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

Refer to:

CERTIFIED MAIL

FEB 05 2016

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

RE: United Regional Health Care System, Provider No. 45-0010, FYE 12/31/2007
PRRB Case No. 13-1107

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal which has been pending since 2013. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

Quality Reimbursement Services, Inc. (QRS) filed an individual appeal on behalf of the Provider on March 19, 2013 to which the Board assigned case number 13-1107. The sole issue appealed was the Rural Floor Budget Neutrality Adjustment (RFBNA).

On May 20, 2013 QRS added the Labor & Delivery Room Days issue.

On November 4, 2013 the Board received the Representative's request for Expedited Judicial Review (EJR) of the RFBNA issue.

By letter dated November 26, 2013 the Board denied jurisdiction over the RFBNA issue and denied the Representative's request for EJR. The case remained open for the other issues under appeal.

The Provider filed a preliminary position paper on November 25, 2013.[1] The sole issue briefed in the preliminary position paper is the RFBNA issue.

[1] The receipt of the position paper had not been logged in at the time the Board issued the RFBNA jurisdiction decision. As only the first page of the preliminary position paper is required to be submitted by the position paper deadline, the Board recently requested the full copy of the preliminary position paper which was submitted on January 22, 2016.

Board Determination:

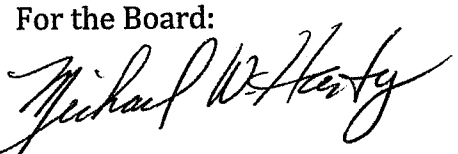
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more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

After reviewing the documentation submitted in this case, the Board finds that the Labor & Delivery Room Day issue was not briefed in the preliminary position paper. Therefore, the Board considers this issue to have been abandoned by the Provider. As the Board previously denied jurisdiction over the RFBNA issue on November 26, 2013, there are no remaining issues in this case. Therefore, the Board closes case number 13-1107 and removes it from the docket.

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

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

For the Board:



Michael W. Harty
Chairman

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

cc: Bruce Snyder, Novitas Solutions, Inc.
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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Refer to: 09-1857GC

FEB 08 2016

CERTIFIED MAIL

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

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

RE: QRS Via Christi HS 2006 DSH Exhausted Benefits Medicaid Dual Eligible Days
Provider: Via Christi Regional Medical Center
Provider No: 17-0122[1]
FYE: 09/30/2000-9/30/2007
PRRB Case No.: 09-1857GC

Dear Mr. Ravindran and Mr. Lamprecht:

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

Background

In May of 2009, the Provider requested to establish a Common Issue-Related Party ("CIRP") group appeal by transferring fiscal year 2006 for the following "Dual Eligible Days" issue:

> Whether the Medicaid Administrative Contractor "MAC" properly excluded exhausted Medicare benefits Medicaid Dual Eligible days from the DSH calculation.

This CIRP group appeal for DSH Dual Eligible Days was assigned Case No. 09-1857GC. On December 4, 2015, the Providers notified the Board that the CIRP group was complete.

By letter dated June 24, 2015 the Medicare Contractor referenced a previous letter submitted by the Medicare Contractor, that cited a jurisdictional impediment for Participant #2 (Provider No.

[1] The Board allowed the Provider to create a CIRP Group for one Provider (Via Christi Regional Medical Center) with multiple years.

17-0122, FYE 9/30/2002). The Medicare contractor stated that it has no record of the existence of the Dual eligible days issue in the individual Case # 05-0694; therefore the transfer to this case (09-1857GC) of the issue is not valid. The Provider did not file any rebuttals to the jurisdictional impediment cited by the Medicare Contractor.

Board Decision

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

The Board finds that it does not have jurisdiction over the DSH Dual Eligible Day issue for Participant #2, FYE 9/30/2002 in Case No. 09-1857GC because the Provider did not properly and timely appeal DSH Dual Eligible Days in its underlying individual appeal. Case Nos. 05-0694 was filed with the Board in February of 2005 and at that time, the regulations required:

> Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof. [2]

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

> Your hearing request must contain an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending that the findings and conclusions are incorrect... You must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not define the issue as "DSH." You must precisely identify the component of the DSH issue that is in dispute.[3]

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

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[2] 42 C.F.R. 405.1841(a)(1) (2004).

[3] Provider Reimbursement Review Board Instructions, Part I § B.II.a (2002), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/Copy-2-of-Copy-2-of-PRRB_Instructions_March_03.pdf (last visited specific February 5, 2016).

period for filing the original hearing request. The following clarification also appeared in the May 23, 2008 Final Rule:

> [f]or appeals pending before ... the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of ... 60 days after the effective date of this rule.[4]

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

The Participant did not raise DSH Dual Eligible Days issue in its initial appeal request for Case Nos. 05-0694, nor did it add the issue to the appeal before the regulatory deadline. The first mention of the Dual Eligible Days issue for Participant #2, FYE 9/30/2002 was made in the Request to Transfer letter filed in October, 2010 to the current CIRP Group which is two years after the applicable deadline to add or clarify issues.

For the reasons stated above, the Board finds that the Dual Eligible Days issue was not properly or timely appealed for Participant #2 and therefore it lacks jurisdiction over participant #2. The Board hereby dismisses Participant #2 from Case # 09-1857GC.

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 case.

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

FOR THE BOARD

Michael W. Harty
Chairman

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

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

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[4] 73 Fed. Reg 30190, 30240 (May 23, 2008).

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Refer to: 04-1730G

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FEB 08 2016

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

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

RE: Stay of Pending Court Proceedings and Request for Board Reopening on Part C Dual Eligible Days
Toyon 1999 DSH Dual Eligible Days Group
PRRB Case No.: 04-1730G

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in order to reconsider Toyon Associates, Inc.'s ("Toyon's")[1] request for case bifurcation of the dual eligible Part A non-covered and Part C days issues in the Toyon 1999 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days Group. The Board initially granted bifurcation of the issues for all but four Providers in the appeal in its February 12, 2014 Decision. Upon reconsideration, the Board hereby grants bifurcation for three additional Providers, as explained below.

Background

On May 17, 2004, the Board received Toyon's group appeal request regarding DSH dual eligible days. The group was initially comprised of 14 providers but following its multiple transfer and withdrawal requests, Toyon's final Schedule of Providers, dated June 15, 2010, consists of 13 providers listed on the Schedule as participants 1, 3, 5-6, 12-16, 18, 23-24, and 26.

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's") request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue." In its February 12, 2014 Decision, the Board granted bifurcation of the issues for all Providers in the group except for four: Participants 6, 12, 24, and 26.[2] The Board subsequently dismissed Participant 6, Enloe Medical Center, from this appeal for lack of jurisdiction. This appeal was then remanded to the Medicare Contractor on June 8, 2015 pursuant to CMS Ruling 1498-R and the appeal was closed.

[1] Toyon is the providers' representative for this appeal.
[2] Enloe Medical Center, Natividad Medical Center, San Joaquin General Hospital, and Stanford University Hospital

Toyon has since submitted this Stay of Pending Court Proceedings and Request for Board Reopening on Part C Dual Eligible Days in which it has requested that the Board reconsider its previous decision to deny bifurcation for: Participant 12 Natividad Medical Center (pn 05-0248, FYE 6/30/1999); Participant 24 San Joaquin General Hospital (pn 05-0167, FYE 6/30/1999); and Participant 26 Stanford University Hospital (pn 05-0441; FYE 8/31/1999).

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

Although the Board initially denied Toyon's request for case bifurcation for Participants 12, 24, and 26, the Board has decided to grant the request for Reopening in order to grant bifurcation for these three Providers. The Board acknowledges that at the time that the providers' individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original common issue-related provider group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 04-1730G in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13 for Participants 12, 24, and 26.[3] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues. The Board hereby reopens case number 04-1730G in order to bifurcate the Part C Days issue from this appeal and transfer the issue to PRRB Case No. 14-2105G, Toyon 1999 DSH Part C Days Group.[4] The Providers' dual eligible Part A non-covered days issue has already been remanded to the Medicare Contractor pursuant to CMS Ruling 1498-R on June 8, 2015. As the Part C days issue has now been transferred to case number 14-2105G for Participants 12, 24, and 26, and the dual eligible days issue in this appeal has been remanded, case number 04-1730G is hereby closed.

Please submit an updated Schedule of Providers and jurisdictional documents in case number 14-2105G including Participants 12, 24, and 26 within 45 days of the date of this letter.

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.

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

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

cc: Wilson Leong, Federal Specialized Services

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Refer to: 08-1726GC

CERTIFIED MAIL

FEB 08 2016

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

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

RE: Stay of Pending Court Proceedings and Request for Board Reopening on Part C Dual Eligible Days
Hawaii Pacific Health 2006 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-1726GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Hawaii Pacific Health 2006 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's ("Hawaii Pacific Health") request that the Board reconsider its June 9, 2015 decision ("June 9, 2015 Decision" or "Decision"). Within that Decision, the Board denied a request to bifurcate the participants' dual eligible days issue within this CIRP group appeal. Upon reconsideration, the Board hereby grants Hawaii Pacific Health's request for case bifurcation of the dual eligible Part A non-covered and Part C[1] days issues within the instant appeal. The Board's decision is set forth below.

BACKGROUND

On April 7, 2008, the Board received Hawaii Pacific Health's request to form a CIRP group appeal based on two participants' appeals of dual eligible days from their respective individual requests for hearing. On March 17, 2015, the Board received Hawaii Pacific Health's Schedule of Providers and Jurisdictional Documentation for 2 participants within the group.

On April 24, 2015, the Board received the Medicare Contractor's request for an extension of time to files its Preliminary Position Paper ("PPP"). The Medicare Contractor stated that the group is not appealing a single common issue and requests an extension "pending a determination by the [Board] that addresses the multiple legal issues being pursued by the

[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.

group."[2] The Board issued a decision on June 9, 2015, finding that the group only consisted of one issue – dual eligible days.

On January 12, 2016, the Board received Hawaii Pacific Health's "Stay of Pending Court Proceedings and Request for Board Reopening on Part C Dual Eligible Days."

BOARD'S DECISION

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

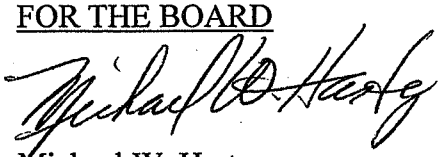
Although the Board initially denied the request for case bifurcation, upon reconsideration, the Board acknowledges that at the time that the providers' individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was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

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-1726GC in violation of 42 C.F.R. § 405.1837(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. 16-0877GC. The Providers' dual eligible Part A non-covered days issue has already been scheduled for hearing before the Board on April 5, 2016. The Board's Acknowledgment Letter for PRRB Case No. 16-0877GC is included as an enclosure along with this determination.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

[2] Medicare Contractor's Request for Extension at 4.
[3] Both the regulation and Board Rule clearly state that a group appeal must only contain one issue.

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated March 16, 2015
Group Acknowledgment Letter for PRRB Case No. 16-0877GC

cc: Wilson Leong, Federal Specialized Services

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FEB 19 2016

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

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

RE: Request for Reconsideration
Providence Holy Cross Medical Center
Provider No,: 05-0278
FYE: 12/31/2001
PRRB Case No.: 07-1225

Dear Mr. Blumberg and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Providence Holy Cross Medical Center's ("Providence Holy Cross") request that the Board reconsider its March 11, 2013 Decision. Within that Decision, the Board denied the Provider's request to transfer the dual eligible Part C days issue to a group appeal. Upon reconsideration, the Board hereby finds that Providence Holy Cross did appeal the dual eligible Part C days issue and grants the Provider's request to transfer the issue to case number 09-1708GC. The Board's decision is set forth below.

BACKGROUND

On March 12, 2007, Holy Cross filed an appeal request with the Board. The Provider included two issues in its appeal request, the Medicare SSI Percentage and the Medicare/Medicaid Dual Eligible Days issue, which was described as follows:

> The Provider contends that the Disproportionate Share (DSH) adjustment has not been calculated in accordance with Medicare regulations and Manual Provisions as described in 42 CFR Section 412.106. Further, the Provider contends that the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation.

The Provider later requested to transfer the dual eligible Part A issue to case number 08-2597GC and the dual eligible Part C issue to case number 09-1708GC. After, Providence Holy Cross submitted a letter requesting to withdraw all remaining issues and close the appeal pending the Board's confirmation of the transfer of the SSI percentage, dual eligible Part A, and dual eligible Part C issues to various group appeals. On March 11, 2013, the Board issued a decision in which

it confirmed the transfers of the SSI percentage and dual eligible Part A issues, but denied the dual eligible Part C transfer after finding that the Provider never appealed or added the issue to its appeal. The Provider subsequently filed a request for reconsideration with the Board.

PROVIDER'S CONTENTIONS

The Provider offers several arguments in support of its position that the Board should reverse its decision as related to the Dual Eligible Part C days issue. The Provider first argues that the Dual Eligible Part C days issue was included in its individual appeal request because the Provider appealed that the MAC omitted inclusion of Medicare/Medicaid dual eligible patient days. Second, the Board imposed an overly narrow interpretation of the standard that a Provider must, "precisely identify the component of the DSH issue that is in dispute." The Provider argues that it is clear that it appealed both the Medicaid fraction because "the fact is that Medicare/Medicaid dual eligible days comprise patients who have exhausted their Part A benefit and patients who are enrolled in a Medicare Advantage plan."[1]

Next, the Provider argues that the decision in Allina Health Services v. Sebelius, 746 F.3d 1102 (D.C. Cir. 2014) vacates the very regulation the Provider referenced in its hearing request. Therefore, it would not make sense for the Board to deny the Provider its right to pursue the issue when the regulation has been vacated.

Finally, the Provider argues that the Board's Common Issue Related Party ("CIRP") rule requires the Provider to appeal the Dual Eligible Part C issue because other CIRP Providers are appealing the issue in a group appeal.

BOARD'S DECISION

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the 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 the Provider's request to transfer the dual eligible Part C issue to a group appeal, upon reconsideration, the Board acknowledges that at the time the Provider filed its individual appeal request, 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. In this case, the Board finds that the Provider's individual appeal using a broad issue statement did encompass both Part A non-covered days and Part C days.

Accordingly, the Board hereby reopens case number 07-1225 and grants Holy Cross's request to transfer the Part C days issue to case number 09-1708GC. As the other issues in case number 07-1225 have been transferred to groups, case number 07-1225 is once again closed.

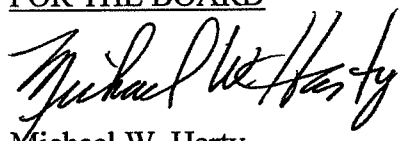
---

[1] Request for Reconsideration at 2.

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

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

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CERTIFIED MAIL FEB 19 2016

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Chief Operating Officer
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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 Reconsideration
Holy Cross Medical Center
Provider No.: 05-0278
FYE: 12/31/2000
PRRB Case No.: 04-1000

Dear Mr. Blumberg and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to Holy Cross Medical Center's ("Holy Cross") request that the Board reconsider its March 11, 2013 Decision. Within that Decision, the Board denied the Provider's request to transfer the dual eligible Part C days issue to a group appeal. Upon reconsideration, the Board hereby finds that Holy Cross did appeal the dual eligible Part C days issue and grants the Provider's request to transfer the issue to case number 09-1708GC. The Board's decision is set forth below.

BACKGROUND

On March 15, 2004, Holy Cross filed an appeal request with the Board. In a letter dated August 20, 2008, that the Board received on August 21, 2008, the Board received the Provider's request to add issues to its individual appeal, including:

> Medicare/Medicaid Dual Eligible Days: The Provider contends that the Disproportionate Share (DSH) adjustment has not been calculated in accordance with Medicare regulations and Manual Provisions as described in 42 CFR Section 412.106. Further, the Provider contends that the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation.

The Provider later requested to transfer the dual eligible Part A issue to case number 08-2597GC and the dual eligible Part C issue to case number 09-1708GC. After, Holy Cross submitted a letter requesting to withdraw all remaining issues and close the appeal pending the Board's confirmation of the transfer of the SSI percentage, dual eligible Part A, and dual eligible Part C

issues to various group appeals. On March 11, 2013, the Board issued a decision in which it confirmed the transfers of the SSI percentage and dual eligible Part A issues, but denied the dual eligible Part C transfer after finding that the Provider never appealed or added the issue to its appeal. The Provider subsequently filed a request for reconsideration with the Board.

PROVIDER'S CONTENTIONS

The Provider offers several arguments in support of its position that the Board should reverse its decision as related to the Dual Eligible Part C days issue. The Provider first argues that the Dual Eligible Part C days issue was included in its individual appeal request because the Provider appealed that the MAC omitted inclusion of Medicare/Medicaid dual eligible patient days. Second, the Board imposed an overly narrow interpretation of the standard that a Provider must, "precisely identify the component of the DSH issue that is in dispute." The Provider argues that it is clear that it appealed both the Medicaid fraction because "the fact is that Medicare/Medicaid dual eligible days comprise patients who have exhausted their Part A benefit and patients who are enrolled in a Medicare Advantage plan."[1]

Next, the Provider argues that the decision in Allina Health Services v. Sebelius, 746 F.3d 1102 (D.C. Cir. 2014) vacates the very regulation the Provider referenced in its hearing request. Therefore, it would not make sense for the Board to deny the Provider its right to pursue the issue when the regulation has been vacated.

Finally, the Provider argues that the Board's Common Issue Related Party ("CIRP") rule requires the Provider to appeal the Dual Eligible Part C issue because other CIRP Providers are appealing the issue in a group appeal.

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.

Although the Board initially denied the Provider's request to transfer the dual eligible Part C issue to a group appeal, upon reconsideration, the Board acknowledges that at the time the Provider filed its request to add the issue to its individual appeal, 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. In this case, the Board finds that the Provider's request to add the issue to its individual appeal using a broad issue statement did encompass both Part A non-covered days and Part C days.

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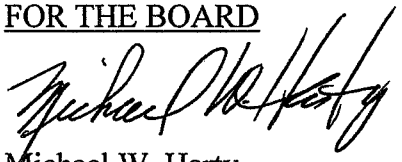
[1] Request for Reconsideration at 2.

Accordingly, the Board hereby reopens case number 04-1000 and grants Holy Cross's request to transfer the Part C days issue to case number 09-1708GC. As the other issues in case number 04-1000 have been transferred to groups or withdrawn, case number 04-1000 is once again closed.

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

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

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

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

Refer to:

CERTIFIED MAIL

FEB 22 2016

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

RE: Harborview Medical Center (50-0064)
FYEs 6/30/1989, 6/30/1991, 6/30/1992 & 6/30/1993
as participants in PRRB Case No. 09-0222GC
QRS UW 1991-1993, 1995 1998 Medicare DSH SSI% CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed your September 11, 2015 Motion and Request for Reinstatement of the above-referenced Provider as a participant in the QRS UW 1991-1993, 1995 1998 Medicare DSH SSI% CIRP Group. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

The Board dismissed Harborview Medical Center (Harborview) for FYEs 6/30/1989, 6/30/1991, 6/30/1992 & 6/30/1993 (participants 1, 4, 6 & 8) from the subject group appeal on August 31, 2015. The Board found that, for FYEs 1989 and 1991, the Provider did not submit proof that the SSI Percentage issue was included in the individual appeal requests, nor did they submit evidence that the issue was properly added to the appeals. In addition, the Provider did not submit evidence that the SSI issue was properly transferred to case no. 95-1407G (the first group to which it transferred prior to transferring to the subject group) for 1989, 1991, 1992 and 1993. The Board remanded the remaining participants in the group appeal pursuant to CMS Ruling 1498-R.

In a letter dated September 11, 2015 the Representative filed a Motion and Request for Reinstatement for Harborview as a participant in the case and provided additional documentation to support proof of the SSI issue and the transfers as follows:

Board Determination:

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

After reviewing the facts and the supplemental information submitted with your request for reinstatement, the Board finds the documentation is sufficient to document that the SSI issue was appealed and transferred to the subject group appeal. Therefore, the Board grants the request to reinstate Harborview Medical Center as a participant in the group for FYEs 1989, 1991, 1992 and 1993, and has reconsidered these providers for remand under CMS Ruling 1498-R.

Enclosed, please find a corrected remand including these participants on the Schedule of Providers.

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

Enclosure: Remand and Schedule of Providers

cc: Lee Crooks, Noridian Healthcare Solutions - WA/AK (w/enclosures)
Wilson C. Leong, Esq., CPA, Federal Specialized Services (W/enclosures)

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

Refer to: 13-0041

FEB 23 2016

CERTIFIED MAIL

Deaconess Medical Center
Dave Luhn
Empire Health Foundation
111 N. Post, Suite 301
Spokane, WA 99201

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

RE: Deaconess Medical Center
Provider No: 50-0044
FYE: 09/30/2008
PRRB Case No.: 13-0041

Dear Mr. Luhn and Mr. Lamprecht,

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

BACKGROUND

On June 29, 2012, the Medicare contractor issued Deaconess Medical Center's (hereinafter "Deaconess MC") Notice of Program Reimbursement (hereinafter "NPR") for the fiscal year end September 30, 2008. Deaconess MC filed an appeal from the NPR on November 2, 2012, and the appeal request contained one issue alleging the Medicare Contractor improperly determined the amount of Crossover Bad Debts owed to the hospital.

Subsequently, Deaconess MC has added six issues to the appeal, outside of the 180 day filing period, but within the 240 days permitted to add issues:

1) Direct Graduate Medical Education costs,
2) Indirect Medical Education adjustments,
3) Outliers Payments, and
4-6) three Disproportionate Share Hospital (hereinafter "DSH")/Supplemental Security Income (hereinafter "SSI") percentage issues:

a. DSH SSI percentage Systemic Errors
b. DSH/SSI Dual Eligible Days (Exhausted Benefit and Secondary Payor days), and
c. DSH/SSI Managed Care days.

Deaconess MC has also filed the following Requests to Transfer Issue to a Group Appeal:

1) transfer the Outlier Payments issue to Case No. 13-2365GC,
2) transfer the DSH SSI Dual Eligible days issue to Case No. 15-3123GC,
3) transfer the DSH SSI percentage Systemic Errors issue to Case No. 15-3126GC, and
4) transfer the DSH SSI Managed Care days issue to Case No. 15-3484GC.

On July 16, 2013, the Board received the Medicare Contractor's Jurisdictional Challenge which alleges the Board does not have jurisdiction over the initial issue in the appeal concerning Crossover Bad Debts. On October 28, 2013, the Board received Deaconess MC's response to the Jurisdictional Challenge.

Medicare Contractor's Contentions

The Medicare contractor challenges the Board's jurisdiction over the Crossover Bad Debts issue in this appeal and argues that it should be dismissed because the Provider did not claim the bad debts it now seeks on its cost report. The Medicare contractor cites to 42 C.F.R. § 405.1835, asserting that providers have a right to a hearing only for specific items claimed for a cost reporting period covered by a final determination. Additionally, the Medicare Contractor states it made no adjustment to the cost report for the Crossover Bad Debts now sought, and that the hospital's request to reopen the cost report for these bad debts admits Deaconess MC "had Medicare crossover patient bad debts that had not been identified, documented and claimed."[1]

Deaconess MC's Contentions

Deaconess MC contends that all jurisdictional requirements have been met as it is dissatisfied with the amount of Medicare payment, that Adjustment No. 4 of the NPR modified the hospital's bad debt reimbursement, and that the amount in controversy exceeds the $10,000 threshold. The Hospital states that it properly invoked the jurisdiction of the Board under 42 U.S.C. 1395oo(a) with respect to other aspects of the appeal from the same NPR, and it has a right to a Board hearing on the Crossover Bad Debts issue pursuant to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 406 (1988). Deaconess MC insists that once the Board has jurisdiction over other issues identified in the appeal pursuant to 42 U.S.C. § 1395oo(a), then "jurisdiction over the bad debt issue was virtually automatic pursuant to 42 U.S.C. § 1395oo(d)."[2]

[1] Medicare Contractor's Jurisdictional Challenge at 3 (July 12, 2013).
[2] Deaconess MC's Jurisdictional Brief at 3 (October 25, 2013).

Analysis and Decision:

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

The Board finds that Deaconess MC does not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the Crossover Bad Debts issue. Deaconess MC received reimbursement for the items and services claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). As the Board does not have jurisdiction over the Crossover Bad Debts issue which was the sole issue stated in the appeal request, Deaconess MC did not establish a jurisdictionally valid appeal to which issues could be properly or timely added. Therefore all Requests to Add and Requests to Transfer of those issues to group appeals are denied. Additionally, the Board finds it cannot exercise its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d) over the issues added after the initial filing deadline expired as Deaconess MC did not establish a jurisdictionally valid appeal within the required 180 day filing period.

The crux of this dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which 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 fiscal intermediary 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 . . .

After jurisdiction is established under 42 U.S.C. § 1395oo(a), the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. § 1395oo(d) which states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

Deaconess MC did not report Crossover Bad Debts correctly on the as-filed cost report and the Medicare contractor did not make a determination regarding the Crossover Bad Debts that the Hospital now seeks. Therefore, Deaconess MC cannot claim dissatisfaction. The error was due solely to Deaconess MC's negligence as indicated by its statement in its cost report reopening request that these additional Crossover Bad Debts "had not been identified, documented and claimed." Only in hindsight did Deaconess MC determine that it should have reported Crossover Bad Debts differently.

The operation of the jurisdictional gateway established by 42 U.S.C § 1395oo(a) was addressed by the Supreme Court in the seminal Medicare case of *Bethesda Hospital Association v. Bowen.*[3] The narrow facts of the *Bethesda* controversy dealt with the self-disallowed apportionment of malpractice insurance costs.[4] The provider failed to claim the cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court wrote:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[5]

The Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[6]

While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost that was unclaimed through inadvertence rather than futility, other appellate courts have. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.[7]

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[3] *Bethesda,* 485 U.S. 399 (1988).
[4] *Id.* at 401-402.
[5] *Bethesda.* at 1258, 1259. (Emphasis added).
[6] *Id.* at 1259. (Emphasis added).
[7] *See Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000); *UMDNH-Univ. Hosp. v. Leavitt*, 539 F. Supp. 2d 70 (D.D.C. 2008), *appeal dismissed sub nom, UMDNJ-Univ. Hosp. v. Johnson*, 2009 WL 412888 (Feb. 5, 2009). *But see Little Company of Mary Hosp. v. Shalala*, 24 F.3d 984 (7th Cir. 1994).

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Co. of Mary Hosp. v. Shalala* ("*Little Co. I*"),[8] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal intermediary, which establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[9]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[10] In *Little Co. II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the Intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[11] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[12]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[13] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[14]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[15] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally

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[8] 24 F.3d 984 (7th Cir. 1994).
[9] *Little Co. I,* 24 F.3d at 992.
[10] *Little Co. of Mary Hosp. v. Shalala*, 165 F.3d 1162 (7th Cir. 1999).
[11] *Little Co. II*, 165 F.3d at 1165.
[12] *Id.*
[13] 73 Fed. Reg. at 30196.
[14] 73 Fed. Reg. at 30203.
[15] *See Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).

regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[16] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal. The Ninth Circuit Court stated:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has *discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense ... even though that particular expense was not expressly claimed or explicitly considered by the intermediary.*[17]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[18] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[19] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[20] which were decisions issued in 2000 and 1987 respectively.[21]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the

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[16] 492 F.3d 1065 (9th Cir. 2007).
[17] *Id.* at 1068 (emphasis added).
[18] *See* 73 Fed. Reg. at 30197.
[19] 205 F.3d 493 (1st Cir. 2000).
[20] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[21] *See Loma Linda,* 492 F.3d at 1068.

provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[22] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 1395oo(d)] does not say that the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[23]

The First Circuit in *MaineGeneral* then found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued."[24] Similarly, in *St. Luke's*, the First Circuit opined that, even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly.[25] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[26]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.*, unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[27] As in *MaineGeneral* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied, but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

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[22] *St. Luke's*, 810 F.2d at 332.
[23] *Id.* at 327-328 (emphasis in original).
[24] *MaineGeneral*, 205 F.3d at 501.
[25] *St. Luke's*, 810 F.2d at 327.
[26] *MaineGeneral*, 205 F.3d at 501.
[27] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d), ...[28]

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[29]

More recently, however, the D.C. District Court upheld the Board's interpretation of the dissatisfaction requirement in § 1395oo(a) in *Saint Vincent Indianapolis Hospital v. Sebelius* 2015 WL 572872 (D.D.C 2015)(hereinafter "*St. Vincent*"). In that case, the Board determined that the provider "failed to meet the jurisdiction prerequisite of being 'dissatisfied' with the amount of Medicare payment because the 'errors and omissions' alleged by the provider in its appeal stemmed from its own 'negligence' in understanding the Medicare regulations governing the reimbursement of such costs rather than the [Medicare Contractor's] action."[30] The Court found the Board's ruling is "based upon a permissible construction of the statute," and therefore affirmed the Board's dismissal.[31]

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[32]

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[28] *Id.* at 79.
[29] *Id.*at 77.
[30] *Id.* at 4 (citation omitted).
[31] *Id.* at 5.
[32] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

42 U.S.C. § 1395oo(a) dictates that to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the intermediary. Thus, it follows that a provider must have claimed reimbursement for items and services for the intermediary to make a "final determination" regarding such items and services. The Provider in this case failed to claim the Crossover Bad Debts it now seeks. The Board generally has interpreted 42 U.S.C. § 1395oo(a) as the gateway to establishing Board jurisdiction to hear an appeal and requiring a provider to establish a right to appeal on a claim-by-claim or issue-specific basis.

The Board notes this case is factually similar to the *St. Vincent* decision, and in applying the *St. Vincent's* rationale to this appeal the Board finds that it does not have jurisdiction under § 1395oo(a) to hear the Crossover Bad Debts issue as these items were not claimed or properly reported on the cost report, and failure to claim these costs was due to inadvertence rather than futility. The Board also finds that because there was no jurisdictionally valid appeal under § 1395oo(a) when the case was filed, that there was no valid appeal to which any added issues could be attached. All of the Requests to Add issues were made outside of the 180 day timely appeal requirement, and therefore, the added issues also fail to independently meet the 180 timely filing requirement of a stand-alone appeal. Consequently, all Requests to Add Issues and Requests to Transfer issues are denied. All issues are now dismissed from this appeal and it is hereby closed.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

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

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Refer to: 08-0170G

CERTIFIED MAIL FEB 26 2016

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Re: **McKay Consulting DSH DE Days Bifurcation to (1) Part A Non-Covered/Exhausted Benefits Days and (2) Part C Days**
PRRB Case No.: 08-0170G
Group: McKay 2003/2004 DSH Dual Eligible Group
FYE: 12/31/2003 and 12/31/2004

Dear Mr. McKay:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible ("DE") days into (1) Exhausted Benefits days and (2) Part C days. The Board determined that, for Providers deemed eligible, it will grant the bifurcation request. The Part C days issue will be adjudicated in Case No. 16-1010G, McKay 2003/2004 Part C Days Group.[1] If the Board grants jurisdiction over Providers appealing Part A Non-Covered and Exhausted Benefit days, those Providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal, established on October 30, 2007, framed the issue as follows:

> Is the [Medicare Administrative 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

[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.

exhausted or who received Part C benefits correct?[2]

The initial appeal request included two providers, Seton Health System (Prov. No. 33-0232), Sisters of Charity (Prov. No. 33-0078).[3]

On December 1, 2008, McKay Consulting sent a letter requesting an extension of an open group. It requested that the group remain open to add multiple providers "in the next few weeks."[4] Then, on May 27, 2009, the Group Representative (Joanne Erde) sent an e-mail stating that "[t]he existing appeal, 08-0170G, would continue to include those providers whose fiscal years end before 10/1/04."[5] Both the Providers and Medicare Administrative Contractor, National Government Services, Inc. ("NGS"), sent in proof of filing their preliminary position papers.[6]

NGS subsequently filed a Jurisdictional Challenge.[7] NGS challenges jurisdiction over 16 of the providers in the group as follows:[8]

- NGS argues that dual eligible days were never raised in the individual appeals of Albemarle Hospital (34-0109), FYE 09/30/01, and St. Luke's (33-0044), FYE 12/31/01.[9] NGS states that they only appealed SSI and ME days, and that DE days were never added.[10] NGS cites to 42 C.F.R. § 405.1835, stating that an issue must be in an individual appeal before it may be transferred.[11]
- NGS argues that the following providers listed audit adjustments for protested amounts; however, they did not submit any detail to prove the exclusion of DE days: New Hanover Regional Medical Center (33-0141), FYE 9/30/03; New Hanover Regional Medical Center (33-0141), FYE 9/30/04; Wyoming Valley Health (39-0137), FYE 6/30/02; Wyoming Valley Health (39-0137), FYE 6/30/03; Wyoming Valley Health (39-0137), FYE 6/30/04.[12]
- Lastly, NGS argues that the following providers appealed RNPRs with no adjustment to DE days: Long Island Jewish Hospital (33-0195), FYE 12/31/94; Mobile Infirmary Medical Center (01-0113), FYE 3/31/00; Mobile Infirmary Medical Center (01-0113), FYE 3/31/01; Nathan Littauer Hospital (33-0276), FYE 12/31/99; Nathan Littauer Hospital (33-0276), FYE 12/31/00; Nathan Littauer Hospital (33-0276), FYE 12/31/01; St. Clare Schenectady (33-0066), FYE 12/31/94; St. Joseph Hospital (33-0108), FYE 12/31/99; St. Vincent Hospital (32-0002), FYE 6/30/97.[13]

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[2] Group Request for Hearing at 1, Oct. 30, 2007.
[3] *See id.* at 4. Seton is not on the Schedule of Providers. Sisters of Charity appears on both DE and Part C Days Schedules of Providers.
[4] Letter from McKay Consulting regarding Extension of Open Group, Dec. 1, 2008.
[5] Email from Joanne Erde, May 27, 2009.
[6] *See* Letter from McKay, Jun. 1, 2009 and Medicare Contractor's Preliminary Position Paper, Oct. 2, 2009.
[7] *See* Jurisdictional Challenge, Sep. 13, 2010.
[8] *See id.*
[9] *Id.* at 1-2.
[10] *Id.*
[11] *Id.*
[12] *Id.* at 2.
[13] *Id.* at 2-3.

The Group filed a Jurisdictional Response, requesting that the Board deny the Medicare Contractor's Jurisdictional Challenge for the reasons stated below:[14]

- NGS argues that dual eligible days were never raised in the individual appeals of Albemarle Hospital (34-0109), FYE 09/30/01, and St. Luke's (33-0044), FYE 12/31/01; however, the providers added DE days to their existing appeals on October 9, 2008 and October 16, 2008, respectively.[15]
- NGS objected to jurisdiction over five providers for failing to provide detail of the protested amounts.[16] An audit adjustment is not necessary for Board jurisdiction and, "... the Supreme Court's decision in *Bethesda Hospital Association v. Bowen* established that submitting a claim on an issue in the cost report for [a Medicare Contractor] determination is not required when the Providers are challenging the application of CMS policy that the [Medicare Contractor] was bound to apply."[17] Notwithstanding this argument, four of the providers included protested amounts for DSH on their cost reports, encompassing the DE days issue.[18]
- For the RNPRs, NGS' challenge must be denied because the RNPR had a revised DSH determination based on the review of a ME days package.[19] The Providers' packages identified DE days for inclusion in ME days as part of a review of ME days; however, the Medicare Contractor excluded these days.[20] The Providers further contend that the DE days in question are ME days that fall within the scope of the Medicare Contractor's determinations.[21]

On December 20, 2010, the Board issued a Jurisdictional Decision letter.[22] The Board found that:

- Providers 3 and 23 did submit Model Form C to add DE days on October 9, 2008 and October 16, 2008, respectively.
- Protested items were not applicable to any hospital in this group and that the Board had jurisdiction over Provider 15 pursuant to *Bethesda* and Providers 16, 27, 28, and 29 showed that Dual Eligible ("DE") days were a part of their protested items.
- In the RNPRs, Medicaid DE days were reviewed/adjusted because DE days were requested but not allowed as part of the reopening requests for Providers 8, 9, 10, 12, 13, 14, 19, 22, and 24.[23]

The Board previously found jurisdiction over all of the challenged Providers.[24]

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[14] Jurisdictional Response, Oct. 18, 2010.
[15] *Id.* at 2.
[16] *Id.* at 3.
[17] *Id.*
[18] *Id.*
[19] *Id.* at 11.
[20] *Id.*
[21] *Id.*
[22] Jurisdictional Decision in Case No. 08-0170G, Dec. 20, 2010.
[23] *See id.*
[24] *See id.*

The Group Representative submitted a Case Management Plan to change the date that the Schedules of Providers were due.[25] The Schedules of Providers were submitted on August 30, 2013. The Group Representative also requested bifurcation of the DE days issue and submitted separate Schedules of Providers for DE days (Exhausted Benefit days) and Part C days.

Board Determination on Bifurcation

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

(1) Dual Eligible Exhausted Benefits days
(2) Part C days

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."[26] 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 2007 group appeal request. The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

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

> The Board accepts jurisdiction over appeals from a [RNPR] where the issue(s) in dispute were specifically adjusted by that [RNPR]. 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).[27]

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[25] *See* Case Management Plan Letter, May 31, 2013.
[26] 42 C.F.R. § 405.1837(a)(2) (2003).
[27] Board Rule B.I.a.3 at 3, Mar. 1, 2002.

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

CMS Ruling 1498-R explains that, under the revised DE days policy, any patient entitled to Part A is included in the DSH Medicare fraction, regardless of whether the patient's stay was covered or the patient's Part A benefits were exhausted.[28] The Ruling discusses the related appeals:

> For cost reports with discharges before October 1, 2004, hospitals have filed [Board] appeals seeking inclusion in the [disproportionate patient percentage] DPP of inpatient days where the patient was entitled to Medicare Part A but the inpatient hospital stay was not covered under Part A. For example, some hospitals have appealed the exclusion from the DPP of inpatient hospital days of patients (whether dual eligible or entitled only to Medicare) whose Part A hospital benefits were exhausted.[29]

Here, the appealed DE days are for discharges prior to 10/01/2004. CMS describes that these appeals will be resolved by CMS and the Medicare Administrative Contractors.[30] A properly pending appeal means that the "applicable jurisdictional and procedural requirements for appeal" are satisfied.[31] The Board determines that jurisdictional requirements have not been met for Long Island Jewish Hospital [33-0195] (Participant #7); Mobile Infirmary Medical Center [01-0113] (Participant #8 and #9); Nathan Littauer Hospital [33-0276] (Participant #11, 12, and 13); St. Clare Schenectady [33-0066] (Participant #19); St. Joseph Hospital Elmira [33-0108] (Participant #21); and, St. Vincent Hospital [32-0002] (Participant #23).

The above Participants all appealed from RNPRs. Although a prior Board reasoned that DE days were "reviewed" during the reopening process, the current Board finds that a specific adjustment to DE days is required in order for these appeals to be jurisdictionally valid.[32] Here, all of the Participants' reopenings were completed in order to process a review of Medicaid Eligible days. Therefore, the Board dismisses the Providers as explained below.

Long Island Jewish Hospital's NPR was reopened according to a Settlement Agreement related to ruling HCFA 97-2. In an August 16, 2007 letter, the Medicare Administrative Contractor wrote that "[w]e have concluded our FINAL review of your reopening for additional Medicaid eligible and HMO DSH days for the Cost Report year ending 12/31/1994." HCFAR 97-2 dealt solely with days related to unpaid Title XIX Medicaid Days which were not entitled to Medicare Part A. The Group Representative claims that Long Island Jewish Hospital submitted DE days as part of its list of days. The Board finds that Long Island's DE days were not specifically revised as required and dismisses the Provider from this appeal.

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[28] *See id.*
[29] *Id.* at 8-9.
[30] *Id.* at 10.
[31] *Id.*
[32] *See* 42 C.F.R. § 405.1840(a)(3) (2008) (The Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal, and must promptly notify the parties of any revised determination.)

Mobile Infirmary was reopened (for both fiscal years 2000 and 2001) to adjust ME days. The Board finds that, since there was no adjustment to DE days, it does not have jurisdiction over this Provider. Likewise, Nathan Littauer Hospital's (all 3 fiscal year ends, 1999, 2000, and 2001) reopenings revised ME paid days and adjusted DSH accordingly. The Board also declines jurisdiction over Nathan Littauer's Hospitals. St. Joseph Hospital Elmira was also reopened for ME Days. The Reopening Notice stated, "[w]e have revised your DSH calculation to incorporate revisions to your [ME] Days in accordance with a reopening of your cost report." Since only HMO/Medicaid days were adjusted, the Board dismisses this provider.

St. Clare's NPR was reopened for " . . . additional Medicaid HMO Days and Paid Days in the DSH calculation in accordance with PRRB Case No. 02-1788." This means that the RNPR was issued as a result of a settlement of a previous case. The Board declines jurisdiction over St. Clare's because the RNPR adjusted only paid ME days (additionally, the Provider cannot prove dissatisfaction since it agreed to the terms of the settlement). Lastly, St. Vincent Hospital is dismissed because its RNPR was reopened "to implement AR [Administrative Resolution] case 00-1221," adjusting ME and DSH. A Provider cannot appeal a RNPR after it agreed to all of the revisions performed by the Medicare Administrative Contractor in the reopening. The Board finds that DE days were not adjusted (additionally, the Provider cannot prove dissatisfaction); therefore, the Board denies jurisdiction over St. Vincent's RNPR appeal.

The Board determines that it lacks jurisdiction over Participants 7, 8, 9, 11, 12, 13, 19, 21 and 23. The Board finds that all of the other Participants have a valid remand. They all timely appealed or added (and later transferred) the DE 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 need not address the protested amounts argument made by NGS since all of the cost reporting periods are prior to 12/31/2008. Rather, the Board finds that it has jurisdiction to remand DE days under *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) (which held that if a provider was barred from claiming an item on its cost report, it was still possible to appeal that item as a "self-disallowed" cost). The Board grants jurisdiction over these DE days pursuant to *Bethesda Hosp. Ass'n* and remands the DE days pursuant to CMS Ruling 1498-R.[33]

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

The Board accepts jurisdiction over Part C days if the Participants' transfers to the group appeal occurred prior to the 2008 change in regulation. If the Participants requested a transfer of Part C days prior to 2008, the Board considers each transfer request an "add/transfer" of the Part C days issue. In the instant case, the Board grants the bifurcation of Part C days prior to 10/01/2004 to continue in a new case (Case No. 16-1010G), except for the Participants who appealed from RNPRs.

Long Island Jewish Hospital [33-0195] (Participant #5); Mobile Infirmary Medical Center [01-0113] (Participant #6 and #7); Nathan Littauer Hospital [33-0276] (Participant #9 and #10); and, St. Vincent Hospital [32-0002] (Participant #15) appealed from RNPRs which did not

[33] A remand letter will be sent under separate cover.

adjust DE days (as described in detail above) or Part C days. Long Island Jewish Hospital's RNPR (fiscal year 1994) adjusted ME days per HCFA 97-2 as part of a Settlement Agreement. Mobile Infirmary (Participant #6 and #7, fiscal years 2000 and 2001) had ME days adjusted. Nathan Littauer (Participant #9 and #10, fiscal years 1999 and 2001) also had ME days adjusted. St. Vincent (fiscal year 1997) had ME days adjusted pursuant to an AR from Case No. 00-1221 (in addition to no adjustment, St. Vincent cannot prove dissatisfaction since it agreed to an AR). For these reasons, the Board hereby dismisses these six Participants from the Part C Schedule of Providers.

St. Vincent's Midtown Hospital [33-0230] (Participant #16, fiscal year 2002) appealed SSI and DE days in its individual appeal dated October 15, 2007. It requested a transfer (dated February 11, 2008) of DE days. On February 20, 2008, St. Vincent's individual appeal was dismissed for failure to file a preliminary position paper. The Board hereby grants the transfer since it was submitted to the Board prior to the issuance of the dismissal letter. St. Vincent's appeal will continue in the new Part C days group case.

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

Board Members Participating:
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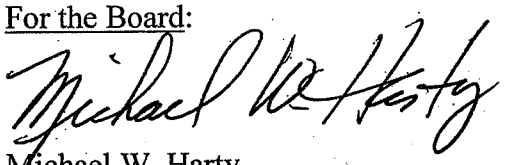
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern (Not Participating)

For the Board:



Michael W. Harty
Chairman

Enclosure

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