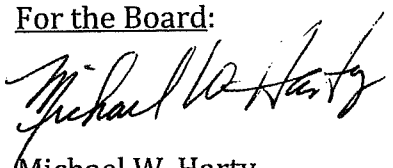
[11] 42 C.F.R. § 405.1837(a)(2) (2003).
[12] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

a group the Board created in December 2015 for post 09/30/2004 participants from various groups. The Dual Eligible days issue will remain in the instant appeal and will be scheduled for hearing. The Parties will receive a Notice of Hearing for this group 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

For the Board:



Michael W. Harty
Chairman

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

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

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APR 25 2016

Quality Reimbursement Services, Inc.
Delbert W. Nord
Senior Consultant
112 N. University Rd., Suite 308
Spokane Valley, WA 99206

RE: UWMC 1999-2005 Part C Days CIRP Group, PRRB Case No. 10-1234GC

Dear Mr. Nord:

The Provider Reimbursement Review Board (Board) has begun a review of your request to bifurcate the above-captioned group appeal which challenges the exclusion of Medicare Managed Care patients who are also eligible for Medicaid in the Medicaid Proxy of the calculation of the disproportionate share (DSH) percentage. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

The group appeal was filed on August 9, 2010 with one participant: University of Washington Medical Center (50-0008) for FYE 06/30/2005.

Subsequently, the following Providers were transferred into the group:

Provider	FYE	Filed On	Transfer From
Harborview Medical Center	06/30/2005	01/22/2015	07-2389G[1]
Harborview Medical Center	06/30/2004	08/31/ 2011	07-2388G[2]

By letter dated January 16, 2016, Quality Reimbursement Services, Inc. requested the bifurcation of this group in order to separate cost reporting period that can be administratively resolved (pre-10/1/2004) from the portions of cost reporting periods that can't be litigated (post 10/1/2004).

Board Determination:

The Circuit Court issued the *Northeast Hosp. Corp. v. Sebelius* decision on September 13th, 2011. This decision affected patient days on cost reports for providers with pending appeals on the issue of inclusion of Medicare Part C Dual Eligible Days in the Medicaid fraction of the disproportionate patient percentage. In light of this decision,

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[1] QRS Post 10/1/2004 - 2005 DSH Medicare Managed Care/Med Eligible Days Group.
[2] QRS Pre-10/1/2004 DSH Medicare Managed Care/Med Eligible Days Group.

Intermediaries began including any disallowed patient days attributable to patients who were enrolled in a Medicare Part C Plan and also eligible for Medicaid for discharges occurring on or after January 1, 1999 through September 30, 2004 in the numerator of the Medicaid fraction of the disproportionate patient percentage on the Medicare cost report.

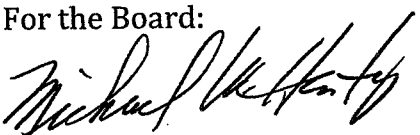
Since CMS may not retroactively apply its policy of including Part C days in the SSI percentage to periods prior to the 2004 PPS rule that set forth that policy, cases involving FYEs prior to 10/1/2004 involve a different legal issue. Consequently, the Board agrees to bifurcate the subject group. The Board notes that there is already a pending appeal for the University of Washington Medicine chain, of which these Providers are related, for the post 9/30/04 period to which we have assigned case number 09-1506GC, the QRS Univ. of WA Medicine 2005 - 2007 Part C Days CIRP Group. Although this group has already been fully formed, the Board will allow the addition of the partial period from 10/1/2004-06/30/2005 for University of Washington Medical Center and Harborview Medical Center. The group name has been modified to reflect the addition of the post 9/30/2004 period and is now called the QRS Univ. of WA Medicine Post 9/30/2004 - 2007 Part C Days CIRP Group.

The remaining partial period from 7/1/2004 to 9/30/2004 for University of Washington Medical Center and Harborview Medical Center will remain in case number 10-1234GC with the 6/30/2004 FYE for Harborview Medical Center. The group name for case number 10-1234GC is being modified to reflect that it is for the pre 10/1/2004 period and will now be called the UWMC 1999- Pre 10/1/2004 Part C Days CIRP Group.

Within 30 days of the date of this letter, the Board is requiring that you submit a supplemental Schedule of Providers for case number 09-1506GC which shows the two participants that have been added to the group with just the appropriate period reflected on the Schedule of Providers (i.e. 10/1/2004-6/30/2005). There is no need to re-file the associated jurisdictional documentation as the Board will use the previously submitted documentation from case number 10-1234GC. Within the same time frame, the Board is also requiring that you submit an updated Schedule of Providers for case number 10-1234GC showing the appropriate periods under appeal.

Should you have any questions, please contact the Board at the above address or by telephoning 410-786-2671.

For the Board:



Michael Harty
Chairman

cc: Lee Crooks, Noridian Healthcare Solutions - WA/AK