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Refer to: 06-2038G

CERTIFIED MAIL

DEC 23 2015

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Kyle Browning
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Re: **Duane Morris/McKay Consulting DSH DE Days Bifurcation to (1) Part A Non-Covered/Exhausted Benefits Days and (2) Part C Days**
PRRB Case No.: 06-2038G
FYE: Various (Pre and Post 10/01/2004 appeals)

Dear Ms. Erde:

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 Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. The Part C days issue with discharges prior to 10/01/2004 will be adjudicated in Case No. 16-0398G, the Duane Morris 04 National DSH Part C Days group.[1] Additionally, Dual Eligible days and Part C days with discharges after 09/30/2004 will be adjudicated in Case No. 16-0403G and 16-0404G, respectively. If the Board finds jurisdiction over providers appealing Part A Non-Covered and Exhausted Benefit days with discharges prior to 10/01/2004, those providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal—established in 2006—framed the issue as follows:

> Is the [Medicare Contractor'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

[1] This letter will serve as the Acknowledgement Letter normally sent via e-mail. The parties will be informed of new position paper deadlines in a Notice of Hearing.

who received Part C benefits correct?[2]

The group was filed with three original providers:

(1) Butler Hospital [39-0168];
(2) St. Vincent Hospital [27-0049]; and,
(3) Washington Hospital [39-0042].[3]

The Group Representative informed the Board that the group was complete on August 31, 2007.[4]

On June 3, 2013, the Group 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 four updated Schedules of Providers from McKay Consulting ("McKay") for both Part C days before and after 10/01/2004 and "Dual Eligible," or Exhausted Benefits, days before and after 10/01/2004. McKay further requested that the Board bifurcate the group into Part C days and "Dual Eligible," or Exhausted Benefits, days.

Board Determination on Bifurcation

The Board has granted the bifurcation request regarding the Dual Eligible days issue into four groups:

(1) Dual Eligible Exhausted Benefits days prior to 10/01/2004
(2) Part C days group with discharges prior to 10/01/2004
(3) Dual Eligible group with discharges after 09/30/2004
(4) Part C days group with discharges after 09/30/2004

The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[6] 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. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). However, the Board has decided to treat the "multi-component" issue as a valid appeal because of the way "Dual Eligible days" were defined in the 2004 group appeal request. The Board concludes that it will grant the

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[2] Group Request for Hearing, Jul. 24, 2006.
[3] *See id.* at Schedule A.
[4] *See* Completion of Group Letter, Aug. 31, 2007.
[5] *See* Case Management Plan Letter, Jun. 3, 2013.
[6] 42 C.F.R. § 405.1837(a)(2) (2003).

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.

Dual Eligible Exhausted Benefits days prior to 10/01/2004

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.[7] The Ruling discusses the related appeals:

> For cost reports with discharges before October 1, 2004, hospitals have filed PRRB appeals seeking inclusion in the 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.[8]

Here, the appealed Dual Eligible days are for discharges prior to 10/01/2004. CMS describes that these properly pending appeals will be resolved by CMS and the Medicare Contractors.[9] A properly pending appeal means that the "applicable jurisdictional and procedural requirements for appeal" are satisfied.[10] The Board finds that jurisdictional[11] and procedural requirements have been met for a majority of the participants; however, the Board has denied jurisdiction over the below providers.

Auburn Memorial Hospital [33-0235] (Participant #5 and #6)

In order for the Board to grant jurisdiction over revised Notice of Program Reimbursement ("RNPR") appeals, Dual Eligible days must have been specifically revised in the RNPR by the Medicare Contractor.[12] The Board Rules state:

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[7] *See* CMS Ruling 1498-R, Apr. 28, 2010.
[8] *Id.* at 8-9.
[9] *Id.* at 10.
[10] *Id.*
[11] The Board grants jurisdiction pursuant to *Bethesda Hosp. Ass'n. v. Bowen*, 485 U.S. 399 (1988), which holds that a provider may "self-disallow" a cost if it is barred by statute, rule, or regulation from claiming that cost (i.e., dual eligible days) on its cost report.
[12] *See* 42 C.F.R. § 405.1889.

> The Board accepts jurisdiction over appeals from a revised Notice of Program Reimbursement (NPR) where the issue(s) in dispute were specifically adjusted by that revised NPR. The Board typically follows the courts by limiting the scope of such an appeal to only the revised issue(s). See Anaheim Memorial Hospital v. Shalala, 130 F.3d 485 (9th Cir. 1997).[13]

Auburn Memorial Hospital appeals from two of its RNPRs for fiscal year ends 1994 and 1995. The July 7, 2006 RNPRs were issued as a result of a Settlement Agreement based on HCFAR 97-2. Per the Settlement Agreement, "[a]fter the Hospital receives a Notice of Reopening, the Hospital shall be entitled to submit to the [Medicare Contractor] one listing of Medicaid eligible unpaid days that it believes should be included in the determination of its DSH payment under HCFAR 97-2."[14] HCFAR 97-2 dealt solely with days related to unpaid Title XIX Medicaid days which were not entitled to Medicare Part A. Further, the January 2, 2004 letter from the Medicare Contractor indicated that "[i]n accordance with the memorandum and settlement agreement, the Provider should submit '*one separate listing of Medicaid Eligible, But Unpaid Patient Days*' for each of the applicable fiscal year[s] . . . [1994 and 1995]."[15] The Group Representative claims that Auburn, in possible violation of these terms, submitted Dual Eligible days as part of its "one list of days." The Board finds that it does not have jurisdiction over Auburn's RNPRs because Dual Eligible days were not specifically revised in Auburn's RNPRs as required by regulation. Therefore, Auburn (Participant #5 and #6) is dismissed from this appeal.

St. Vincent Hospital and Healthcare [27-0049] (Participant #27)

St. Vincent also appealed from a RNPR. The Notice of Reopening states:

> . . . [W]e are hereby reopening your cost report for the following reasons:
> 1. . . . to use the provider's 5-31-00 specific fiscal year end rather than the Federal FY 1999 year end, per the provider's request, to determine the SSI percentage used to compute the Medicare DSH calculator.
> 2. To adjust Medicaid Eligible Days, total patient days, and Total and Medicaid Labor & Delivery Room Days used in the Operating and Capital . . . [DSH] calculation . . .
> 3. To adjust IME/GME FTE's to determine and apply the correct resident to bed ratio . . .[16]

The Board finds that Dual Eligible days were not specifically revised in the reopening; therefore, the Board denies jurisdiction over St. Vincent's RNPR appeal. St. Vincent is hereby dismissed.

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[13] Board Rule B.I.a.3 at 3.
[14] Settlement Agreement ¶ 4 *attached at* Schedule of Providers 1 of 5 Tabs 5D, 6D.
[15] Letter from Medicare Contractor, Jan. 2, 2004 (emphasis in original) *attached at* Schedule of Providers 1 of 5 Tabs 5D, 6D.
[16] Notice of Reopening, Jul. 12, 2006 *attached at* Schedule of Providers 4 of 5 Tab 27D.

Wilson Medical Center [34-0126] (Participant #34)

Wilson Medical Center is appealing fiscal year end 09/30/2005. That means its cost report covers days that are not governed by CMS Ruling 1498-R. The Board hereby dismisses Wilson from the pre-10/01/2004 Schedule of Providers.

Other Participants

The Board finds that all of the other Providers have a valid remand. They all timely appealed or added (and later transferred) the Dual Eligible days issue to the instant group appeal. They also all have a valid portion of their fiscal years to which CMS Ruling 1498-R applies. The Board grants jurisdiction over these Dual Eligible days pursuant to *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988), and will remand these days pursuant to CMS Ruling 1498-R under separate cover.

Part C days group with discharges prior to 10/01/2004

All of the Providers in the Part C days group requested transfers prior to the 2008 regulation change, which limited the ability to add issues to an open appeal. Prior to the regulatory change, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Therefore, the Board will deem the "transfer" of "Dual Eligible days" as a transfer of Dual Eligible Exhausted Benefits days and an "add/transfer" of the Part C days issue. The Board finds that the group appeal the providers were transferring to explicitly defined the issue under appeal as including the Part C days component. This Part C days appeal will continue in Case No. 16-0398G. However, there was one provider that appealed from an RNPR and will be dismissed.

St. Vincent Hospital and Healthcare [27-0049] (Participant #18)

St. Vincent's Notice of Reopening states that the purpose of its reopening was to use the provider's 05/31/2000 specific fiscal year end rather than the Federal fiscal (1999) year end to: determine its SSI%; adjust Medicaid Eligible days, total patient days, and Total and Labor and Delivery Room days in DSH; and, adjust IME/GME full time equivalents.[17] Therefore, the Board finds that Part C days were not adjusted in St. Vincent's RNPR and hereby dismisses St. Vincent from this appeal.

Dual Eligible group with discharges after 09/30/2004

The Board finds that all of the Providers timely appealed or added Dual Eligible days to their individual appeals. The Board further finds that it has jurisdiction over all of Providers in this appeal pursuant to *Bethesda*. This Dual Eligible group will continue in Case No. 16-0403G.

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[17] Notice of Reopening, Jul. 12, 2006 *attached at* Schedule of Providers 3 of 4 Tab 18D.

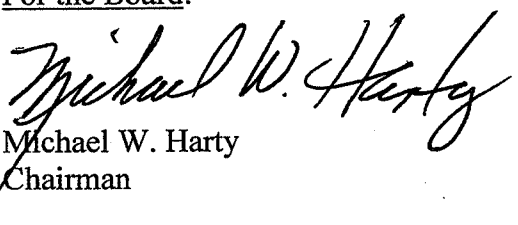
Part C days group with discharges after 09/30/2004

As with the Part C days group with discharges prior to 10/01/2004, the Providers in the Part C days group with discharges after 09/30/2004 all transferred Part C days prior to the 2008 rule change. Therefore, the Board finds that all of the transfer requests into the instant group appeal will be treated as "add/transfer" requests of the Part C days issue. The Board grants jurisdiction over all 10 Providers. This Part C days appeal will continue in Case No. 16-0404G.

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

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

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

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DEC 23 2015

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Re: **Duane Morris/McKay Consulting DSH Dual Eligible/Part C Days Bifurcations**
Bon Secours 2000 Dual Eligible Day CIRP Group, Case No. 09-1733GC

Dear Mr. McKay and Ms. Hartley:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the Representative's request for the bifurcation of Dual Eligible days and Part C days. The Board determined that it does not have jurisdiction over four Providers (three of which are requesting bifurcation, see below) in this group. For those Providers appealing Part A Non-Covered and Exhausted Benefit days over which the Board finds jurisdiction, the Board will issue a remand pursuant to CMS Ruling 1498-R.

Background

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

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

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

The Representative attached a preliminary Schedule of Providers to the Request for a Hearing, naming two Providers:[2]

- DePaul Medical Center (49-0011) FY 00 (transfer from 08-0170G)
- Maryview Medical Center (49-0017) FY 00 (transfer from 08-0170G)

In June 2009, additional participants transferred to the group:[3]

- Mary Immaculate Hospital -FY 99 (transfer from 08-0170G)
- Maryview Medical Center – FY 01(transfer from 05-2173G)
- Mary Immaculate Hospital – FY 00 (transfer from 06-2038G)

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[1] 09-1733GC Group Request for Hearing at 2, May 27, 2009.
[2] *See id.* at Schedule A.
[3] *See id.* at Schedule A.

- DePaul Hospital- FY 01 (transfer from 05-2173G)

Of the six participants in the group, only Mary Immaculate Hospital for FYEs 1999 and 2000 and Maryview Medical Center for FYE 2000 are on both the Dual Eligible Days Schedule of Providers and the combined Part C Days Schedule.[4]

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

Pertinent Facts Regarding revised Notices of Program Reimbursement (NPRs):

The Board notes that four of the six participants in this group appeal, (three of the four also requesting bifurcation of the Part C days issue) appealed from revised NPRs. Consequently, the Board must first decide the four Providers' appeal rights before it makes a determination regarding whether the issues in the group appeal should be bifurcated:

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

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 (1996) explains the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

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[4] In the Representative's August 30, 2013 Bifurcation Request, the Representative identifies various Part C Days groups that will have to be combined to meet the $50,000 group threshold amount in controversy.

[5] *See* Case Management Plan Letter, Jun. 3, 2013.

[6] *See* Bifurcation Letter, Aug. 30, 2013; *see also* Schedule of Providers, Aug. 30, 2013.

[7] *Id.* at 1.

DePaul Medical Center (Participant 1) for FYE 2000: In its request for administrative resolution, the Provider asks the Medicare Contractor to review an eligible days listing of 4945 days. The Provider further states that they identified 81 dual eligible days which were not included in the 4945 days, but the Medicare Contractor should review. The adjustment provided only shows an adjustment to the DSH payment, but no Medicaid Days adjustment. There are no workpapers to review, nor a reopening notice. Therefore, the Board finds that there is not enough evidence to support that the Medicare Contractor reviewed or adjusted Dual Eligible days or Part C days in the revised NPR appealed. This Provider is hereby dismissed from the group.

Mary Immaculate Hospital (Participant 3) for FYE 1999: There was an audit adjustment to increase Medicaid days (including Medicaid HMO's), and a corresponding adjustment to include a first time DSH payment, but there is nothing in the record to support that there was an adjustment to any type of Dual Eligible days (including Part C days). This Provider is hereby dismissed from the group.

Mary Immaculate Hospital (Participant 4) for FYE 2000: In its request for administrative resolution, the Provider asks the Medicare Contractor to review an eligible days listing of 2724 days. The Provider further states that they identified 94 dual eligible days which were not included in the 2724 days, but the Medicare Contractor should also review. The Notice of Reopening from the Medicare Contractor states that they were including 2723, but not including the one error day as that day was a dual eligible day. The Board denies jurisdiction for the one Dual Eligible day for this participant. Although the Medicare Contractor reviewed the one day, it determined it should not be included in the revised NPR. Further, the Board finds no evidence to support an adjustment to Part C days. This Provider is hereby dismissed from the group.

Maryview Medical Center (Participant 5) for FYE 2000: In its request for administrative resolution, the Provider admits that the sample provided to be audited as part of the reopening does not include the 343 dual eligible days identified. There is no evidence that any type of Dual Eligible days (including Part C days) were part of the reopening or administrative resolution. This Provider is hereby dismissed from the group.

Board Determination on Bifurcation

Because the Board found that it is does not have jurisdiction over Mary Immaculate Hospital (FYEs 1999 & 2000) and Maryview Medical Center (FYE 2000), the Board denies the Providers request for bifurcation of the Dual Eligible days and Part C days issues. Had the Board found jurisdiction over these Providers, the Board would have consolidated them into a newly established group, the McKay 1999-Pre 10/1/2004 Medicaid Fraction Part C Days Group, case number 16-0314G. Since bifurcation has been denied, the Representative is advised to remove the participants from the final Schedule of Providers in case number 16-0314G.

Dual Eligible days Remand:

The remaining participants, DePaul Medical Center (FYE 2001) and Maryview Medical Center (FYE 2001) are subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal is included as an enclosure along with this determination.

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

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

For the Board:

Charlotte F. Benson, CPA
Board Member

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

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

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CERTIFIED MAIL

DEC 24 2015

Michael K. McKay
President
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Re: **Dual Eligible Days/Medicare Part C Days Bifurcations**
Catholic Health System NY 2004 Dual Eligible CIRP Group and Catholic Health System NY 2005 Dual Eligible Days Group
Provider Nos.: Various
FYEs: Various
PRRB Case Nos. 09-0144GC and 09-1606GC

Dear Mr. McKay:

The Provider Reimbursement Review Board ("PRRB or Board") has reviewed your August 30, 2013 letter regarding the bifurcation of the above-referenced appeals into separate group appeals including: (1) pre 10/1/2004 dual eligible days (2) post 9/30/2004 dual eligible days (3) pre 10/1/2004 Part C days and (4) post 9/30/2004 Part C days. The Board has determined that for providers deemed eligible, it will grant the bifurcation requests of the pre 10/1/2004 and post 9/30/2004 dual eligible days and the pre 10/1/2004 and post 9/30/2004 Part C days issues. The Board's decision rests on the framing of the groups' issues, the regulations and Board Rules applicable at the time the group appeals were filed.

Background

On May 3, 2013, the group representative submitted a Case Management Plan for the "McKay Consulting Appeals," which includes the instant appeals, which adopted new deadlines for the Schedule of Providers.[1] On August 30, 2013, the group representative submitted the Schedule of Providers and a letter requesting the bifurcation of the dual eligible days issue into Part C and Part A eligible-but unpaid days and further requesting that the groups be subdivided into pre 10/1/04 and post 10/1/04 groups.[2] The group representative wrote that it determined that "each of the group appeals . . . challenges the exclusion of both non-covered and Medicare part C dual eligible patients from the numerator of the DSH Medicaid fraction."[3]

On October 17, 2008, and May 1, 2009, the Providers' filed a Request for Hearing in case numbers 09-0144GC and 09-1606GC which contained the following issue in dispute: "whether the Providers' Intermediaries correctly excluded from the Providers' Medicaid percentages all

[1] May 3, 2013 Case Management Plan Letter.
[2] August 30, 2013 Bifurcation Letter.
[3] *Id.* at 1.

days of care that were rendered to dual eligible patients."[4] The Providers identified four categories of days which were excluded from the Medicaid Percentages: exhausted benefit days, Medicare secondary payer days, Medicare non-covered days and Medicare Part C days.[5]

The group representative in case number 09-0144GC attached a preliminary Schedule of Providers to the Request for a Hearing naming the following Providers:

- Mercy Hospital of Buffalo (Provider No. 33-0279, FYE 12/31/04) and
- Sisters of Charity Hospital (Provider No. 33-0078, FYE 12/31/04).

The group representative in case number 09-1606GC attached a preliminary Schedule of Providers to the Request for Hearing naming the following Provider:

- Sisters of Charity Hospital (Provider No. 33-0078, FYE 12/31/05).

The following Provider was added to the group appeal on July 16, 2009:

- Mercy Hospital of Buffalo (Provider No. 33-0279, FYE 12/31/05).

Board Determination on Bifurcation

The Board grants the bifurcation of the dual eligible days and Part C days issues and the division of the groups into pre 10/1/04 and post 10/1/04 groups for the Providers in case number 09-0144GC and 09-1606GC. The Board's decision rests on the framing of the groups' issues, the regulations and the Board Rules applicable at the time the group appeals were filed.

Prior to the 2008 revisions to the Board's Rules, the regulation 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."[6] After the 2008 revisions to the Board's Rules, the regulation required, that for a group"[t]he matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group."[7]

In the instant case, the group appeals were filed after the 2008 revisions and described the "matter at issue" as dual eligible days and clearly included the categories of exhausted benefit days, Medicare secondary payer days, Medicare non-covered days and Medicare Part C days. Since the Board views exhausted benefit days, Medicare secondary payer days, and Medicare non-covered days (dual eligible days) as a separate issue than Medicare Part C days, the groups appealed multiple issues in violation of the regulation and PRRB Board Rule 13.[8] The Board therefore, grants the bifurcation of the dual eligible days and Part C days issue and the further division of the groups into pre 10/1/04 and post 10/1/04 groups, as long as all other jurisdictional

[4] Providers' Request for Hearing at Tab 2, 1.
[5] *Id.* at 2-3.
[6] 42 C.F.R. § 405.1837(a)(2)(2003).
[7] *Id.* (Effective August 21, 2008).
[8] PRRB Rule 13-Common Group Issue, states "[t]he matter at issue must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling." (August 21, 2008).

requirements are met.

Board Determination on Jurisdiction

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 (or $50,000 for a group), and the request for a hearing is filed within 180 days of the NPR.

In the instant case, all of the Providers in case number 09-0144GC and 09-1066GC timely appealed, met the amount in controversy requirement and met the dissatisfaction requirement and thus, met all of the jurisdictional requirements. For case number 09-0144GC, both Providers in the group appeal were transferred from other appeals. Provider 1, Mercy Hospital of Buffalo (provider no. 33-0279, FYE 12/31/04), added the dual eligible and Part C days issue to its individual appeal on the same day it set up the group appeal (October 17, 2008). Both its individual and the group issue statement clearly included Medicare Part C. Provider 2, Sisters of Charity Hospital (provider no. 33-0078, FYE 12/31/04) appealed dual eligible days in its original hearing request on April 14, 2008, and transferred to this group on October 17, 2008. As the Provider's actions took place before the deadline to add issues (October 20, 2008)[9] the Board deems that both dual eligible days and Part C days were appealed for this Provider.

For case number 09-1606GC, Provider 1, Mercy Hospital of Buffalo (provider no. 33-0279, FYE 12/31/05), appealed both dual eligible days and Part C days in its original hearing request dated December 12, 2008, and thereafter transferred to the group appeal. Provider 2, Sisters of Charity Hospital (provider no. 33-0078, FYE 12/31/05) was a direct add into the group appeal when it was established on May 1, 2009, and thus, is deemed to have appealed both dual eligible days and Part C days.

Summary

In summary, the Board finds that there are two distinct issues pending within PRRB case numbers 09-0144GC and 09-1606GC, dual eligible days and Medicare Part C days, in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13. The Board is, therefore, bifurcating the dual eligible Part A non-covered and Medicare Part C days issues into four separate group appeals as follows:

- The pre 10/1/2004 dual eligible days issue in case number 09-0144GC for the period of 1/1/2004-9/30/2004 will remain in case number 09-0144GC and the group will be renamed the Catholic Health System NY Pre-10/1/2004 Dual Eligible CIRP Group and is subject to remand under the Centers for Medicare and Medicaid Services' (CMS) Ruling 1498-R.

[9] Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. For appeals already pending when 42 C.F.R. § 405.1835 was promulgated, Providers were given 60 days from the date that the new regulations took effect, August 21, 2008, to add issues to their appeals. In practice this means that issues had to be added to pending appeals by October 20, 2008. *See* 73 Fed. Reg. 30,236 (May 23, 2008).

- The post 9/30/2004 dual eligible days issue in case number 09-0144GC for the period 10/1/2004-12/31/04 will be transferred to the Catholic Health System NY 2005 Dual Eligible Days Group, case number 09-1606GC. The group will be renamed the Catholic Health System NY Post 9/30/2004-2005 Dual Eligible CIRP Group.

- The pre 10/1/2004 Part C days issue in case number 09-0144GC for the period of 1/1/2004-9/30/2004 is now within newly formed PRRB case number 16-0411GC, the Catholic Health System NY Pre-10/1/2004 Part C Days CIRP Group.

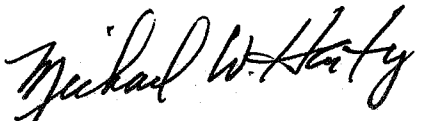
- The post 9/30/2004 Part C days issue in case number 09-0144GC for the period 10/1/2004-12/31/2004 and the Part C days issue in case number 09-1606GC for the period 1/1/2005-12/31/2005 is now within the newly formed PRRB case number 16-0412GC, the Catholic Health System NY Post 9/30/2004-2005 Part C Days CIRP Group.

Because the newly formed Part C days groups, case numbers 16-0411GC and 16-0412GC, were bifurcated from older pending groups, the Board is deeming the newly formed groups to be fully formed. This letter serves as an acknowledgment letter for these new group appeals. Please find enclosed Critical Due Dates letters for these new group appeals. As previously noted, the dual eligible Part A non-covered days issue for the period 1/1/2004-9/30/2004 in case number 09-0144GC is subject to remand pursuant to CMS Ruling 1498-R. The Board's Remand Letter for these providers is also 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 cases on the merits.

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

For the Board:



Michael W. Harty
Chairman

Enclosures:
-Critical Due Dates Letters for case numbers 16-0411GC and 16-0412GC
-Standard Remand of Dual Eligible Days Pursuant to CMS Ruling 1498-R
-Schedule of Providers

cc: Kyle Browning, National Government Services Inc.
Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

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Refer to: 08-1683GC

CERTIFIED MAIL

DEC 30 2015

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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
Fremont Rideout 2004 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-1683GC

Dear Mr. Knight and Ms. Alcantara:

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

Background

On March 24, 2008, the Board received Fremont Rideout's request to form a CIRP group comprised of three common-related party participants. On July 25, 2014, the Board received Fremont Rideout's Schedule of Providers and Jurisdictional Documentation for the three participants within the instant appeal.

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

Board's Decision

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

[1] Toyon is the group representative for this Fremont Rideout appeal.

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

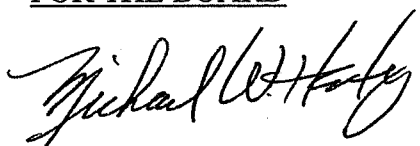
Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-1683GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[2] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' HMO days issue is now within newly formed PRRB Case No. 16-0479GC. 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. 16-0479GC are included as enclosures along with this determination.

Participant 2 on the Schedule of Providers, Fremont Medical Center (provider no. 05-0207) is appealing the fiscal period from 7/1/2004 – 10/30/2004. The Board notes that both the dual eligible Part A non-covered and Part C days issues are treated differently for periods ending before 10/1/2004 and after 10/1/2004. Therefore the period from 10/1/2004-10/30/2004 is hereby transferred to the following groups: case number 10-1371G, Toyon 2005 DSH Dual Eligible Days Group #2, and case number 11-0037G, Toyon 2005 DSH Dual Eligible Part C Days Group.[3]

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

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

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 25, 2014
Group Acknowledgment Letter for PRRB Case No. 16-0479GC
Standard Remand Letter for PRRB Case No. 08-1683GC

cc: Wilson Leong, Federal Specialized Services

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[2] Both the regulation and Board Rule clearly state that a group appeal must contain only one issue.
[3] There are no 2005 Fremont Rideout CIRP Groups pending for the dual eligible or Part C days issues, therefore the Board has transferred the period from 10/1/2004 – 10/30/2004 to Toyon optional group appeals.

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Refer to: 07-2238G

CERTIFIED MAIL

DEC 30 2015

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

RE: Request for Case Bifurcation
Toyon 2002 DSH Dual Eligible Days Group #2
PRRB Case No.: 07-2238G

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 2002 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days Group #2 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 June 11, 2007, the Board received Toyon's request to form a CIRP group comprised of seven initial participants. On March 10, 2010, the Board received Toyon's jurisdictional documentation for the participants within this appeal.[1]

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's") request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue." In its March 13, 2014 Decision, the Board denied Toyon's request to bifurcate the providers' dual eligible days issue and establish a separate appeal for the Providers' Part C days because the Board "determined that [the Providers'] documents . . . are not sufficient to establish that the Providers intended the Part C days to be an issue in this group appeal . . ."[2] In the same Decision, the Board denied jurisdiction over Participant 1 on the Schedule of Providers, Community Hospital of the Monterey Peninsula (provider no. 05-0145, FYE 12/31/2002).

[1] The Schedule of Providers submitted is dated November 24, 2008.
[2] March 13, 2014 Decision at 3.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2004), 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 bifurcation, upon reconsideration, the Board acknowledges that at the time 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 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. 07-2238G in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The Providers' Part C issue is now within newly formed PRRB Case No. 16-0465G. 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. 16-0465G are included as enclosures along with this determination.

Since the Board denied jurisdiction over Participant 1, Community Hospital of the Monterey Peninsula (provider no. 05-0145, FYE 12/31/2002), and dismissed the Provider from the initial appeal, this Provider is also excluded from the newly formed group.

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:
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

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

Schedule of Providers dated November 24, 2008
Group Acknowledgment Letter for PRRB Case No. 16-0465G
Standard Remand Letter for PRRB Case No. 07-2238G

cc: Wilson Leong, Federal Specialized Services

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Refer to: 08-2467GC

CERTIFIED MAIL DEC 30 2015

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Noridian Healthcare Solutions, LLC
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RE: Request for Case Bifurcation
Fremont-Rideout 2002-2003 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2467GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Fremont-Rideout 2002-2003 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Provider's ("CIRP")] Group's ("Fremont-Rideout's") request for case bifurcation. The Board hereby grants Fremont-Rideout's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues as set forth below.

Background

On July 24, 2008, the Board received Fremont-Rideout's request to form a CIRP group comprised of two initial participants. Subsequently, Fremont-Rideout requested to consolidate case number 08-2473GC[1] into this appeal so that the amount in controversy requirement would be met. On June 15, 2010, the Board received Fremont-Rideout's jurisdictional documentation for the participants 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."

Board's Decision

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

[1] Fremont-Rideout 2003 DSH Dual Eligible Days CIRP Group.
[2] Toyon is the representative for Fremont-Rideout's appeal.

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

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

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2467GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The Providers' Part C issue is now within newly formed PRRB Case No. 16-0443GC. 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. 16-0443GC are included as enclosures along with this determination.

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

Board Members:
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 15, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0443GC
Standard Remand Letter for PRRB Case No. 08-2467GC

cc: Wilson Leong, Federal Specialized Services

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

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DEC 30 2015

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

RE: Request for Case Bifurcation
Fremont-Rideout 2000-2001DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2626GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Fremont-Rideout 2000-2001 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Provider's ("CIRP")] Group's ("Fremont-Rideout's") request for case bifurcation. The Board hereby grants Fremont-Rideout's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues as set forth below.

Background

On July 25, 2008, the Board received Fremont-Rideout's request to form a CIRP group comprised of two initial participants. Subsequently, Fremont-Rideout requested to consolidate case number 08-2457GC[1] into this appeal so that the amount in controversy requirement would be met. On June 15, 2010, the Board received Fremont-Rideout's jurisdictional documentation for the participants 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."

Board's Decision

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

[1] Fremont-Rideout 2000 DSH Dual Eligible Days CIRP Group.
[2] Toyon is the representative for Fremont-Rideout's appeal.

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

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

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2626GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The Providers' Part C issue is now within newly formed PRRB Case No. 16-0441GC. 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. 16-0441GC are included as enclosures along with this determination.

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

Board Members:
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 15, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0441GC
Standard Remand Letter for PRRB Case No. 08-2626GC

cc: Wilson Leong, Federal Specialized Services

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

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DEC 30 2015

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

RE: Request for Case Bifurcation
Sutter Helath 2000 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2492GC

Dear Mr. Knight and Ms. Alcantara:

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

Background

On July 24, 2008, the Board received Sutter Health's request to form a CIRP group comprised of five initial participants that were previously participants in various optional group appeals.[1] On July 22, 2010, the Board received Sutter Health's jurisdictional documentation for the participants within this appeal.

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

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2004), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is

[1] Providers were previously in case numbers 04-1731G (Toyon 2000 DSH Dual Eligible Days Group) and 07-0364G (Toyon 2000 DSH Dual Eligible Days Group #2).
[2] Toyon is the representative for Sutter Health's appeal.

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

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

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2492GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The Providers' Part C issue is now within newly formed PRRB Case No. 16-0444GC. 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. 16-0444GC are included as enclosures along with this determination.

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

Board Members:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
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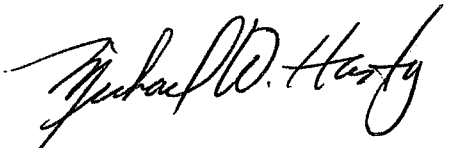
FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 22, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0444GC
Standard Remand Letter for PRRB Case No. 08-2492GC

cc: Wilson Leong, Federal Specialized Services

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

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Kyle Browning, Manager
National Government Services
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P. O. Box 6474
Indianapolis, IN 46206-6474

RE: Northshore LIJ 2000- 2003 DSH Dual Eligible Days CIRP Group, Case No. 09-0534G

Dear Ms. Webster and Mr. Browning:

The Provider Reimbursement Review Board (the Board) is in receipt of the Providers June 19, 2015 correspondence in which you request to withdraw the Noncovered Part A component of the Dual Eligible days issue leaving only the Part C Days component remaining in the group. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

McKay Consulting's (McKay) Request for a Hearing, filed on December 30, 2008, contained a lengthy group issue statement that included the following language:

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

On June 20, 2014, McKay requested that the Northshore LIJ 2003 DSH Dual Eligible Days CIRP Group be bifurcated and a separate Part C Days group established.

On January 14, 2015, the Board denied the transfer of the Dual Eligible Days issue for one of the providers in the group, Southside Hospital (33-0043) for FYE 12/31/2002, because the issue had already been remanded from the individual appeal pursuant to CMS Ruling 1498-R.

---

[1] 09-0534GC Group Request for Hearing (Dec. 29, 2008) at 1-2.
[2] Id. at 2-3.

The Board, however, allowed the Part C Days sub-component to be transferred to the subject group, pending further review regarding a bifurcation of the Dual Eligible and Part C Days issues. This Provider was subsequently withdrawn in the Representative's March 19, 2015 letter submitted with the Schedule of Providers.

On February 3, 2015, the Board responded to McKay's bifurcation request. The Board noted that only one of the participants included a statement demonstrating that the Part C Days component of the Dual Eligible Days issue was appealed. Consequently the Board requested a Schedule of Providers with the associated jurisdictional documentation which supported that the Providers in the group included the Medicare Part C Days sub-component.

On March 20, 2015 the Board received a reply from Akin, Gump, Strauss, Hauer & Feld (Akin Gump), a newly appointed Representative, in which it withdrew the Non-covered Part A Days component of Dual Eligible Days from the group, making the request for bifurcation moot.[3] Further, the Representative withdrew the Part C Days component for cost report years prior to 1/1/2000, and for Southside Hospital for FYE 12/31/2002. Finally, Akin Gump advised that the text of all participants hearing requests and letters adding issues explicitly referenced the exclusion of Medicaid eligible Part C Days as part of their Dual Eligible Days, except for three:

Ptcp#	Provider	FYE
4	Forest Hills Hospital (33-0353)	12/31/2003
6	Long Island Jewish (33-0195)	12/31/2001
7	Long Island Jewish (33-0195)	12/31/2003

Akin Gump argues that the fact that the Providers did not explicitly utter the "magic words" Part C Days in their hearing requests does not deprive the Board of jurisdiction over those days and maintains that the number of Dual Eligible Days identified by the Providers in their hearing requests included Part C Days.[4]

Board Determination:

The group appeal request 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. Thus, the group appealed multiple issues, in violation of 42 C.F.R 1837 (a)(2) and PRRB Rule 13.

After reviewing the facts, the Board finds that all remaining providers properly appealed multiple Dual Eligible components including the Part C issue. The Board has created a new appeal, 16-0496GC labeled Northshore LIJ 2000-2003 Part C days. The Board has transferred the requested providers, 1, 2, 3, 5 and 8, still pursuing the Part C issue to the newly established appeal. Previously, the Board was notified that there were still providers in this

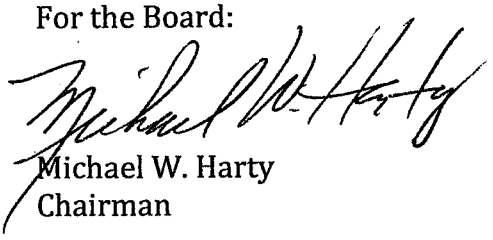
[3] The Representative has requested the group name be redesignated the North Shore LIJ 2000-2003 DSH Part C Dual Eligible Days Group.
[4] Akin Gump letter at 2, Mar. 19, 2015.

chain that had not yet received their NPR's, therefore the new Part C appeal could not be deemed complete. Within 30 days of the date of this letter, you must advise which Providers are still awaiting NPRs and specify for what year(s).

As the provider has withdrawn the Dual Eligible issue remaining in Case 09-0534GC, this appeal has been 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 C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 07-1284GC

DEC 30 2015

CERTIFIED MAIL

Thomas Knight
Toyon Associates, Inc.
President
1800 Sutter St, Suite 600
Concord, CA 94520

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

RE: Jurisdictional Decision
Toyon University of CA 1996 Dual Eligible Days Group
FYEs: 1996
PRRB Case No.: 07-1284GC

Dear Mr. Knight and Ms. Alcantara,

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

Board's Decision

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

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

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

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

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

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

Participant 2, UC Davis Medical Center, provider no. 05-0599, 6/30/1996

Participant 2 appealed the dual eligible days issue from the revised NPR dated June 12, 2001. The Provider referenced Adjs R2-077 and 0778. Both adjustments are generic adjustments to the DSH payment and Medicaid Days. The Board finds that it does not have jurisdiction over Participant 2 because the Provider had not documented that the revised NPR adjusted dual eligible days. There are no workpapers, or supporting documentation to support that a specific adjustment was made to the issue under appeal. Therefore, Participant 2 is hereby dismissed because its appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
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Refer to: 09-0497GC

CERTIFIED MAIL

DEC 30 2015

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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
UC 2002 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 09-0497GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the University of California ("UC") 2002 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request to bifurcate the dual eligible days issue within this appeal. The Board hereby denies UC's bifurcation request and dismisses one of the participants, as explained below.

Pertinent Facts

On December 22, 2008, the Board received UC's request to form a CIRP group comprised of related participants. Within its request, UC describes its common issue in the following manner:

> Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments (DSH) accurately reflects the number of patient days furnished to patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part A benefits.
>
> We contend that the number of Medicaid eligible patient days used in the Medicare DSH calculation is understated due to exclusion of various categories of Medicaid eligible patients who enrolled in Medicare Part A but are not entitled to Medicare Part A benefits. Specifically, the [Medicare contractor] has incorrectly implemented a review process that excludes patient days applicable to patients that are eligible for Medicare Part A benefits without Medicare Part A entitlement in determining the number [of] Medicaid eligible patient days to be included in the Medicaid patient day ratio of Medicare DSH calculation.

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

On December 31, 2012, the Board received UC's Schedule of Providers and Jurisdictional Documentation for the instant appeal that now contains three participants.

Board's Decision

Applicable Regulatory Provisions and Board Rules

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

On May 23, 2008, the Secretary[2] 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 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 . . ."[6]

The May 23, 2008 Final Rule also clarified a provider's right to add issues to its original hearing request. Effective August 21, 2008, 42 C.F.R. § 405.1835(c)(3) (2008) states that the Board must receive a provider's request to add issues to its appeal within a 60-day time period that commences with the expiration of the applicable 180-day period for filing the original hearing request.[7]

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[1] Toyon is the participants' representative for this appeal.
[2] The term "Secretary" refers to the Secretary of the Department of Health and Human Services.
[3] Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008) ("May 23, 2008 Final Rule" or "Final Rule").
[4] *Id.*
[5] 42 C.F.R. § 405.1835(b)(2).
[6] PRRB Rules at 6-7 (Aug. 21, 2008).
7 Within the Final Rule, the Secretary specifically permitted a provider with an appeal pending before the Board prior to the effective date of the Final Rule to add issues to its pending appeal "by the expiration of the later of the following periods: . . . [s]ixty days after the expiration of the applicable 180-day period prescribed in . . .

Jurisdiction for Participant 2, UC Irvine Medical Center

Based on UC's December 31, 2012 Jurisdictional Documentation, UC Irvine Medical Center (Provider No. 05-0348) ("UC Irvine") filed a January 21, 2005 request for hearing with the Board that challenged seven issues from its July 30, 2004 notice of program reimbursement. In its March 13, 2009 "Model Form D—Request to Transfer Issue to a Group Appeal" document ("Request to Transfer"), UC Irvine requested to transfer its DSH Dual Eligible Days issue to the instant appeal. Within its Request to Transfer, UC Irvine indicates that the DSH dual eligible days issue was included within its original request for hearing.

After reviewing UC Irvine's jurisdictional documentation, the Board finds that UC Irvine did not include or reference dual eligible days within its initial hearing request nor did it timely add the issue to its appeal. Based on UC Irvine's documents, the Board determined that UC Irvine's first reference to the dual eligible days issue was within its March 13, 2009 Request to Transfer. As the Board received UC Irvine's Request to Transfer well beyond the regulatory time frame to add issues to its appeal, the Board must find not only that UC Irvine failed to include the dual eligible days issue within its original request for hearing, but also that it did not timely add that issue to its appeal. The Board, therefore, dismisses UC Irvine from the instant CIRP group.

Bifurcation Request

The Board notes that UC filed its December 22, 2008 CIRP group appeal request after the August 21, 2008 effective date of the Secretary's Final Rule. As such, the newly effective regulations mandate that, within a request for hearing, providers 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 providers to appeal each contested component of a multiple-component issue as a separate issue and to describe each issue as narrowly as possible.

In the instant appeal, the Board finds that UC's December 22, 2008 CIRP group request for hearing contains an issue statement (quoted above) that describes its participants' challenge to dual eligible days generally. The Board finds that this issue statement does not identify dual eligible Part C days with the requisite specificity, as required by the regulations, to allow the Board to assume jurisdiction over this issue. Accordingly, the Board hereby denies UC's request to bifurcate its dual eligible days issue.

Conclusion

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

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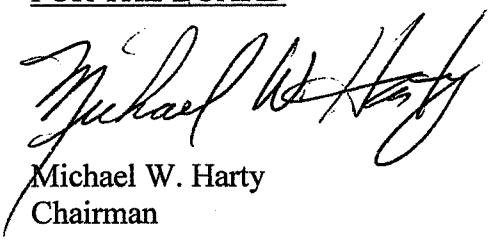
§ 405.1835(a)(3) . . . or 60 days after the effective date of this rule." 73 Fed. Reg. at 30240.

The Board has also determined that UC Irvine Medical Center (Provider No. 05-0348) failed to include or timely add the dual eligible days issue to its appeal and is, therefore, dismissed from the instant CIRP group.

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
Standard Remand Letter for PRRB Case No. 09-0497GC
Schedule of Providers dated December 21, 2012

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL

DEC 30 2015

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

Re: **Dual Eligible Days/Medicare Part C Days Bifurcations**
Geisinger 2004/2005 Dual Eligible Group and Geisinger 2006 Dual Eligible Days Group
Provider Nos.: Various
FYEs: Various
PRRB Case Nos. 09-0112GC and 09-0114GC

Dear Mr. McKay:

The Provider Reimbursement Review Board ("PRRB or Board") has reviewed your August 30, 2013 letter regarding the bifurcation of the above-referenced appeals into separate group appeals including: (1) pre 10/1/2004 dual eligible days (2) post 9/30/2004 dual eligible days (3) pre 10/1/2004 Part C days and (4) post 9/30/2004 Part C days. The Board has determined that for providers deemed eligible, it will grant the bifurcation requests of the pre 10/1/2004 and post 9/30/2004 dual eligible days and the pre 10/1/2004 and post 9/30/2004 Part C days issues. The Board's decision rests on the framing of the groups' issues, the regulations and Board Rules applicable at the time the group appeals were filed.

Background

On May 3, 2013, the group representative submitted a Case Management Plan for the "McKay Consulting Appeals," which includes the instant appeals, which adopted new deadlines for the Schedule of Providers.[1] On August 30, 2013, the group representative submitted the Schedule of Providers and a letter requesting the bifurcation of the dual eligible days issue into Part C and Part A eligible-but unpaid days and further requesting that the groups be subdivided into pre 10/1/04 and post 10/1/04 groups.[2] The group representative wrote that it determined that "each of the group appeals . . . challenges the exclusion of both non-covered and Medicare part C dual eligible patients from the numerator of the DSH Medicaid fraction."[3]

On October 16, 2008, the Providers' filed a Request for Hearing in case numbers 09-0012GC and 09-0014GC which contained the following issue in dispute: "whether the Providers' Intermediaries correctly excluded from the Providers' Medicaid percentages all days of care that were rendered to dual eligible patients."[4] The Providers identified four categories of days which

[1] May 3, 2013 Case Management Plan Letter.
[2] August 30, 2013 Bifurcation Letter.
[3] *Id.* at 1.
[4] Providers' Request for Hearing at Tab 2, 1.

were excluded from the Medicaid Percentages: exhausted benefit days, Medicare secondary payer days, Medicare non-covered days and Medicare Part C days.[5]

The Providers' Representative in case number 09-0112GC attached a preliminary Schedule of Providers to the Request for a Hearing naming the following Providers (both of these providers were transfers from an optional group, 06-2038G, of which the Board has bifurcated the Part C issue as the issue statement included the required Part C language):

- Geisinger Medical Center (Provider No. 39-0006, FYE 6/30/04) and
- Geisinger Wyoming (Provider No. 39-0270, FYE 06/30/04).

The following Providers were transferred to the group appeal on January13, 2010 from PRRB appeal 09-0115GC, Geisinger 2005 Dual Eligible Days as that appeal did not meet the amount in controversy. That appeal had also previously been established from transfers from 06-2038G.

- Geisinger Medical Center (Provider No. 39-0006, FYE 6/30/05)
- Geisinger Wyoming (Provider No. 39-0270, FYE 06/30/05)

The Providers' Representative in case number 09-0114GC attached a preliminary Schedule of Providers to the Request for Hearing naming the following Provider:

- Geisinger Medical center (Provider No. 39-0006, FYE 6/30/06)
- Geisinger Wyoming (Provider No. 39-0270, FYE 06/30/06)
- Geisinger South Wilkes-Barre (Provider No. 39-0169 FYE 6/30/2006)

Board Determination on Bifurcation

The Board grants the bifurcation of the dual eligible days and Part C days issues and the division of the groups into pre 10/1/04 and post 10/1/04 groups for the Providers in case number 09-0112GC and 09-0114GC. The Board's decision rests on the framing of the groups' issues, the regulations and the Board Rules applicable at the time the group appeals were filed.

Prior to the 2008 revisions to the Board's Rules, the regulation 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."[6] After the 2008 revisions to the Board's Rules, the regulation required, that for a group"[t]he matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group."[7]

In the instant case, the group appeals were filed after the 2008 revisions and described the "matter at issue" as dual eligible days and clearly included the categories of exhausted benefit days, Medicare secondary payer days, Medicare non-covered days and Medicare Part C days.

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[5] *Id.* at 2-3.
[6] 42 C.F.R. § 405.1837(a)(2)(2003).
[7] *Id.* (Effective August 21, 2008).

The group appeals were created from transfers from optional group appeal 06-2038G, which the Board has also found includes both Dual eligible exhausted and Dual Eligible Part C issues. Since the Board views exhausted benefit days, Medicare secondary payer days, and Medicare non-covered days (dual eligible days) as a separate issue than Medicare Part C days, the groups appealed multiple issues in violation of the regulation and PRRB Board Rule 13.[8] The Board therefore, grants the bifurcation of the dual eligible days and Part C days issue and the further division of the groups into pre 10/1/04 and post 10/1/04 groups, 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. §§ 405.1835-405.1841 (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 (or $50,000 for a group), and the request for a hearing is filed within 180 days of the NPR.

In the instant case, all of the Providers in case number 09-0112GC and 09-0114GC timely appealed, met the amount in controversy requirement and met the dissatisfaction requirement and thus, met all of the jurisdictional requirements. All of the providers in the two CIRP appeals had been timely transferred to 06-2038G, then were transferred to CIRP group appeals. transferred from other appeals.

Summary

In summary, the Board finds that there are two distinct issues pending within PRRB case numbers 09-0112GC and 09-0114GC, dual eligible days and Medicare Part C days, in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13. The Board is, therefore, bifurcating the dual eligible Part A non-covered and Medicare Part C days issues into four separate group appeals as follows:

- The pre 10/1/2004 dual eligible days issue in case number 09-0112GC for the period of 1/1/2004-9/30/2004 will remain in case number 09-0112GC and the group will be renamed the Geisinger Pre-10/1/2004 Dual Eligible CIRP Group and is subject to remand under the Centers for Medicare and Medicaid Services' (CMS) Ruling 1498-R.

- The post 9/30/2004 dual eligible days issue in case number 09-0112GC for the period 10/1/2004-12/31/04 will be transferred to the Geisinger 2005 Dual Eligible Days Group, case number 09-0114GC. The group will be renamed the Geisinger Post 9/30/2004-2006 Dual Eligible CIRP Group.

- The pre 10/1/2004 Part C days issue in case number 09-0112GC for the period of 1/1/2004-9/30/2004 is now within newly formed PRRB case number 16-0494GC, the Geisinger Pre-10/1/2004 Part C Days CIRP Group.

---

8 PRRB Rule 13-Common Group Issue, states "[t]he matter at issue must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling." (August 21, 2008).

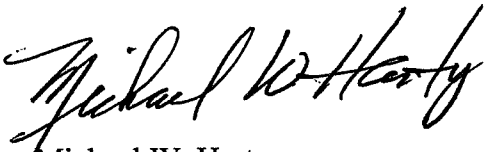
- The post 9/30/2004 Part C days issue in case number 09-0112GC for the period 10/1/2004-12/31/2004 and the Part C days issue in case number 09-0114GC is now within the newly formed PRRB case number 16-0495GC, the Geisinger Post 9/30/2004-2006 Part C Days CIRP Group.

Because the newly formed Part C days groups, case numbers ?16-0411GC and ?16-0412GC, were bifurcated from older pending groups, the Board is deeming the newly formed groups to be fully formed. This letter serves as an acknowledgment letter for these new group appeals. Please find enclosed Critical Due Dates letters for these new group appeals. As previously noted, the dual eligible Part A non-covered days issue for the period 1/1/2004-9/30/2004 in case number 09-0112GC is subject to remand pursuant to CMS Ruling 1498-R. The Board's Remand Letter for these providers is also 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 cases on the merits.

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

For the Board:



Michael W. Harty
Chairman

Enclosures:
-Critical Due Dates Letters for case numbers 16-0494GC and 16-0495GC
-Standard Remand of Dual Eligible Days Pursuant to CMS Ruling 1498-R
-Schedule of Providers

cc: Kyle Browning, National Government Services Inc.
Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

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Refer to: 09-2175GC

DEC 30 2015

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

RE: Jurisdictional Decision
Group Name: MHS 1986-2003 DSH SSI & Accuracy CIRP Group
Provider No.: Various
FYE: 1989-2003
PRRB Case No.: 09-2175GC

Dear Isaac Blumberg and Evaline Alcantara:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and noted jurisdictional impediments.

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 from the date of receipt of the final determination.

Five of the Providers in this group appeal have filed appeals from revised Notices of Program Reimbursement ("NPR"). The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (1995) provides in relevant part:

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

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889 (1995), stated:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been

> reopened ... such revision shall be considered a separate and distinct determination to decision to which the provisions of §§ 405.811, 405.1835, 405.1875 and 405.1877 are applicable.

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

The issue in this CIRP group appeal is whether the Providers' Disproportionate Share Hospital ("DSH") Supplemental Security Income ("SSI") percentage was properly calculated.

Participants that appealed from original and revised NPRs

Participant 6. Long Beach Memorial Medical Center, provider no. 05-0485, Fiscal Year End 6/30/1993

Participant 6 appealed from an original NPR dated 9/30/95 and a revised NPR dated 2/28/05. Regarding the original NPR, the Provider self-disallowed the issue of the SSI percentage, therefore the Board takes jurisdiction pursuant to the rationale in *Bethesda Hospital Ass'n v. Bowen,* 485 U.S. 399 (1988). However, after review of the remaining documents the Provider has not provided documentation to show that the revised NPR specifically adjusted the SSI; the adjustment relates to DSH generally.

The Board finds that it does not have jurisdiction over the SSI percentage issue appealed from this Provider's revised NPR because the revised NPR did not specifically adjust the SSI percentage.

However, this Provider remains pending in this appeal because the Board has determined that it has a jurisdictionally valid appeal pending from the original NPR.

Participant 7. Anaheim Memorial Medical Center, provider no. 05-0226, Fiscal Year End 6/30/94

Participant 7 appealed from an original NPR dated 9/18/96 and a revised NPR dated 1/30/97. Regarding the original NPR, the Provider did not provide an audit adjustment report but provided the appeal noting the issue of the SSI percentage, therefore the Board takes jurisdiction pursuant to the rationale in *Bethesda Hospital Ass'n v. Bowen,* 485 U.S. 399 (1988). However, after review of the remaining documents the Provider has not provided documentation to show that the revised NPR specifically adjusted the SSI; the adjustment relates to DSH generally.

The Board finds that it does not have jurisdiction over the issue of this Provider's revised NPR because the revised NPR did not specifically adjust the SSI percentage.

However, this Provider will remain pending in this appeal because the Board has determined that it has a jurisdictionally valid appeal pending from the original NPR.

Participant 22. Anaheim Memorial Medical Center, provider no. 05-0226, Fiscal Year End 6/30/01

Participant 22 appealed from an original NPR dated 9/23/05 and a revised NPR dated 11/21/05. Regarding the original NPR, the audit adjustment is for DSH and the Provider's appeal raised the issue of the SSI percentage, therefore the Board takes jurisdiction pursuant to the rationale in *Bethesda Hospital Ass'n v. Bowen,* 485 U.S. 399 (1988). However, after review of the remaining documents the

Provider has not provided documentation to show that the revised NPR specifically adjusted the SSI; the adjustment relates to the total capital payment.

The Board finds that it does not have jurisdiction over the issue of this Provider's revised NPR because the revised NPR did not specifically adjust the SSI percentage.

However, this Provider will remain pending in this appeal because the Board has determined that it has a jurisdictionally valid appeal pending from the original NPR.

Providers appealing from revised NPRs only

Participant 8. Long Beach Memorial Medical Center, provider no. 05-0485, Fiscal Year End 6/30/1994

Participant 8 is appealing only from a revised NPR. The Board finds that it does not have jurisdiction over Participant 8 because it is appealing from a revised NPR which does not specifically adjust the SSI percentage. The audit adjustment report submitted by this Provider indicates that adjustment was made to DSH generally. Therefore, Participant 8 is hereby dismissed because its appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

Participant 10. Long Beach Memorial Medical Center, provider no. 05-0485, Fiscal Year End 6/30/1995

The Board finds that it does not have jurisdiction over Participant 10 because it is appealing from a revised NPR which does not specifically adjust the SSI percentage. The audit adjustment report submitted by this Provider indicates that adjustment was made to DSH generally and to Capital Payments. Therefore, Participant 10 is hereby dismissed because its appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

Conclusion

In this decision, the Board has dismissed Participants 8 and 10 listed on the Schedule of Providers. The Board has also dismissed the revised NPR appeals, for Participants 6, 7 and 22. Participants 6, 7 and 22 remain pending in this appeal as they have filed jurisdictionally valid appeals from original NPRs.

Review of these determinations may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of this appeal.[1]

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, Chairperson

[1] Providers with a jurisdictionally proper appeal will be remanded pursuant to CMS Ruling 1498-R under separate cover.

Enclosure: Schedule of Providers

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

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

Refer to: 09-2320GC

DEC 30 2015

CERTIFIED MAIL

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

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

RE: Jurisdictional Decision
MediSys Health Network 1986-1998 SSI Percentage CIRP Group
FYEs: Various
PRRB Case No.: 09-2320GC

Dear Mr. Blumberg and Mr. Browning,

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

Board's Decision

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

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

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

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

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

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

Participants that appealed from revised NPRs

Participant 1, Jamaica Hospital Medical Center, provider no. 33-0014, 12/31/1995

Participant 1 appealed the dual eligible days issue from a revised NPR dated December 29, 1998. Participant 1 cited adjustment #1, which indicates that HMO days were adjusted. The Board finds that it does not have jurisdiction over Participant 1 because the Provider had not documented that the revised NPR adjusted the SSI%. There are no workpapers, or supporting documentation to support that a specific adjustment was made to the issue under appeal. Therefore, Participant 1 is hereby dismissed because its appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

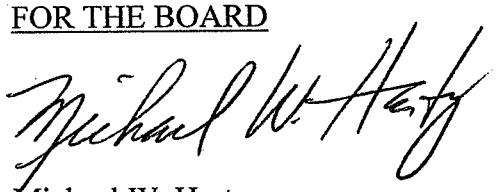
Participants 5-8, Flushing Hospital Medical Center, provider no. 33-0193, FYE's 12/31/1995, 12/31/1996, 12/31/1997 and 12/31/1998

Participants 5-8 9 all state that there is no adjustment related to the SSI%. As there must be a specific adjustment in a revised NPR for the Board to find it has jurisdiction, the Board hereby dismisses participants 5-8 from this appeal as they have not satisfied the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
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Refer to: 07-2238G

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DEC 30 2015

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

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

RE: Request for Case Bifurcation
Toyon 2002 DSH Dual Eligible Days Group #2
PRRB Case No.: 07-2238G

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 2002 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days Group #2 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 June 11, 2007, the Board received Toyon's request to form a CIRP group comprised of seven initial participants. On March 10, 2010, the Board received Toyon's jurisdictional documentation for the participants within this appeal.[1]

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's") request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue." In its March 13, 2014 Decision, the Board denied Toyon's request to bifurcate the providers' dual eligible days issue and establish a separate appeal for the Providers' Part C days because the Board "determined that [the Providers'] documents . . . are not sufficient to establish that the Providers intended the Part C days to be an issue in this group appeal . . ."[2] In the same Decision, the Board denied jurisdiction over Participant 1 on the Schedule of Providers, Community Hospital of the Monterey Peninsula (provider no. 05-0145, FYE 12/31/2002).

[1] The Schedule of Providers submitted is dated November 24, 2008.
[2] March 13, 2014 Decision at 3.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2004), 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 bifurcation, upon reconsideration, the Board acknowledges that at the time 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 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. 07-2238G in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The Providers' Part C issue is now within newly formed PRRB Case No. 16-0465G. 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. 16-0465G are included as enclosures along with this determination.

Since the Board denied jurisdiction over Participant 1, Community Hospital of the Monterey Peninsula (provider no. 05-0145, FYE 12/31/2002), and dismissed the Provider from the initial appeal, this Provider is also excluded from the newly formed group.

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:
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

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

Schedule of Providers dated November 24, 2008
Group Acknowledgment Letter for PRRB Case No. 16-0465G
Standard Remand Letter for PRRB Case No. 07-2238G

cc: Wilson Leong, Federal Specialized Services

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Refer to: 08-2013G

DEC 30 2015

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Isaac Blumberg
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315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

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

RE: Jurisdictional Decision
Blumberg-Ribner 2003 Dual Eligible Days Group
FYEs: 2003
PRRB Case No.: 08-2013G

Dear Mr. Blumberg and Mr. Browning,

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

Board's Decision

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

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

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

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

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

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

Participant 12, St. Luke's Hospital, provider no. 39-0049, 6/30/2003

Provider 12 is appealing from a RNPR. The audit adjustment referenced is an increase to Medicaid days of 1592 days. There is no mention on the adjustment of a revision to Dual Eligible days, nor are there workpapers to support that Dual Eligible Days were adjusted as part of the RNPR. Therefore, Participant 12 is hereby dismissed because its appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
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Refer to: 09-0405

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DEC 30 2015

Isaac Blumberg
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Chief Operating Office
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

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

RE: Jurisdictional Decision
Providence St. Joseph
FYE: 12/31/04
PRRB Case No.: 09-0405

Dear Mr. Blumberg and Ms. Alcantara,

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

Background

The provider filed this appeal with two issues, The SSI Realignment Issue and the DSH Dual Eligible Issue. The provider subsequently added the SSI % accuracy issue and transferred that issue to 09-0829GC. The Board issued a remand of the SSI accuracy issue in 09-0829GC in 2012.

Board's Decision

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

The Board finds that the appeal of the SSI Realignment is moot and dismisses it from the appeal, as their appeal of the SSI accuracy % has been remanded back to the MAC under CMS Ruling 1498-R. CMS issued CMR Ruling 1498-R, to implement the new data matching process related to the SSI%, subsequent to the *Baystate* decision. The provider will not be able to obtain the underlying data to "realign" the SSI% under appeal in this case, as CMS Ruling 1498-R requires the MAC to incorporate the updated SSI %'s. There is no longer a relevant dispute of the "old" SSI data.

The DSH Dual Eligible days issue prior to 10/1/04, is also subject to remand under CMS Ruling 1498-R. The remand for that period of time for that issue will be addressed in the attached remand letter. The remaining portion of the dual eligible days issue, 10/1/04-12/32/2004, will be transferred to CIRP group 09-0937GC, Providence 10/1/04-2007 DSH Dual eligible Days, as this Provider is part of the Providence chain. This appeal is now closed as there are no remaining issues.

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
Standard Remand of DSH Dual Eligible Days 1/1/04-09/30/04

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

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Refer to: 09-0604GC

CERTIFIED MAIL

DEC 30 2015

Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
P.O. Box 1604
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Trinity Health
Cynthia F. Wisner
Associate Counsel
20555 Victor Parkway
Livonia, MI 48152

RE: Jurisdictional Decision
Trinity Health 2002-2005 DSH-SSI Days Proxy CIRP Group
Provider No.: Various
FYE: Various
PRRB Case No.: 09-0604GC

Dear Byron Lamprecht and Cynthia F. Wisner:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and noted jurisdictional impediments.

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 from the date of receipt of the final determination.

Four of the Providers in this group appeal have filed appeals from revised Notices of Program Reimbursement ("NPR"). The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2005) provides in relevant part:

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

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889 (2005), stated:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened ... such revision shall be considered a separate and distinct determination to decision to which the provisions of §§ 405.811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 are applicable.

More recently, 42 C.F.R. 1889 was addressed in *Emanuel Med. Ctr., Inc. v. Sebelius,* 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014). In that case the court held that the "issue specific" interpretation of the revised NPR regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

The issue in this CIRP group appeal is whether the Providers' Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) percentage was properly calculated.

Providers appealing from revised NPRs

Participants Nos. 2, 3 and 4:

Participant Nos. 2, 3 and 4 are appealing from a revised NPRs. Having reviewed the submitted with the appeals, the Board finds that it does not have jurisdiction over these Participants because the revised NPRs did not adjust the SSI percentage specifically. The Participants' audit adjustment report shows adjustments for DSH and Medicaid eligible days. Therefore, Participants 2, 3 and 4 are hereby dismissed because the appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

Participant 13:

Participant 13 is appealing from a revised NPR. Having reviewed the documents submitted with the appeal, the Board finds that it does not have jurisdiction over Participant 13 because the revised NPRs did not adjust the SSI percentage specifically. The audit adjustment for Participant 13 was for employee discount days.

Therefore, Participant 13 is hereby dismissed because the appeal does not satisfy the requirements of 42 C.F.R. §§ 405.1885, 405.1889.

Conclusion

In this decision, the Board dismisses the following Participants listed on the Schedule of Providers as nos.: 2, 3, 4 and 13, for having failed to satisfy the jurisdictional requirements.

Review o these determinations may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of this appeal.[1]

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, Chairperson

Enclosure: Schedule of Providers

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

[1] Providers with a jurisdictionally proper appeal will be remanded pursuant to CMS Ruling 1498-R under separate cover.

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

RE: Transfer Request and Request for Case Bifurcation
Sutter Health 1998 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2624GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Sutter Health 1998 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 HMO days[1] issues as set forth below but denies Blumberg Ribner, Inc.'s August 11, 2010 transfer requests for eight additional Sutter Health providers. Instead, the Board has created a separate CIRP group for these eight providers requesting to transfer into the instant appeal.

Background

On July 25, 2008, the Board received Sutter Health's request to form a CIRP group comprised of four common-related participants[2] contained within the Toyon 1998 DSH Dual Eligible Days Group Appeal, PRRB Case No. 04-1729G. On July 29, 2010, the Board received Sutter Health's jurisdictional documentation for the four participants within this appeal.

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

[2] The four participants are Alta Bates Medical Center (Provider No. 05-0305), Memorial Hospital Modesto (Provider No. 05-0557), Summit Medical Center (Provider No. 05-0043) and Sutter Delta Medical Center (Provider No. 05-0523).

On August 11, 2010, the Board received Blumberg Ribner, Inc.'s request[3] to transfer an additional eight providers into the Sutter Health 1998 DSH Dual Eligible Days CIRP Group. These eight providers appealed cost reporting periods for FYE 1995-1997.

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

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.

Regarding Blumberg Ribner, Inc.'s August 11, 2010 request to transfer eight additional providers into the instant group appeal, the Board hereby denies that request but, instead, has created a separate CIRP group for those providers, PRRB Case No. 16-0446GC.

With respect to the instant appeal and its four 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 HMO/Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2624GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[5] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' HMO days issue is now within newly formed PRRB Case No. 16-0445GC. 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. 16-0445GC are included as enclosures along with this determination.

The eight providers included within Blumberg Ribner, Inc.'s August 11, 2010 transfer request are not included in the newly formed HMO days CIRP group or the remand of the instant appeal, as explained prior.

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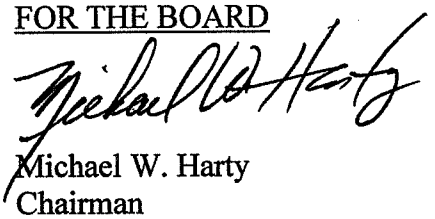
[3] Blumberg Ribner, Inc.'s request was co-signed by a representative of Toyon Associates, Inc.
[4] Toyon is the representative for Sutter Health's appeal.
[5] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

Case No.: 08-2624GC

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

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

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 22, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0445GC
Standard Remand Letter for PRRB Case No. 08-0071GC

cc: Wilson Leong, Federal Specialized Services

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

Refer to: 08-2486GC

DEC 30 2015

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 Case Bifurcation and Jurisdictional Determination
Sutter Health 1993 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2486GC

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 ("Sutter Health") 1993 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. Upon review, the Board finds that it does not have jurisdiction over two of the participants' appeals: Marin General Hospital's (Provider No. 05-0360) ("Marin General") appeal of its fiscal year end ("FYE") December 31, 1993 cost report and Alta Bates Summit Medical Center's (Provider No. 05-0305) ("Alta Bates") appeal of its FYE December 31, 1994 cost report. The Board hereby dismisses these participants from this appeal, as explained below. With respect to the remaining participant's appeal, Alta Bates' appeal of its FYE December 31, 1993 cost report, the Board is granting bifurcation of this participant's dual eligible days issue, transferring Alta Bates' HMO days[1] issue into PRRB Case No. 16-0445GC and remanding Alta Bates' dual eligible no Part A payment days issue in the instant appeal pursuant to the Centers for Medicare & Medicaid Services ("CMS") Ruling 1498-R ("CMS 1498-R").

Background

On July 24, 2008, the Board received Sutter Health's request to form a CIRP group with two common-related party participants transferring from the Toyon 1993 DSH Dual Eligible Days Group, PRRB Case No. 04-1724G. On July 27, 2010, the Board received Sutter Health's Schedule of Providers and Jurisdictional Documentation for the three participants now within the instant appeal.

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

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

Board's Decision

Applicable Regulatory Provisions

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

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

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

Jurisdiction for Participant 2, Marin General Hospital

According to the information contained within Sutter Health's July 27, 2010 Jurisdictional Documentation, Participant 2, Marin General, filed its appeal based on its November 12, 2004 RNPR. The November 12, 2004 RNPR states that the Medicare contractor reopened Marin General's FYE December 31, 1993 cost report in order to incorporate the terms within its Administrative Resolution for DSH Adjustment and "Inpatient Part B 5.8% Reduction." Marin General's corresponding Audit Adjustment Report states that the DSH was adjusted in order to "properly reflect [the Medicare Contractor's] calculatio[n] and to include additional paid days per the state report." Based on this information, Marin General is able to show that the Medicare contractor adjusted DSH generally within its November 12, 2004 RNPR, but not that its dual eligible days were specifically adjusted during the reopening. As Marin General's documentation fails to show that its dual eligible days were specifically revised within its November 12, 2004 RNPR, the Board finds that it does not have jurisdiction to hear Marin General's appeal of this issue.

This conclusion is consistent with the United States Court of Appeals for the District of Columbia Circuit's decision in *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case, the Court held that when a fiscal intermediary[2] reopens it original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on

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

reopening and does not extend further to all determinations underlying the original NPR. In *Emanuel Medical Center, Inc. v. Sebelius,* 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014) the District Court held that the Secretary's "issue-specific" interpretation of the NPR reopening regulation was reasonable and stated that it was "not persuaded" that any change to an element of the DSH adjustment calculation serves to establish that all of the DSH elements have been reconsidered.

In the instant appeal, while Marin General has shown that the Medicare contractor adjusted its DSH calculation generally within its November 12, 2004 RNPR, it has not demonstrated that its dual eligible days were "revisited on reopening" or, in fact, adjusted in any way. The Board, therefore, finds that as Marin General has filed its dual eligible days appeal from an RNPR that does not show a specific adjustment to dual eligible days, it lacks the jurisdiction to hear Marin General's appeal of this issue and hereby dismisses Marin General from this CIRP group.

Jurisdiction for Participant 3, Alta Bates Summit Medical Center

According to the information contained within Sutter Health's July 27, 2010 Jurisdictional Documentation, Participant 3, Alta Bates, filed its FYE December 31, 1994 appeal based on its February 4, 2008 RNPR. The February 4, 2008 RNPR states that the Medicare contractor reopened Alta Bates' FYE December 31, 1994 cost report in order to incorporate a directive from CMS described as a "Mandamus Action: Settlement Agreement Regarding Disproportionate Share Hospital Payments . . ."[3] Within its June 6, 2008 Request for Hearing, Alta Bates cited to Audit Adjustment Numbers 1 and 3 in describing its "DSH—Dual Eligible Days" issue. However, according to Alta Bates' corresponding Audit Adjustment Report, Audit Adjustment 1 "adjust[ed] the Medi-Cal eligible days to agree with the audited amounts and to adjust for the Medi-Cal labor & delivery room days[,]" and Audit Adjustment 3 "adjust[ed] the disproportionate share adjustment based on the audited Medi-Cal eligible days." Considering all this information, Alta Bates is able to show that the Medicare contractor adjusted Medi-Cal Days and DSH generally within its February 4, 2008 RNPR, but not that its dual eligible days were specifically adjusted during the reopening.

Based on the analysis set out above, the Board finds that as Alta Bates filed its FYE December 31, 1994 appeal of dual eligible days from an RNPR that does not show a specific adjustment to dual eligible days, the Board lacks the jurisdiction to hear Alta Bates' appeal of this issue, as contained within its FYE December 31, 1994 appeal,[4] and hereby dismisses Alta Bates' from this CIRP group.

Request for Case Bifurcation

The Board acknowledges that at the time that Sutter Health's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days

[3] Emphasis omitted.
[4] This CIRP group also contains an appeal of Alta Bates' FYE December 31, 1993 cost report filed from its June 28, 1996 original notice of program reimbursement. This appeal remains within this group.

therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that Alta Bates added the dual eligible days issue to its individual appeal of its FYE December 31, 1993 cost report using a broad issue statement that encompassed both Part A non-covered days and HMO days.

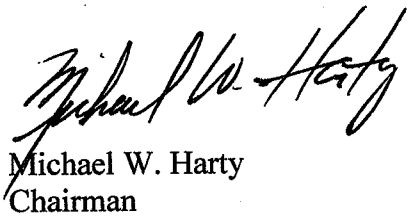
Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2486GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[5] The Board is, therefore, bifurcating Alta Bates' dual eligible Part A non-covered and HMO days issues contained within its FYE December 31, 1993 cost report appeal into separate cases. Alta Bates' HMO days issue is being transferred to the newly formed PRRB Case No. 16-0445GC. Alta Bates' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the CMS 1498-R. The Board's Remand Letter for the instant appeal is included as an enclosure along with this determination.

As the Board has determined that it does not have jurisdiction over Marin General's appeal of its FYE December 31, 1993 cost report and Alta Bates' appeal of its FYE December 31, 1994 cost report, these two participant appeals are excluded from the newly formed HMO days appeal and not included in the dual eligible Part A non-covered days issue remand for the instant appeal.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 22, 2010
Standard Remand Letter for PRRB Case No. 08-2486GC

cc: Wilson Leong, Federal Specialized Services

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

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CERTIFIED MAIL

DEC 30 2015

Jordan B. Keville
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2799

RE: Orange Coast Memorial Medical Center
Provider No.: 05-0678
FYE: 6/30/05
PRRB Case No.: 08-0439

Dear Mr. Keville and Mr. Lowe,

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's request to transfer the Dual Eligible Days issue to group appeals and withdraw the case. The Board's determination is set forth below.

Background

The Provider timely filed an appeal on December 20, 2007 from a Notice of Program Reimbursement ("NPR") dated July 3, 2007. The Provider initially raised four issues in its appeal request and subsequently raised a fifth issue by letter dated July 2, 2008 as follows;

1. Supplemental Security Income ("SSI") Percentage;
2. Medicaid Percentage – Medicaid Eligible Days;
3. Unbilled Crossover Bad Debts;
4. Settlement Data;
5. Rural Floor Budget Neutrality Adjustment ("RFBNA).

The Board remanded the DSH SSI issue to the Medicare Contractor on May 30, 2014 pursuant to CMS Ruling 1498-R. The Provider subsequently requested a remand for the Labor and Delivery Room ("LDR") Days issue, but on December 7, 2015, the Board found that it did not have jurisdiction over LDR days as this issue had not been timely raised or added to the appeal.

The Provider requested transfer of the RFBNA issue to Case No. 07-2252G and the Crossover Bad Debt issue to Case No. 14-0612GC. In November 2015, the Provider also requested to transfer the Dual Eligible Days issue to two cases: PRRB Case No. 13-3960GC – MHS 7/1/2003 – 9/20/2004 Dual Eligible CIRP Group for the Provider's cost reporting period from 7/1/04 to 9/30/04 and PRRB Case No. 09-2232GC – MHS 10/1/2004 – 2007 Dual Eligible CIRP Group for the Provider's cost reporting period from 10/1/04 to 6/30/05.

The Provider submitted a letter dated November 30, 2015 (received December 1, 2015), in which the Provider requested to withdraw its appeal in its entirety "because the parties have agreed in principal that the issues remaining in the case can be administratively resolved." The Provider conditioned the withdrawal on two points:

- pursuant to Board Rule 46.2, the right to reinstate the case if administrative resolution is not reached and implemented; and
- the transfer of certain issues to established group appeals.

Board's Decision

Upon review of the record in this appeal, the Board finds that the Dual Eligible Days issue was not specifically raised in the original appeal request, nor subsequently added to the appeal. As such, the Board does not have jurisdiction over the issue as it not properly in the appeal. Accordingly, the Board denies the Provider's request to transfer the Dual Eligible Days issue to PRRB Case Nos. 13-3960GC and 09-2232GC. The Board acknowledges the proper transfers of the RFBNA issue to Case No. 07-2252G and the Crossover Bad Debt issue to Case No. 14-0612GC.

As to the conditional withdrawal, the Board notes that Board Rule 48 addresses the withdrawal of an appeal, specifically:

> A Provider's request to withdraw an issue(s) or case must be in writing. It is the Provider's responsibility to withdraw: (1) an issue(s) or case that the Provider no longer intends to pursue; (2) an issue(s) or case in which an administrative resolution has been executed and attach a copy of such administrative resolution; (3) an issue(s) for which the Intermediary has agreed to reopen the final determination for that issue(s) and attach a copy of the correspondence from the Intermediary where the Intermediary agreed to that reopening; and (4) a case in which all issues have been handled, whether by resolution, transfer, dismissal, or withdrawal.[1]

In addition, Board Rule 46.2A, addressing reinstatements for administrative resolutions, states:

> Upon written motion, the Board will grant reinstatement of an issue(s)/case if an issue(s)/case was withdrawn as a result of an administrative resolution in which the Intermediary agreed to reopen a final determination under appeal with the Board but failed to issue a new final determination (e.g., Revised NPR) for that issue(s) as agreed. In its motion for reinstatement, the Provider must attach a copy of the relevant administrative resolution.[2]

In this case, the Provider states that there is an "agreement in principal" but it appears that the parties have not yet executed an administrative resolution. If it has been executed, the Provider did not furnish a copy as required by Rule 48. The Board hereby closes Case No. 08-0439 per the Provider's withdrawal

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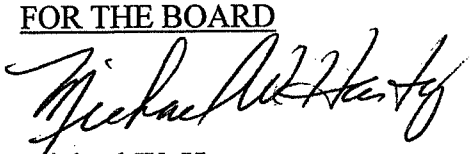
[1] PRRB Rules (Jul. 1, 2015) (emphasis added). *See* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRULES_07_01_2015.pdf.
[2] *Id.*

request. However, as a fully executed administrative resolution was not submitted, the Board finds that the Provider's withdrawal request did not comply with the requirements as set forth in Board Rule 48.

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
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: James Lowe
Cahaba Safeguard Administrators, LLC
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Morrisville, NC 27560-2008

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

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Refer to: 09-1612G

DEC 31 2015

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Partner
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Washington DC 20004

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

RE: Jurisdictional Decision
Morgan Lewis 2001-2007 DSH SSI Group
FYEs: Various
PRRB Case No.: 09-1612GC

Dear Mr. Shay and Mr. Lamprecht,

The Provider's representative was notified on August 8, 2013 that this appeal was subject to remand under CMS Ruling 1498-R and that they were required to submit a schedule of providers with supporting documentation for the Board to make a decision as to which Providers had jurisdictionally valid appeals. The Schedule of Providers was submitted on September 13, 2013.

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

Board's Decision

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

Participant Nos. 1, 2, 4, 8, and 10 (University of Colorado Hospital (provider no. 06-0024) FYEs 2001 - 2003, 2005 - 2006) only submitted two documents in the RSOP: a "Proposed Joint Scheduling Order;" and a "Model Form D – Request to Transfer Issue to a Group Appeal." Without having the Notice of Program Reimbursement ("NPR"), the individual appeal request, and the audit adjustment report, the Board is unable to determine whether each appeal: 1) was timely; 2) raised the SSI percentage issue; 3) concerned an original or revised NPR, and therefore which standard to apply; and 4) concerned an adjustment that would satisfy the revised NPR standard, if applicable.

Participant Nos. 3 and 5 (Nebraska Medical Center (provider no. 28-013) FYE 2002 and 2003) only submitted two documents in the RSOP: an individual appeal request; and a "Model Form D – Request to Transfer Issue to a Group Appeal." Without having the NPR and the audit adjustment report, the Board is unable to determine whether each appeal: 1) was timely; 2) concerned an original or revised NPR, and therefore which standard to apply; and 3) concerned an adjustment that would satisfy the revised NPR standard, if applicable.

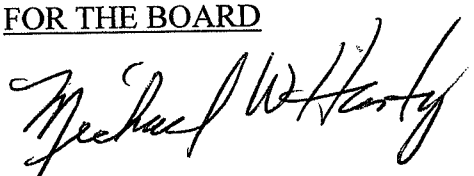
Participant No. 12 (University of Colorado Hospital (provider no. 06-0024) FYE 2007) failed to submit its individual appeal request. The only documents submitted by Participant No. 12 were: a letter requesting the transfer of the individual appeal into this group; a "Model Form D – Request to Transfer Issue to a Group Appeal;" the NPR; a "Model Form A – Individual Appeal Request;" and a cover letter stating that the individual appeal was attached, but without the actual individual appeal. Without having the individual appeal request, the Board is unable to determine whether the individual appeal raised the SSI percentage issue.

The Board hereby dismisses providers 1, 2, 3, 4, 5, 8, 10 and 12 as they did not provide adequate documentation for the Board to determine if their appeals of the SSI% were jurisdictionally valid. The remaining providers are subject to CMS Ruling 1498-R and will be addressed under separate cover.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Federal Specialized Services
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Refer to: 08-2436GC

DEC 31 2015

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

RE: Request for Case Bifurcation
St. Joseph Health System 2000 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2436GC

Dear Mr. Knight and Ms. Alcantara:

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

Background

On July 21, 2008, the Board received Sutter Health's request to form a CIRP group comprised of two initial participants that were previously participants in an optional group appeal.[1] The Board requested an updated Schedule of Providers to include a Provider that was transferred into the group after the initial Schedule, which it received on December 2015. On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon")[2] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2003), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Jurisdiction for Participant 3

The Board finds that it does not have jurisdiction over Participant 3, Santa Rosa Memorial

[1] Providers were previously in case numbers 04-1731G (Toyon 2000 DSH Dual Eligible Days Group.
[2] Toyon is the representative for Sutter Health's appeal.

Hospital (provider no. 05-0174, FYE 6/30/1999) because there were no documents submitted to establish that the Provider filed a jurisdictionally valid appeal. When the Board asked for an updated Schedule of Providers, this Provider was added, but there were no supporting documents included. As the Board cannot make a determination that this Provider filed a jurisdictionally valid appeal it is hereby dismissed from PRRB Case No. 08-2436GC.

Request for Case Bifurcation

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

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2432GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The Providers' Part C issue is now within newly formed PRRB Case No. 16-0506GC. 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. 16-0506GC are included as enclosures along with this determination.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated December 15, 2015
Group Acknowledgment Letter for PRRB Case No. 16-0506GC
Standard Remand Letter for PRRB Case No. 08-2436GC

cc: Wilson Leong, Federal Specialized Services

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

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

CERTIFIED MAIL

DEC 31 2015

Davis Wright Tremaine LLP
Kathleen Houston Drummy
865 South Figueroa Street
Suite 2400
Los Angeles, CA 90017-2566

RE: Cedars-Sinai Medical Center, PRRB Case No. 04-2297
Standard Remand of SSI Proxy Issue

Dear Ms. Drummy:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal which is subject to remand under CMS Ruling 1498-R. The Board has found jurisdictional impediments with regard to three of the fiscal years in the appeal. The pertinent facts for these three fiscal years and the Board's determination are set forth below.

Pertinent Facts:

On September 30, 2004, the Board received Cedars-Sinai Medical Center's request to establish a group appeal for multiple years. On October 14, 2004, the Board acknowledged this request however it established Case No. 04-2297 as an individual appeal for multiple years. The FYEs involved are 1990 through 2004.

By letter dated April 5, 2013, the Board requested that the Provider submit various missing jurisdictional documentation to the Board within 60 days. On August 1, 2013, the Provider filed a revise copy of the SOP with some but not all of the requested documentation.

By letter dated April 21, 2015, the Board listed various deficiencies in the Provider's SOP. The Provider was given 60 days to submit the jurisdictional documentation. The Provider again submitted a revised SOP with jurisdictional documentation on September 8, 2015.

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 Notice of Program Reimbursement (NPR).

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The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (1999) provides in relevant part:

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

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective October 1, 1998, through May 22, 2008, stated:

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

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

The Board finds that the fiscal years listed as numbers 10, 12 and 13 on the Schedule of Providers do not satisfy the applicable jurisdictional and procedural requirements of 42 U.S.C. §1395oo(a), 42 C.F.R. §§405.1835-1840 and 42 C.F.R. § 405.1889. The Provider has not filed a jurisdictionally valid appeal for fiscal years 1999, 2002 and 2003 because they did not submit documentation indicating that the SSI percentage was specifically adjusted on the revised NPRs. Consequently, the Board hereby dismisses these three fiscal year ends from Case No. 04-2297.

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. Enclosed, please find the Board's Standard Remand of the SSI fraction under CMS Ruling-1498-R for the remaining participants in the group 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

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Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877
Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R

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

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

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Refer to: 08-2316

CERTIFIED MAIL DEC 31 2015

Shaw Seely, CPA
Director of Reimbursement
Baptist Health System
800 Prudential Drive
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Geoff Pike
First Coast Service Options, Inc. - FL
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32231-0014

Re: **Baptist Medical Center (10-0088)**
PRRB Case No.: 08-2316
FYE: 09/30/1997

Dear Mr. Shaw:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding Baptist Medical Center's ("Baptist") fiscal year 1997. The Board determined that it lacks jurisdiction in this case. The Board further determined that it will deny Baptist's Request for Reinstatement regarding the Dual Eligible ("DE") and HMO days issues.

Background

Baptist appealed three issues to the Board for fiscal year 1997:

(1) DSH Medicaid Eligible days (including unpaid days)
(2) Capital DSH flow-through
(3) SSI Fraction[1]

Exhibit A of Baptist's Hearing Request was the "Notice of Amount of Change of Program Reimbursement," dated January 7, 2008.[2] Exhibit C listed the audit adjustment numbers being appealed for each issue (audit adjustment numbers 1, 4, and 10 were appealed).[3] Baptist attached its Audit Adjustment Report, which showed that Adjustment 1 "[c]ompleted cost reporting forms and pages in accordance with current regulations," and Adjustments 4 and 10 were entered "[t]o adjust per AR for PRRB Case # 01-2113 Mediation."[4]

[1] Baptist's Hearing Request at 2, Jul. 7, 2008.
[2] *See id.* Ex. A.
[3] *See id.* Ex. C.
[4] *See id.* Ex. B.

Subsequently, Baptist and the Medicare Administrative Contractor, First Coast Service Operations ("First Coast"), filed their respective Preliminary Position Papers with the other party.[5] First Coast filed its Final Position Paper in July 2009.[6] Baptist has not filed its Final Position Paper.[7]

In May 2014, Baptist requested to transfer two issues to new CIRP Groups. It requested to transfer "DSH Payment (Medicaid Ratio) – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days and No Pay Part A Days)/Audit Adjustment No(s).: 1, 4, 10" using Model Form D.[8] Baptist also requested to transfer "DSH Payment – Medicare HMO Days Audit Adjustment No(s).: 1, 4, 10" on a second Model Form D.[9] As a result, the Board established two new cases, Case No. 14-3524GC and Case No. 14-3525GC. Since Baptist never appealed (or added) the issues of DE days and HMO days, the Board denied the transfer requests and closed the new cases since Baptist was the sole provider in those CIRP groups.[10] Additionally, the Board issued a separate Remand Letter for Baptist's SSI Fraction on August 20, 2014.

On May 8, 2015, the Board sent Baptist a Request for Additional Information.[11] The Request stated that, "[o]ur records show that this final determination in this appeal was a revised Notice of Program Reimbursement (RNPR) from a mediation agreement in PRRB appeal 01-2113."[12] The Board requested more documentation (copy of the mediation agreement; workpapers; other proof that the issues under appeal were adjusted in the RNPR; and, a list of any transfers from Case No. 01-2113 to group appeals prior to the withdrawal of Case No. 01-2113) in order to make its jurisdictional determination.[13] Baptist was given 30 days to respond.[14]

On June 1, 2015, Baptist sent in a response to the Board's closing letter and denial of its transfer requests. Baptist states that it believes language included in its Preliminary Position Paper, filed in 2009, addressed DE and HMO days. It requests the Board to reevaluate its prior decision dismissing DE and HMO days.

On June 8, 2015, Baptist e-mailed documents to the Board in response to the Board's Request for Additional Information. One of these documents was the Administrative Resolution ("AR"). The AR shows that the parties in Case No. 01-2113 resolved the issues pending before the Board, including the following:

(1) IME and GME FTE Count

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[5] *See* Baptist's PPP, Mar. 4, 2009; First Coast's PPP, Apr. 20, 2009.
[6] *See* First Coast's FPP, Jul. 2, 2009.
[7] This case is scheduled for a Hearing on May 5, 2016.
[8] Baptist's Model Form D Transfer Request for DE Days, May 21, 2014.
[9] Baptist's Model Form D Transfer Request for HMO Days, May 21, 2014.
[10] Board's Denial of Transfer Requests Letter, Aug. 8, 2014; *see also* Board Closing Case Nos. 14-3524GC and 14-3525GC Letter, Aug. 13, 2014.
[11] Board Request for Additional Information Email, May 8, 2015.
[12] *Id.*
[13] *Id.*
[14] *Id.*

(2) DSH Medicaid Eligible ("ME") days
(3) Outlier Reimbursement
(4) Collection Expense
(5) Private & Semi-private Days & Charges
(6) Subprovider Target Limitation, Bonus and Relief
(7) Capital [DSH] payments
(8) Inpatient Part B 5.8% Reduction
(9) Inclusion of Medicare MSP-LCC Days in GME Reimbursement
(10) Revenue Classification on Worksheet G-2
(11) DSH SSI Percentage[15]

As part of the AR, Baptist agreed to a ME days adjustment that allowed the hospital 19,154 eligible days total. The AR stated that "[t]he parties agree to resolve this issue . . . [and] [t]he [Medicare Contractor] will revise the DSH calculation as the Provider has shown that additional Title XIX eligible days are to be included in the DSH calculation. This issue is resolved in accordance with HCFA-Pub 60A no. A-99-62, and 42 CFR 412.106."[16] Regarding Capital Payments, the AR stated that "[t]here was an adjustment to capital payments on the cost report W/S L at audit. The hospital appealed the capital payments to include the adjustments noted in Issue 1 relative to IME/GME and Issue 2 for DSH. We propose to revise the Hold Harmless Capital Payment amount for ($423,875)."[17] Finally, for the SSI%, the AR stated that "[t]he Provider will transfer this issue to a PRRB group appeal case."[18] The AR also states that:

> The Provider will withdraw all issues and request this [Board] case dismissed. The [Medicare Contractor] will reopen, settle and make payment to the Provider within 180 days of the signing of this administrative resolution. If the [Medicare Contractor] fails to properly effectuate this [AR,] the Provider may reinstate the appeal.[19]

First Coast issued a RNPR to implement the AR, which is the subject of this appeal.

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. Additionally, appeals stemming from RNPRs have a different set of regulations that apply in the instant case:

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[15] *See id.* at 1-3.
[16] Administrative Resolution ("AR") at 2, Sep. 26, 2007.
[17] *Id.* at 3.
[18] *Id.*
[19] *Id.* at 4.

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
> (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.[20]

Therefore, Baptist may only appeal those items that were specifically revised in its RNPR.

Although ME days and Capital DSH were revised in Baptist's RNPR, the Board finds that Baptist fails to satisfy the requirement that it be "dissatisfied with the final determination."[21] In *Illinois-Masonic Medical Center v. Sebelius*, 859 F. Supp. 2d 137, 145 (D.D.C. 2012), the court upheld the decision to deny jurisdiction because the provider signed an AR and then attempted to appeal an additional set of days that were never presented to the contractor for consideration.[22] The additional 2,244 ME days sought by the provider in that case were outside the scope of review of the RNPR, which was based on an AR.[23] Per that AR, the provider submitted 230 days to be reviewed by the contractor and the contractor allowed 24 of those days.[24] The court held that, as a result of signing the AR, the provider disclaimed any dissatisfaction with the contractor's determination in the RNPR.[25] *Illinois-Masonic* explained that a provider who agreed to the adjustments cannot demonstrate that it was dissatisfied with the matters addressed in the RNPR.[26] In *Illinois-Masonic*, as in the instant case, the contractor expressly stated it was revising the determination to specifically incorporate the AR.[27]

Utilizing the AR process, the parties intended to resolve all of Baptist's previously-appealed issues. Here, the parties agreed to the treatment of ME days and Capital DSH. Further, by signing the AR, Baptist consented to the dismissal of its appeal before the Board.[28] The Board finds that Baptist failed to prove its dissatisfaction with First Coast's treatment of ME days and Capital DSH. The Board hereby dismisses the remaining issues of ME days and

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[20] 42 C.F.R. § 405.1889 (2008).
[21] *See* 42 C.F.R. § 405.1889.
[22] *Illinois-Masonic Medical Center v. Sebelius*, 859 F. Supp. 2d 137, 145 (D.D.C. 2012).
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.* (holding that the Secretary's interpretation—that the scope of the RNPR was limited by operation of the AR—was reasonable).
[27] *Id.* at 146.
[28] *Id.* at 4.

Capital DSH from this case.

Additionally, it should be noted that DSH SSI was not revised during First Coast's reopening.[29] In fact, the AR stated that Baptist was going to transfer the SSI issue to a group appeal. However, the Board previously remanded the SSI issue to the Medicare Contractor and, according to CMS Ruling 1498-R, lacks the jurisdiction to change this action.[30]

Finally, the Board denies Baptist's Reinstatement Request regarding the denial of transfers for DE and HMO days. Baptist argues that, in its Preliminary Position Paper filed with First Coast on March 4, 2009, it "incorporates language under the ***Issue #1: Medicare DSH Reimbursement Based on Medicaid Eligible Days*** caption" to specifically identify DE and HMO days.[31] Baptist includes the pertinent language in its letter:

> - The Intermediary adjustment did not include all Medicaid eligible days as defined in HCFA Ruling No. 97-2 dated February 27, 1997. A comprehensive list of all Medicaid eligible days should include all Medicaid eligible days even if unpaid, patient days applicable to Medicare Managed Care Part C patients who were also eligible for Medicaid, Medi-Medi patient days (patients who are eligible for Medicaid and have days paid and/or covered by Medicare), Medi-Medi patient days for Medicare Part A patients whose Medicare Part A benefits were exhausted but who were still eligible for Medicaid, patient days associated with certain Medicare Part A and Title XIX dual eligible patients that were unpaid by Medicare Part A, Medicaid eligible Florida Charity Care Days and other Medicaid eligible days that were excluded or omitted for other various reasons.
> - The list was revised to exclude days for Medicare/Medicaid dual eligible days.
> - The provider has been consistently prohibited from including any Medicare/Medicaid dual eligible days and many other categories of Medicaid eligible days as listed above. However, the provider believes that Medicaid eligible days with Medicare managed care eligibility and the many other categories of Medicaid eligible days listed above should also be included in the Medicaid fraction or the SSI fraction.[32]

Baptist argues that at the time it filed its appeal and Preliminary Position Paper, "it was generally

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[29] In fact, per the AR, Baptist stated it was transferring the DSH SSI issue from its original appeal (Case No. 02-1710) to a group appeal. Baptist cannot appeal the same issue in more than one appeal. *See* Board Rule 4.5 at 3, Jul. 1, 2009.

[30] In the previous Remand Memorandum to the Board, it was mistakenly identified as an appeal of an original NPR. The Remand Letter was sent on Aug. 20, 2014.

[31] Baptist's Response to Board's Letter, Jun. 1, 2015.

[32] *Id.* at 1.

the practice and assumption that by appealing both [ME days] and [SSI fraction], the provider covered all of these day subsets that were eventually defined as separate appeal issues."[33] Baptist requests a review by the Board and a determination " . . . that the provider is properly includable" in the transfer filings.[34]

Board Rule 11 states that:

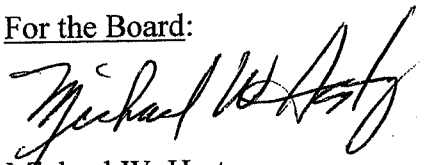
> Subject to the provisions of 42 C.F.R. § 405.1835(c), an issue may be added to an individual appeal if the Provider:
> - timely files a request to the Board to add issues no later than 60 days after the expiration of the applicable 180 days period for filing the hearing request . . . **AND**
> - includes all supporting documentation listed on Model Form C.[35]

The Board did not receive a copy of Baptist's Preliminary Position Paper until June 1, 2015, far past the deadline to add any issues to the appeal. The Board finds that this is not a valid and timely addition of an issue under Board Rules. Baptist further failed to follow Board Rules requiring issue specificity in identifying what issues are under appeal.[36] Notwithstanding Baptist's failure to follow Board Rules, neither DE nor HMO days were specifically revised in its RNPR. Therefore, the Board determines that it will deny any Reinstatement Request for these issues.

With these findings, the Board dismisses Case No. 08-2316. Review of this 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

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

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[33] *Id.* at 2.
[34] *Id.*
[35] Board Rule 11.1 at 9, March 1, 2013 (emphasis in original).
[36] *See* Board Rules 7 and 7.1 at 6.

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Refer to: 09-1612G

DEC 31 2015

CERTIFIED MAIL

Albert W. Shay
Morgan, Lewis & Bockius LLP
Partner
1111 Pennsylvania Avenue, NW
Washington DC 20004

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

RE: Jurisdictional Decision
Morgan Lewis 2001-2007 DSH SSI Group
FYEs: Various
PRRB Case No.: 09-1612GC

Dear Mr. Shay and Mr. Lamprecht,

The Provider's representative was notified on August 8, 2013 that this appeal was subject to remand under CMS Ruling 1498-R and that they were required to submit a schedule of providers with supporting documentation for the Board to make a decision as to which Providers had jurisdictionally valid appeals. The Schedule of Providers was submitted on September 13, 2013.

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

Board's Decision

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

Participant Nos. 1, 2, 4, 8, and 10 (University of Colorado Hospital (provider no. 06-0024) FYEs 2001 - 2003, 2005 - 2006) only submitted two documents in the RSOP: a "Proposed Joint Scheduling Order;" and a "Model Form D – Request to Transfer Issue to a Group Appeal." Without having the Notice of Program Reimbursement ("NPR"), the individual appeal request, and the audit adjustment report, the Board is unable to determine whether each appeal: 1) was timely; 2) raised the SSI percentage issue; 3) concerned an original or revised NPR, and therefore which standard to apply; and 4) concerned an adjustment that would satisfy the revised NPR standard, if applicable.

Participant Nos. 3 and 5 (Nebraska Medical Center (provider no. 28-013) FYE 2002 and 2003) only submitted two documents in the RSOP: an individual appeal request; and a "Model Form D – Request to Transfer Issue to a Group Appeal." Without having the NPR and the audit adjustment report, the Board is unable to determine whether each appeal: 1) was timely; 2) concerned an original or revised NPR, and therefore which standard to apply; and 3) concerned an adjustment that would satisfy the revised NPR standard, if applicable.

Participant No. 12 (University of Colorado Hospital (provider no. 06-0024) FYE 2007) failed to submit its individual appeal request. The only documents submitted by Participant No. 12 were: a letter requesting the transfer of the individual appeal into this group; a "Model Form D – Request to Transfer Issue to a Group Appeal;" the NPR; a "Model Form A – Individual Appeal Request;" and a cover letter stating that the individual appeal was attached, but without the actual individual appeal. Without having the individual appeal request, the Board is unable to determine whether the individual appeal raised the SSI percentage issue.

The Board hereby dismisses providers 1, 2, 3, 4, 5, 8, 10 and 12 as they did not provide adequate documentation for the Board to determine if their appeals of the SSI% were jurisdictionally valid. The remaining providers are subject to CMS Ruling 1498-R and will be addressed under separate cover.

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

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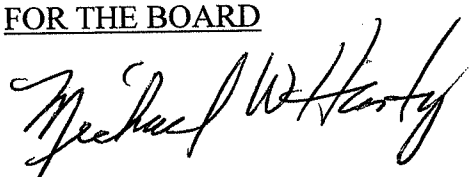
Jack Ahern, MBA

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: Federal Specialized Services
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Refer to:

07-2841G

DEC 31 2015

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National Government Services, Inc.
Kyle Browning, Manager
MP: INA 102-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: QRS 02 DSH/Medicaid Proxy Group 2
Provider No: 06-0022
FYE: 12/31/2002
PRRB Case No.: 07-2841G

Dear Mr. Ravindran and Mr. Browning,

The Provider Reimbursement Review Board (hereinafter "Board") has reviewed the jurisdictional documents in this appeal. The decision of the Board with regard to jurisdiction is set forth below.

BACKGROUND

The Providers filed this group appeal in September, 2007, stating the issue as

> The provider contends that the Fiscal Intermediary did not determine Medicare reimbursement for disproportionate share hospitals (DSH) in accordance with the statutory instructions at 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). Specifically, the provider disagrees with the calculation of the second computation of the disproportionate share patient percentage, set forth at 42 C.F.R. 412.106(b)(4) of the Secretary's regulations. The intermediary, contrary to the regulation, failed to include as Medicaid-Eligible Days services to patients eligible for Medicaid.

The Providers submitted a final Schedule of Providers (dated January 15, 2013) which listed five Participants in the appeal. In July, 2013, the Medicare Contractor filed a jurisdictional challenge and the Providers subsequently responded to the challenge on September 5, 2013. In their response the Providers requested that Participant No.2 (Middlesex Memorial Hospital, Provider No. 07-0020, FYE 09/30/2002) and Participant No. 3 (Danbury Hospital, Provider No. 07-0033, FYE 09/30/2002) be withdrawn from the appeal. On December 18, 2015, the Providers notified the Board that Participant No. 4 (Leesburg Regional Medical Center, Provider No. 10-0084, FYE 06/30/20020 and Participant No. 5 (Wuestoff Medical Center, Provider No. 10-0092, FYE 09/30/2002) are also withdrawn from the appeal. The sole remaining Provider in the appeal is now Participant No. 1, Memorial Hospital Central, Provider No. 06-0022, FYE 12/31/2002, and the Provider representative has requested that the Board rule on the Medicare Contractor's jurisdictional challenge regarding this Provider.

MEDICARE CONTRACTOR'S POSITION

The Medicare Contractor states the Board should deny jurisdiction for the Medicaid eligible days issue for Memorial Hospital Central in accordance with 42 C.F.R. § 405.1835 and 42 C.F.R. § 405.1840. The Medicare Contractor contends it accepted the Medicaid days as claimed by the Provider, and that Medicaid paid and eligible days were not adjusted during the settlement of the Medicare cost report. Therefore, the Medicare Contractor asserts that this issue cannot be included in the Providers appeal and this Provider should be removed from the group.

PROVIDER'S POSITION

Memorial Hospital Central contends in its jurisdictional response that the Medicare Contractor's argument is incorrect, and that the appeal clearly states that the Medicare Contractor has failed to include all Medicaid eligible days contrary to the regulation. Memorial Hospital Central also argues in its jurisdictional response that HCFA Ruling 97-2 made the distinction between Medicaid paid and unpaid days irrelevant, and per the Ruling, the only relevant factor for inclusion in the Medicaid Proxy of the DSH calculation is Medicaid eligibility regardless of paid or unpaid status.

Then, in its December 18, 2015 letter, the Provider clarifies that "it is not pursuing any Medicaid eligible days paid by the State and is in agreement with the [Jurisdictional] Challenge that only unclaimed Medicaid eligible days NOT paid by the State will be pursued."

BOARD'S DECISION

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835 – 1841 (2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it

is dissatisfied with the final determination of the Medicare contractor's, 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 after the date of receipt by the provider of the Medicare contractor determination. 42 U.S.C. §1395oo(a) provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its [Medicare contractor] pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report.

There is no evidence in the record to indicate that Memorial Hospital Central claimed the Medicaid eligible days it now seeks on its FYE 12/31/2002 cost report.

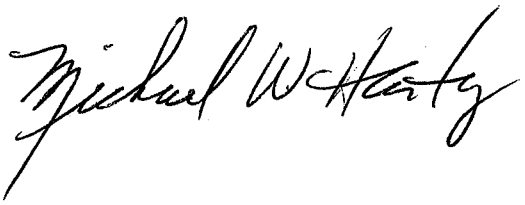
Pursuant to the rationale in *Barberton Citizens Hosp. vs. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015)(*"Barberton"*), the Board can take jurisdiction over a hospital's appeal of additional Medicaid eligible days for the DSH adjustment calculation if that hospital can establish a "practical impediment" as to why it could not claim these days at the time that it filed its cost report (*i.e.*, the fact that only Medicaid eligible days verified by the State can be claimed on the cost report and that the hospital, through no fault of its own, was unable to verify the Medicaid eligible days at issue from States' records prior to filing its cost report due to lack of availability or access to the relevant State records). Based on the record in this case, the Board finds that Memorial Hospital Central has not established that there was a practical impediment that prevented it from claiming the additional Medicaid eligible days it now seeks on its cost reports for FYE 12/31/2002.

The Board concludes that it does not have jurisdiction over Memorial Hospital Central's claim of additional Medicaid eligible days, that the Provider has not met the "practical impediment" standard of the *Barberton* case, and Memorial Hospital Central is dismissed from this appeal.

This case is now closed as there are no remaining Providers in the appeal. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte 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: 10-0351G

Certified Mail

DEC 31 2015

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

RE: Toyon 2009-2010 SCH Hospital Specific Rate Rebasing Group
Provider Nos. Various
FFY 2009-2010
PRRB Case No. 10-0351G

Dear Mr. Knight:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 1, 2011 comments responding to the Board's October 6, 2011 notice that it was considering finding that own motion expedited judicial review (EJR) was appropriate for the issue under appeal. The Board final decision with respect to EJR is set forth below.

Issue Under Appeal

Whether the Sole Community Hospital (SCH) Hospital Specific Rate (HSR) calculated by the Intermediary or Medicare Administrative Contractor (MAC) is accurately stated in accordance with Section 122 of the Medicare Improvements for Patients and Providers Act of 2008?[1]

Background: SCH Rebasing

An 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.[2] Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110-275) provided an option for SCHs to rebase their HSR including data from their 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.[3]

The August 19, 2008 Federal Register ("August 2008 Final Rule), which published the final inpatient prospective payment system (IPPS) rule for 2009, 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

[1] Providers' January 4, 2010 Hearing Request, Tab 2.
[2] *See* 42 U.S.C. § 1395ww(d)(5)(D)(iii).
[3] 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. 72 Fed. Reg. 48434, 48630 (Aug. 19, 2008).

case, that was the updated HSR based on the FY 2006 costs per discharge.[4] 42 C.F.R. § 412.78(j) requires an adjustment to the 2006 HSR "in the manner set forth in §412.77(j)."[5] CMS promulgated §412.77(j) in the Final Rule published on August 12, 2005 ("August 2005 Final Rule").[6] In the preamble to the August 2005 Final Rule, CMS established the cumulative nature of this adjustment by stating that the Budget neutrality adjustment for a particular year "is made without removing the Budget neutrality adjustment for the prior year."[7] The CMS Medicare Claims Processing Manual[8] instruction issued October 3, 2008 initially directed intermediaries to apply the 2007 budget neutrality factor to the providers' 2006 cost report data. Later, in the August 27, 2009 Federal Register, the Secretary[9] 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 DRG changes *since FY 1993* in determining an SCH's [HSR] based on . . . FYE 2006 cost data."[10] These instructions had been furnished in a Joint Signature Memorandum (JSM), JSM/TDL-09052 issued on November 17, 2008, shortly after the August 2008 Final Rule.

Position of the Provider

The Providers explain that this appeal concerns the calculation of the Providers' HSR for their 2006 base years. By statute, the Providers' HSR for their 2006 base year must reflect "100 percent" of their "allowable operating costs" per discharge for that year. The Intermediaries did not use 100 percent of those costs. The Providers assert that, in violation of the statutes plain command, the Intermediaries included less than 98 percent of the Providers' allowable operating costs for the 2006 base year.

The Providers believe the Intermediaries took this action as the result of the issuance of a Joint Signature Memorandum which directed Intermediaries to reduce the 2006 base year HSRs, used to determine payments beginning in 2009, by applying a "budget neutrality" adjustment reflecting the cumulative effect of the budget neutrality adjustments that were applied to the prospective payment system rates in prior years dating back to 1993. The Providers protest this action, claiming that the budget neutrality adjustment was not neutral at all, but produced HSRs that were less than 98 percent of allowable costs for the 2006 base year and reduced payments in 2009 and forward.[11]

The Providers believe that the Board has the authority to grant the relief sought and EJR, therefore, is not appropriate. The Providers do not believe that there is nothing in the regulation, 42 C.F.R. 412.78, dealing with the calculation of the HSR that authorizes or requires CMS to the intermediaries to reduce the 2006 HSR by applying a cumulative, prior year budget neutrality adjustment for past adjustments to the IPPS rates for DRG and wage index changes since 1993.[12] They believe that the only authority for this action is the Joint Signature Memorandum.[13]

Decision of the Board

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[4] 73 Fed. Reg. 48434, 48630, 48754 - 48755 (Aug. 19, 2008).
[5] Promulgated at 73 Fed. Reg. 48754 - 48755.
[6] 70 Fed. Reg. 47278, 47485 (Aug. 12, 2005).
[7] 70 Fed. Reg. at 47430.
[8] CMS Manual (CMS Pub. 100-04), Transmittal 1610 (Change Request 6189).
[9] of the Department of Health and Human Services
[10] 74 Fed. Reg. at 43895.
[11] Providers' March 25, 2011 Preliminary Position Paper at 1-2.
[12] Providers' December 1, 2011 Comments Regard Proposed EJR at 1.
[13] *Id.* at 2.

The Board has reviewed the Providers' comments regarding EJR and jurisdictional documents. The regulation, 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 Providers timely filed their requests for hearing and the amount in controversy exceeds the $50,000 threshold for a group appeal.[14] 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 a rate published in the Federal Register and its implementation in the Notice of Re-Basing.[15] The Board is bound by this regulation and the publication of these notices in Federal Register.[16] 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' reimbursement 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 years 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 on its own motion for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

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

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[14] *See* 42 C.F.R. §§ 405.1837(a)(3).
[15] *See* 42 C.F.R. § 412.78(h).
[16] *See Washington Hospital Center v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ([A] year end cost report is not a report necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal) and *District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1), Schedule of Providers

cc: Evaline Alcanara, Noridian Healthcare Solutions (w/Schedule of Providers)
Wilson C. Leong, Federal Specialized Services (w/Schedule of Providers)

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Refer to: 09-1864GC

Certified Mail

DEC 31 2015

Laurence D. Getzoff, Esq.
Hooper, Lundy & Bookman
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

RE: HCA 2010 Sole Community Re-basing Group
Provider Nos. Various
FFY 2010
PRRB Case No. 09-1864GC

Dear Mr. Getzoff:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' comments regarding the Board's proposed own motion expedited judicial review (EJR) and the parties' comments with respect to the Board's jurisdiction over the issue under appeal. Set forth below is the Board's decision with respect to both the proposed EJR and jurisdiction.

Issue Before the Board

Whether the rebasing of each Provider's hospital-specific rate (HSR) using its fiscal year (FY) 2006 Medicare cost report properly included prior year budget neutrality factors in the calculation[1]

Background: SCH Rebasing

An 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.[2] Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110-275) provided an option for SCHs to rebase their HSR including data from their 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.[3]

The August 19, 2008 Federal Register ("August 2008 Final Rule), which published the final inpatient prospective payment system (IPPS) rule for 2009, 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.[4] 42 C.F.R. § 412.78(j) requires an adjustment to the 2006 HSR "in the manner set forth in §412.77(j)."[5] CMS promulgated

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[1] Providers' June 5, 2009 Hearing Request, Tab 3at 1.
[2] *See* 42 U.S.C. § 1395ww(d)(5)(D)(iii).
[3] 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. 72 Fed. Reg. 48434, 48630 (Aug. 19, 2008).
[4] 73 Fed. Reg. 48434, 48630, 48754 - 48755 (Aug. 19, 2008).
[5] Promulgated at 73 Fed. Reg. 48754 - 48755.

§412.77(j) in the Final Rule published on August 12, 2005 ("August 2005 Final Rule").[6] In the preamble to the August 2005 Final Rule, CMS established the cumulative nature of this adjustment by stating that the Budget neutrality adjustment for a particular year "is made without removing the Budget neutrality adjustment for the prior year."[7] The CMS Medicare Claims Processing Manual[8] instruction issued October 3, 2008 initially directed intermediaries to apply the 2007 budget neutrality factor to the providers' 2006 cost report data. Later, in the August 27, 2009 Federal Register, the Secretary[9] 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 DRG changes *since FY 1993* in determining an SCH's [HSR] based on . . . FYE 2006 cost data."[10] These instructions had been furnished in a Joint Signature Memorandum (JSM), JSM/TDL-09052 issued on November 17, 2008, shortly after the August 2008 Final Rule.

Providers' Position

The Providers explained that CMS directed Medicare contractors to calculate a new HSR for SCH by adjusting their 2006 actual, audited costs. Initially, the agency specified that the actual 2006 costs were to be adjusted by the FY 2007 update factor and the FY 2007 budget neutrality factor in order to compare 2007 rates in the provider-specific file. Then CMS revised its instructions with the that an addition 14 years of budget neutrality factors—factors predating the 2006 actual costs—would be applied to 2006 costs.

The Providers contend that this method of calculating the updated HSR is erroneous for two reasons. First, there is nothing in the statute that demands or even suggests such a calculation. Second, the application of the prior-year budget neutrality factors to the actual 2006 cost cannot be justified. The 2006 actual costs came into being after the prior years, they were actual costs and the Providers assert that they should not be reduced by budget neutrality factors related to earlier years. The Providers argue that EJR is not appropriate because they believe that the Board can decide the question of a particular budget neutrality factor at issue is authorized by statute.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and comments regarding EJR. The regulation, 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 Providers timely filed their requests for hearing and the amount in controversy exceeds the $50,000 threshold for a group appeal.[11] Consequently, the Board has determined that it has jurisdiction over the appeals.[12] This issue involves a challenge to the validity 42 C.F.R § 412.77(j) and of

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[6] 70 Fed. Reg. 47278, 47485 (Aug. 12, 2005).
[7] 70 Fed. Reg. at 47430.
[8] CMS Manual (CMS Pub. 100-04), Transmittal 1610 (Change Request 6189).
[9] of the Department of Health and Human Services
[10] 74 Fed. Reg. at 43895.
[11] *See* 42 C.F.R. §§ 405.1837(a)(3).
[12] The Board notes that in a December 2, 2011 jurisdictional brief, the Medicare Contractor filed an objection to jurisdiction over the application budget neutrality adjustment based on the provisions of 42 C.F.R. § 405.1804. This regulation barred Board review of budget neutrality adjustments. However, this regulation has been revised, permitting the Board to review budget neutrality adjustments of the type under appeal in this case. *See* 78 Fed. Reg. 74,826, 75,163 and 75,198 (December 10, 2013). *See also New Republic Bank of Miami v. U.S.*, 506 U.S. 80, 100-

a rate published in the Federal Register and its implementation in the Notice of Re-Basing. The Board is bound by this regulation and the publication of these notices in final rules in the Federal Register. 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' reimbursement 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

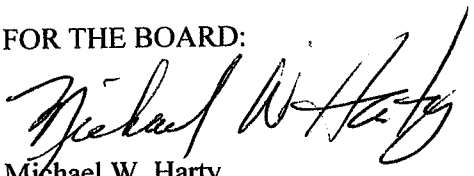
3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867).

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 on its own motion for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1), Schedule of Providers

cc: Byron Lamprecht, Wisconsin Physicians Service (w/Schedule of Providers)
Wilson C. Leong, Federal Specialized Services (w/Schedule of Providers)

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102 (1992) (newly enacted laws enlarging jurisdiction are applied to cases before the tribunal at the time of enactment, even though the law governing jurisdiction at the time of the event was different.)

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Refer to: 10-0352GC

Certified Mail

DEC 31 2015

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

RE: CHW 2009-2010 SCH HSR Rebasing Group
Provider Nos. Various
FFY 2009-2010
PRRB Case No. 10-0352GC

Dear Mr. Knight:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' December 1, 2011 comments responding to the Board's October 6, 2011 notice that it was considering finding that own motion expedited judicial review (EJR) was appropriate for the issue under appeal. The Board final decision with respect to EJR is set forth below.

Issue Under Appeal

Whether the Sole Community Hospital (SCH) Hospital Specific Rate (HSR) calculated by the Intermediary or Medicare Administrative Contractor (MAC) is accurately stated in accordance with Section 122 of the Medicare Improvements for Patients and Providers Act of 2008?[1]

Background: SCH Rebasing

An 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.[2] Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110-275) provided an option for SCHs to rebase their HSR including data from their 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.[3]

The August 19, 2008 Federal Register ("August 2008 Final Rule), which published the final inpatient prospective payment system (IPPS) rule for 2009, 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

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[1] Providers' January 4, 2010 Hearing Request, Tab 2.
[2] *See* 42 U.S.C. § 1395ww(d)(5)(D)(iii).
[3] 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. 72 Fed. Reg. 48434, 48630 (Aug. 19, 2008).

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.[4] 42 C.F.R. § 412.78(j) requires an adjustment to the 2006 HSR "in the manner set forth in §412.77(j)."[5] CMS promulgated §412.77(j) in the Final Rule published on August 12, 2005 ("August 2005 Final Rule").[6] In the preamble to the August 2005 Final Rule, CMS established the cumulative nature of this adjustment by stating that the Budget neutrality adjustment for a particular year "is made without removing the Budget neutrality adjustment for the prior year."[7] The CMS Medicare Claims Processing Manual[8] instruction issued October 3, 2008 initially directed intermediaries to apply the 2007 budget neutrality factor to the providers' 2006 cost report data. Later, in the August 27, 2009 Federal Register, the Secretary[9] 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 DRG changes *since FY 1993* in determining an SCH's [HSR] based on . . . FYE 2006 cost data."[10] These instructions had been furnished in a Joint Signature Memorandum (JSM), JSM/TDL-09052 issued on November 17, 2008, shortly after the August 2008 Final Rule.

Position of the Provider

The Providers explain that this appeal concerns the calculation of the Providers' HSR for their 2006 base years. By statute, the Providers' HSR for their 2006 base year must reflect "100 percent" of their "allowable operating costs" per discharge for that year. The Intermediaries did not use 100 percent of those costs. The Providers assert that, in violation of the statutes plain command, the Intermediaries included less than 98 percent of the Providers' allowable operating costs for the 2006 base year.

The Providers believe the Intermediaries took this action as the result of the issuance of a Joint Signature Memorandum which directed Intermediaries to reduce the 2006 base year HSRs, used to determine payments beginning in 2009, by applying a "budget neutrality" adjustment reflecting the cumulative effect of the budget neutrality adjustments that were applied to the prospective payment system rates in prior years dating back to 1993. The Providers protest this action, claiming that the budget neutrality adjustment was not neutral at all, but produced HSRs that were less than 98 percent of allowable costs for the 2006 base year and reduced payments in 2009 and forward.[11]

The Providers believe that the Board has the authority to grant the relief sought and EJR, therefore, is not appropriate. The Providers do not believe that there is nothing in the regulation, 42 C.F.R. 412.78, dealing with the calculation of the HSR that authorizes or requires CMS to the intermediaries to reduce the 2006 HSR by applying a cumulative, prior year budget neutrality adjustment for past adjustments to

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[4] 73 Fed. Reg. 48434, 48630, 48754 - 48755 (Aug. 19, 2008).
[5] Promulgated at 73 Fed. Reg. 48754 - 48755.
[6] 70 Fed. Reg. 47278, 47485 (Aug. 12, 2005).
[7] 70 Fed. Reg. at 47430.
[8] CMS Manual (CMS Pub. 100-04), Transmittal 1610 (Change Request 6189).
[9] of the Department of Health and Human Services
[10] 74 Fed. Reg. at 43895.
[11] Providers' May 13, 2011 Preliminary Position Paper at 1.

the IPPS rates for DRG and wage index changes since 1993.[12] They believe that the only authority for this action is the Joint Signature Memorandum.[13]

Decision of the Board

The Board has reviewed the Providers' comments regarding EJR and the jurisdictional documentation. The regulation, 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 Providers timely filed their requests for hearing and the amount in controversy exceeds the $50,000 threshold for a group appeal.[14] 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 a rate published in the Federal Register and its implementation in the Notice of Re-Basing.[15] The Board is bound by this regulation and the publication of these notices in final rules. 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' reimbursement 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 years 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 on its own motion for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

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

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[12] Providers' December 1, 2011 Comments Regard Proposed EJR at 1.
[13] *Id.* at 2.
[14] *See* 42 C.F.R. §§ 405.1837(a)(3).
[15] *See* 42 C.F.R. § 412.78(h) (a Notice of Re-basing is subject to appeal under the provisions of 42 C.F.R. Subpart R).

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1), Schedule of Providers

cc: Evaline Alcanara, Noridian Healthcare Solutions (w/Schedule of Providers
Wilson C. Leong, Federal Specialized Services (w/Schedule of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 10-0167GC

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DEC 31 2015

Christopher L. Keough, Esq.
Akin, Gump Strauss, Hauer & Feld, LLP
Robert S. Strauss Building
1333 New Hampshire Avenue, NW
Washington, D.C. 20036-1564

RE: CHI 2010 SCH Re-basing HSR/Budget Neutrality Group
Provider Nos. Various
FFY 2010
PRRB Case No. 10-0167GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' comments regarding the Board's proposed own motion expedited judicial review (EJR) and the parties comments with respect to the Board's jurisdiction over the issue under appeal. Set forth below is the Board's decision with respect to both the proposed EJR and jurisdiction.

Issue Before the Board

Whether the application of a cumulative budget neutrality adjustment to the Providers' hospital-specific rates for their 2006 base years used for [the] purpose of payments to the Providers is valid.[1]

Background: SCH Rebasing

An 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.[2] Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110-275) provided an option for SCHs to rebase their HSR including data from their 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.[3]

The August 19, 2008 Federal Register ("August 2008 Final Rule), which published the final inpatient prospective payment system (IPPS) rule for 2009, 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.[4] 42 C.F.R. § 412.78(j) requires an adjustment to the 2006 HSR "in the manner set forth in §412.77(j)."[5] CMS promulgated

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[1] Providers' April 28, 2011 Response to Jurisdictional Challenge at 1.
[2] *See* 42 U.S.C. § 1395ww(d)(5)(D)(iii).
[3] 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. 72 Fed. Reg. 48434, 48630 (Aug. 19, 2008).
[4] 73 Fed. Reg. 48434, 48630, 48754 - 48755 (Aug. 19, 2008).
[5] Promulgated at 73 Fed. Reg. 48754 - 48755.

§412.77(j) in the Final Rule published on August 12, 2005 ("August 2005 Final Rule").[6] In the preamble to the August 2005 Final Rule, CMS established the cumulative nature of this adjustment by stating that the Budget neutrality adjustment for a particular year "is made without removing the Budget neutrality adjustment for the prior year."[7] The CMS Medicare Claims Processing Manual[8] instruction issued October 3, 2008 initially directed intermediaries to apply the 2007 budget neutrality factor to the providers' 2006 cost report data. Later, in the August 27, 2009 Federal Register, the Secretary[9] 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 DRG changes *since FY 1993* in determining an SCH's [HSR] based on . . . FYE 2006 cost data."[10] These instructions had been furnished in a Joint Signature Memorandum (JSM), JSM/TDL-09052 issued on November 17, 2008, shortly after the August 2008 Final Rule.

Providers' Position

The Providers explain that Congress amended the statute to grant SCH the option of using "100%" of the 2006 HSR in calculating their payments beginning in 2009.[11] Despite the statutory mandate to use "100%" of the hospital target amount, CMS allegedly reduced the applicable SCH "hospital target amount," to reflect all budget neutrality adjustments prior to the 2006 base year. The Providers contend that the budget neutrality adjustments to the base year should not be applied to the base year HSR because, among other things, the cumulative budget neutrality factor has been calculated in an arbitrary and capricious manner because it includes wage index adjustments that CMS purportedly agrees should not be applied to the HSR going forward.[12] The Providers believe that the plain meaning of the statute prohibits the application of a cumulative budget neutrality factor to the HSR. Rather, they believe, the statute is clear; CMS should use "100 percent of the hospital's target amount" in calculating the SCH payment which is the "allowable operating costs of inpatient hospital services" for the base period.[13]

Further, the Providers argue, even if a cumulative budget neutrality factor should be applied, it was wrongly calculated for at least two reasons. First, CMS agreed to stop applying the wage index portion of the budget neutrality adjustment to the HSR of SCHs, however, many of the years used to calculated the cumulative budget neutrality factor still contain the wage index budget neutrality adjustment. Second, the cumulative budget neutrality adjustment mandated by CMS includes at least one inadequately explained departure from the budget neutrality adjustment mandated in the Federal Register which results in lower payment.[14] The Providers believe that the Board has the power to grant the relief sought in this because no statute or regulation requires or permits CMS to reduce the Providers HSR through the application of budget neutrality adjustments.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and comments regarding EJR. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider whether it lacks the authority to decide

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[6] 70 Fed. Reg. 47278, 47485 (Aug. 12, 2005).
[7] 70 Fed. Reg. at 47430.
[8] CMS Manual (CMS Pub. 100-04), Transmittal 1610 (Change Request 6189).
[9] of the Department of Health and Human Services
[10] 74 Fed. Reg. at 43895.
[11] *See* Providers' November 19, 2009 Hearing Request at 1.
[12] *Id.* at 4.
[13] *Id.*
[14] Id. at 10-11.

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 Providers timely filed their requests for hearing and the amount in controversy exceeds the $50,000 threshold for a group appeal.[15] Consequently, the Board has determined that it has jurisdiction over the appeals.[16] This issue involves a challenge to the validity of 42 C.F.R § 412.77(j) and a rate published in the Federal Register and its implementation in the Notice of Re-Basing. The Board is bound by this regulation and the publication of these notices in final rules in the Federal Register. 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' reimbursement 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 on its own motion for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

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

[16] The Board notes that in a preliminary position paper received May 16, 2011, the Medicare Contractor filed an objection to jurisdiction over the application budget neutrality adjustment based on the provisions of 42 C.F.R. § 405.1804. This regulation barred Board review of budget neutrality adjustments. However, this regulation has been revised, permitting the Board to review budget neutrality adjustments of the type under appeal in this case. *See* 78 Fed. Reg. 74,826, 75,163 and 75,198 (December 10, 2013). *See also New Republic Bank of Miami v. U.S.*, 506 U.S. 80, 100-102 (1992) (newly enacted laws enlarging jurisdiction are applied to cases before the tribunal at the time of enactment, even though the law governing jurisdiction at the time of the event was different.)

Enclosures: 42 U.S.C. § 1395oo(f)(1), Schedule of Providers

cc: Bill Tisdale, Novitas Solutions, Inc. (w/Schedule of Providers)
Wilson C. Leong, Federal Specialized Services (w/Schedule of Providers)

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DEC 31 2015

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RE: Request for Case Bifurcation and Jurisdictional Determination
CHW 1997 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 06-0032GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Catholic Healthcare West ("CHW") 1997 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. Upon review, the Board finds that it does not have jurisdiction over the appeals for Mercy General Hospital (Provider No. 05-0017), Mercy Medical Center Redding (Provider No. 05-0280) and Mercy San Juan Hospital (Provider No. 05-0516). The Board hereby dismisses these participants from this appeal but grants bifurcation of the remaining participants' dual eligible days issue,[1] as explained below.

Background

On October 14, 2005, the Board received CHW's request to form the above-captioned CIRP group. The Board received the Medicare Contractor's Final Position Paper ("FPP") for this appeal on April 25, 2007. Within its FPP, the Medicare Contractor noted jurisdictional "impediments" for two of the group's participants, Dominican Santa Cruz Hospital (Provider No. 05-0242) and Glendale Memorial Hospital (Provider No. 00-0058). The Medicare Contractor states that the Board had previously approved these providers' requests to withdraw their individual appeals: Dominican Santa Cruz Hospital's appeal was closed as of May 24, 2006, and Glendale Memorial Hospital's appeal was closed as of October 8, 2004. On June 7, 2007, the Board received CHW's response ("Response") to the Medicare Contractor's jurisdictional challenges.

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

On July 14, 2010, the Board received CHW's Schedule of Providers and Jurisdictional Documentation for the 12 participants within the instant 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."

Board's Decision

Applicable Regulatory Provisions

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2004), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

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

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

Medicare Contractor's Jurisdictional Challenge to Participants 1 and 2

Participant 1, Dominican Santa Cruz Hospital

As noted prior, within its FPP, the Medicare Contractor raised jurisdictional challenges for Participants 1 (Dominican Santa Cruz Hospital, Provider No. 05-0242) and 2 (Glendale Memorial Hospital, Provider No. 00-0058),[3] stating that the Board had previously approved the providers' requests to withdraw their individual appeals.[4] Within its Response, however, CHW explains that Dominican Santa Cruz Hospital transferred its dual eligible days issue from its individual appeal to PRRB Case No. 04-1728G on October 26, 2006.[5] As this provider was an affiliate of CHW, CHW then requested that the provider be transferred into the instant appeal in an October 26, 2006 letter that CHW included within its July 14, 2010 Jurisdictional Documentation.[6]

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[2] Toyon is CHW's representative in the instant appeal.
[3] These are the numerical designations for these participants on CHW's Schedule of Providers dated July 7, 2010.
[4] April 25, 2007 FPP at 5.
[5] June 7, 2007 Response at 1.
[6] July 14, 2010 Jurisdictional Documentation, Tab 1G.

The Board concludes that Dominican Santa Cruz Hospital transferred its dual eligible days issue out of its individual appeal and into PRRB Case No. 04-1728G prior to the closing date referenced by the Medicare Contractor and then transferred the issue into the instant appeal. The Board finds, therefore, that Dominican Santa Cruz Hospital's dual eligible days issue is properly within the instant appeal and dismisses the Medicare Contractor's jurisdictional challenge for this provider.

Participant 2, Glendale Memorial Hospital

Within its Response, CHW explains that Glendale Memorial Hospital also transferred its dual eligible days issue from its individual appeal to PRRB Case No. 04-1825G on September 27, 2004.[7] CHW goes on to state that, similar to Dominican Santa Cruz Hospital, "[t]he Provider subsequently requested this issue be moved from . . . Case No. 04-1825G to . . . Case No. 04-1728G . . ."[8] Finally, as this provider was an affiliate of CHW, CHW then requested that the provider be transferred into the instant appeal in an October 26, 2006 letter that CHW included within its July 14, 2010 Jurisdictional Documentation.[9]

As such, the Board concludes that Glendale Memorial Hospital transferred its dual eligible days issue out of its individual appeal and into PRRB Case No. 04-1825G prior to the closing date referenced by the Medicare Contractor. The provider then transferred its issue into PRRB Case No. 04-1728G and finally into the instant appeal. The Board finds, therefore, that Glendale Memorial Hospital's dual eligible days issue is properly within the instant appeal and dismisses the Medicare Contractor's jurisdictional challenge for this provider.

Jurisdiction for Participant 4, Mercy General Hospital ("Mercy General")

Based on the information provided to the Board by CHW within its July 14, 2010 Jurisdictional Documentation, Mercy General appealed its fiscal year ending on ("FYE") March 31, 1997 cost report in an October 25, 2006 letter to the Board. On that same date, Mercy General requested to transfer its dual eligible days issue to PRRB Case No. 06-0081G, not the instant appeal, PRRB Case No. 06-0032GC.[10] CHW has not provided any documentation to show that Mercy General subsequently transferred that issue to this appeal. The Board, therefore, concludes that Mercy General's FYE 1997 appeal was never properly added to this group and finds that it does not have jurisdiction to hear Mercy General's dual eligible days issue as part of this CIRP group appeal.

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[7] June 7, 2007 Response at 2.
[8] *Id.*
[9] July 14, 2010 Jurisdictional Documentation, Tab 2G.
[10] *Id.* at Tab 4G.

Jurisdiction for Participants 6 and 7, Mercy Medical Center Redding and Mercy San Juan Hospital

CHW's July 14, 2010 Jurisdictional Documentation shows that Participants 6 and 7 filed their individual appeals based on their respective RNPRs for the FYE 1997 cost reporting period.

For Participant 6, the Medicare contractor's July 9, 2004 RNPR letter listed the adjustments that the contractor made to the cost report in question: (1) to correct Worksheet S-2, Line 36.01, Column 2 answer from "No" to "Yes" in order to have proper capital reimbursement; (2) to include Medi-Cal eligible days for DSH reimbursement: and (3) to exclude labor and delivery room days for DSH reimbursement.

For Participant 7, the Medicare contractor's May 13, 2005 RNPR letter states that it reopened the providers' cost report "[t]o recalculate the DSH settlement to include the Eligible Days per HCFA 97-2." The Board notes that HCFA Ruling 97-2 ("Ruling 97-2") required that the Centers for Medicare & Medicaid Services ("CMS") include, within the DSH adjustment calculation, all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.[11]

The United States Court of Appeals for the District of Columbia Circuit's decision in *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), held that when a fiscal intermediary[12] reopens it original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations underlying the original NPR. In *Emanuel Medical Center, Inc. v. Sebelius,* 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014) the District Court held that the Secretary's "issue-specific" interpretation of the NPR reopening regulation was reasonable and stated that it was "not persuaded" that any change to an element of the DSH adjustment calculation serves to establish that all of the DSH elements have been reconsidered.

In the instant appeal, CHW has not presented any documentation to show that dual eligible days were specifically adjusted when the Medicare contractor reopened Participants 6 and 7's FYE 1997 cost reports. The Board finds, therefore, that it does not have jurisdiction to review the dual eligible days issue for these two participants in this CIRP group and dismisses both of them from the appeal.

Request for Case Bifurcation

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 the participants

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

within this appeal added the dual eligible days issue to their respective appeals using a broad issue statement that encompassed both Part A non-covered days and HMO days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 06-0032GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[13] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' dual eligible HMO days issue is now within newly formed PRRB Case No. 16-0497GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the CMS Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0497GC are included as enclosures along with this determination.

As the Board has determined that it does not have jurisdiction over Mercy General Hospital (Provider No. 05-0017), Mercy Medical Center Redding (Provider No. 05-0280) and Mercy San Juan Hospital (Provider No. 05-0516), these participants are excluded from the newly formed HMO days appeal and not included in the dual eligible Part A non-covered days issue remand for the instant appeal.

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

Board Members Participating:
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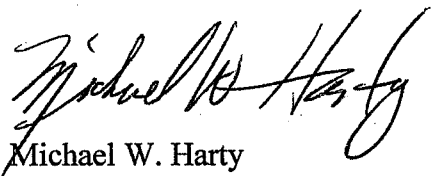
FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 7, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0497GC
Standard Remand Letter for PRRB Case No. 08-2486GC

cc: Wilson Leong, Federal Specialized Services

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

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RE: Request for Case Bifurcation and Jurisdictional Determination
CHW 1999 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 06-0081GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Catholic Healthcare West ("CHW") 1999 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. Upon review, the Board finds that it previously denied the transfer request, dated June 21, 2006, for Participant 1, California Hospital Medical Center (Provider No. 05-0149), to join the instant CIRP group. As for the remaining participants, the Board hereby grants bifurcation of the participants' dual eligible days issue,[1] as explained below.

Background

On October 7, 2005, the Board received CHW's request to form the above-captioned CIRP group. After CHW added a number of participants to the appeal, the Board received the Medicare Contractor's Final Position Paper ("FPP") on April 25, 2007. Within its FPP, the Medicare Contractor noted jurisdictional "impediments" for three of the group's participants, California Hospital Medical Center (Provider No. 05-0149), Dominican Santa Cruz Hospital (Provider No. 05-0242) and Mercy Medical Center Redding (Provider No. 05-0280). The Medicare Contractor states that the Board had previously closed these providers' individual appeals, per the providers' requests, as follows: California Hospital Medical Center's appeal was closed as of September 14, 2005; Dominican Santa Cruz Hospital's appeal was closed as of October 8, 2004; and Mercy Medical Center Redding's appeal was closed as of May 17, 2006.

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

On June 7, 2007, the Board received CHW's response ("Response") to the Medicare Contractor's jurisdictional challenges. CHW filed an Updated Schedule of Providers and Jurisdictional Documentation dated July 8, 2010, for the 10 participants within the instant 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."

Board's Decision

Applicable Regulatory Provisions

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2004), 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.

Jurisdictional Determinations

Participant 1, California Hospital Medical Center

Although CHW included this participant within its July 8, 2010 Schedule of Providers, the Board notes that it has previously denied this participant's transfer into the instant CIRP group within a June 30, 2006 letter. The Board's June 30, 2006 letter states the following: "Upon review, it is noted that the subject appeal was withdrawn based on a fully executed administrative resolution. The Board acknowledged the withdrawal request and closed the case by letter dated September 14, 2005." The Board goes on to conclude that "the request to add the Disproportionate Share issues to the subject appeal and transfer said issues to the referenced group appeals is hereby **denied**. The subject appeal was closed and not actively pending before the Board at the time the request to add and transfer the issues was filed."[3]

Participant 2, Dominican Santa Cruz Hospital

As noted prior, within its FPP, the Medicare Contractor raised jurisdictional challenges for Participants 2 (Dominican Santa Cruz Hospital, Provider No. 05-0242) and 5 (Mercy Medical Center Redding, Provider No. 05-0280),[4] stating that the Board had previously closed these providers' individual appeals, per the providers' requests.[5] Within its Response, however, CHW explains that Dominican Santa Cruz Hospital transferred its dual eligible days issue from its individual appeal to PRRB Case No. 04-1730G on June

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[2] Toyon is CHW's representative in the instant appeal.
[3] Emphasis in original.
[4] These are the numerical designations for these participants on CHW's Schedule of Providers dated July 7, 2010.
[5] April 25, 2007 FPP at 4.

4, 2004.[6] As this provider was an affiliate of CHW, CHW then requested that the provider be transferred into the instant appeal in an October 26, 2006 letter that CHW included within its July 8, 2010 Jurisdictional Documentation.[7]

The Board concludes that Dominican Santa Cruz Hospital transferred its dual eligible days issue out of its individual appeal and into PRRB Case No. 04-1730G prior to the October 8, 2004 closing date referenced by the Medicare Contractor, and then transferred the issue into the instant appeal. The Board finds, therefore, that Dominican Santa Cruz Hospital's dual eligible days issue is properly within the instant appeal and dismisses the Medicare Contractor's jurisdictional challenge for this provider.

Participant 5, Mercy Medical Center Redding

Within its Response, CHW explains that Mercy Medical Center Redding also transferred its dual eligible days issue from its individual appeal to PRRB Case No. 04-1730G on June 4, 2004.[8] As this provider was also an affiliate of CHW, CHW then requested that the provider be transferred into the instant appeal in an October 26, 2006 letter that CHW included within its July 8, 2010 Jurisdictional Documentation.[9]

As such, the Board concludes that Mercy Medical Center Redding transferred its dual eligible days issue out of its individual appeal and into PRRB Case No. 04-1730G prior to the May 17, 2006 closing date referenced by the Medicare Contractor and then transferred the issue into the instant appeal. The Board finds, therefore, that Mercy Medical Center Redding's dual eligible days issue is properly within the instant appeal and dismisses the Medicare Contractor's jurisdictional challenge for this provider.

Request for Case Bifurcation

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 the participants within this appeal added the dual eligible days issue to their respective appeals using a broad issue statement that encompassed both Part A non-covered days and HMO days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 06-0081GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[10] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' dual eligible HMO days issue is now within newly formed PRRB Case No. 16-0523GC. The providers' dual eligible Part A non-covered days issue remains in the

[6] June 7, 2007 Response at 2.
[7] July 8, 2010 Jurisdictional Documentation, Tab 2G.
[8] June 7, 2007 Response at 2.
[9] July 8, 2010 Jurisdictional Documentation, Tab 5G.
[10] Both the regulation and Board Rule clearly state that a group appeal must contain only one issue.

instant appeal and is subject to remand under the CMS Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0523GC are included as enclosures along with this determination.

As the Board has determined that it previously dismissed California Hospital Medical Center (Provider No. 05-0149) from this appeal, this participant is excluded from the newly formed HMO days appeal and not included in the dual eligible Part A non-covered days issue remand for the instant appeal.

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

Board Members Participating:
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FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 7, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0523GC
Standard Remand Letter for PRRB Case No. 08-0081GC

cc: Wilson Leong, Federal Specialized Services

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Refer to: 08-2410GC

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RE: Request for Case Bifurcation and Jurisdictional Determination
CHW 1995 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2410GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Catholic Healthcare West ("CHW") 1995 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. Upon review, the Board finds that it does not have jurisdiction over one of the participants, Mercy Medical Center Redding (Provider No. 05-0280), and hereby dismisses this participant from this appeal, but grants bifurcation of the remaining participants' dual eligible days issue,[1] as explained below.

Background

On July 24, 2008, the Board received CHW's request to form this CIRP group. On April 27, 2010, the Board received CHW's Updated Schedule of Providers and Jurisdictional Documentation for the three participants remaining within the instant 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 CHW's appeal.

Board's Decision

Applicable Regulatory Provisions

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

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

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

Jurisdiction for Mercy Medical Center Redding ("Mercy")

According to the information contained within CHW's April 27, 2010 Jurisdictional Documentation, Mercy filed its appeal based on its January 23, 2007 RNPR. The January 23, 2007 RNPR states that the Medicare Contractor's purpose in revising Mercy's June 30, 1995 cost report NPR was in order "to reopen the disproportionate share hospital payment in accordance with the Mandamus action-settlement agreement issued by the Office of the General Counsel." The Medicare Contractor's Audit Adjustment Report that corresponds to Mercy's January 23, 2007 RNPR shows that DSH was adjusted generally, but the documentation fails to show that dual eligible days were specifically revised within this reopening.

The United States Court of Appeals for the District of Columbia Circuit's decision in *HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), held that when a fiscal intermediary[3] reopens it original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations underlying the original NPR. In *Emanuel Medical Center, Inc. v. Sebelius,* 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014) the District Court held that the Secretary's "issue-specific" interpretation of the NPR reopening regulation was reasonable and stated that it was "not persuaded" that any change to an element of the DSH adjustment calculation serves to establish that all of the DSH elements have been reconsidered.

In the instant appeal, while Mercy has shown that the Medicare contractor adjusted its DSH calculation generally within its January 23, 2007 RNPR, it has not demonstrated that its dual

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

eligible days were "revisited on reopening" or, in fact, adjusted in any way. The Board, therefore, finds that as Mercy has filed its dual eligible days appeal from an RNPR that does not show a specific adjustment to dual eligible days, it lacks the jurisdiction to hear Mercy's appeal of this issue and hereby dismisses Mercy from this CIRP group.

Request for Case Bifurcation

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 the participants within this appeal added the dual eligible days issue to their respective appeals using a broad issue statement that encompassed both Part A non-covered days and HMO days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2410GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[4] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' dual eligible HMO days issue is now within newly formed PRRB Case No. 16-0512GC. 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 & Medicaid Services Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0512GC are included as enclosures along with this determination.

As the Board has determined that it does not have jurisdiction over Mercy Medical Center Redding (Provider No. 05-0280), this participant is excluded from the newly formed HMO days appeal and not included in the dual eligible Part A non-covered days issue remand for the instant appeal.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

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. 16-0512GC
Standard Remand Letter for PRRB Case No. 08-2410GC

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to: 08-2449GC

CERTIFIED MAIL

DEC 31 2015

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RE: Request for Case Bifurcation
Daughters of Charity 1996 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2449GC

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 ("Daughters of Charity") 1996 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's request for case bifurcation. The Board hereby grants Daughters of Charity's request for case bifurcation of the dual eligible Part A non-covered and HMO days[1] issues as set forth below.

Background

On July 24, 2008, the Board received Daughter of Charity's request to form a CIRP group comprised of two commonly-related providers within PRRB Case No. 04-1727G. On July 19, 2010, the Board received Daughter of Charity's Schedule of Providers and jurisdictional documentation for the CIRP 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 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 Daughter of Charity'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 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.

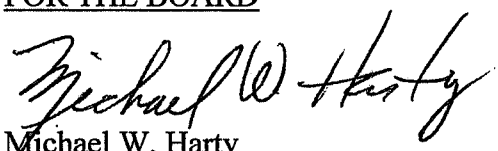
The Board acknowledges that at the time that Daughter of Charity's individual and group appeal requests were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently 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 original optional group appeal described the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and HMO days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2449GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and HMO days issues into separate group appeals. The providers' HMO issue is now within newly formed PRRB Case No. 16-0508GC. 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. 16-0508GC are included as enclosures along with this determination.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated September 17, 2008
Group Acknowledgment Letter for PRRB Case No. 16-0508GC
Standard Remand Letter for PRRB Case No. 08-2449GC

cc: Wilson Leong, Federal Specialized Services

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