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: 11-0090

CERTIFIED MAIL

OCT 15 2015

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

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

RE: St. Francis Hospital & Medical Center
Provider No. 07-0002
FYE September 30, 2006
PRRB Case No. 11-0090

Dear Mr. Ravindran and Mr. Browning:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's challenge to the Board's jurisdiction to the Disproportionate Share Hospital ("DSH") Medicaid Eligible Days and SSI percentage issues. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

Background

On March 6, 2007, the Medicare Contractor accepted the Provider's as-filed cost report that included 11,152 Medicaid paid days and 10,290 Medicaid eligible days.[1] On October 26, 2009, the Provider submitted additional Medicaid eligible days per Medicare Contractor request.[2] On May 10, 2010 the Medicare Contractor issued a Notice of Program Reimbursement ("NPR") incorporating those additional Medicaid days (and making other audit adjustments). On November 10, 2010, the Provider submitted a request for hearing for its 09/30/2006 cost report appealing the following issues.

1. DSH-Medicaid Eligible Days
2. DSH-Dual Eligible Days[3]
3. DSH-No Pay Part A Days[4]
4. DSH-Part C Days[5]
5. DSH-General Assistance Days[6]

[1] *See* MAC's jurisdictional challenge at 1.
[2] *See* MAC's jurisdictional challenge, Exhibit I-3 at 9.
[3] Transferred to Case No. 09-1002G on December 21, 2010.
[4] Transferred to Case No. 08-2598G on December 21, 2010. Remanded pursuant to CMS Rule 1498-R and closed on August 7, 2015.
[5] Transferred to Case No. 09-0996G on December 21, 2010.
[6] Transferred to Case No. 08-2169G on December 21, 2010. Board issued decision 2015-D8 on May 7, 2015.

6. DSH-Labor and Delivery Room Days[7]
7. DSH-SSI realignment
8. DSH-SSI %[8]

On July 21, 2014 the Board received the Provider's Alert 10 submission.

On November 5, 2014, the Medicare Contractor challenged the Board's jurisdiction over the DSH – Medicaid eligible days and DSH-SSI % issues. On December 3, 2014 the Provider submitted a responsive brief to the jurisdictional challenge.

Medicare Contractor's Contentions:

DSH-Medicaid Eligible Days

The MAC states that it accepted the Provider's submitted 2006 Medicare cost report on March 6, 2007. On the as-filed cost report, the Provider included 11,152 Medicaid paid days and 10,290 Medicaid eligible days. Prior to the review and issuance of the NPR, the MAC requested and the Provider submitted revised Medicaid listings. The MAC adjusted Medicaid days to match the revised listings.

The MAC asserts that the Board does not have jurisdiction over the DSH – Medicaid eligible days issue. The MAC accepted the Provider's amended listings without review and adjusted Medicaid days to match the listings. The MAC argues that there was no final determination for this issue. The MAC argues that the days in dispute are not the days that were adjusted on the Provider's finalized cost report.

The MAC also contends that the Provider requested and received a reopening NPR in 2013 for bad debts and the Indirect Medical Education and Graduate Medical Education cap[9], but that the Provider did not request a reopening to add Medicaid eligible days.

The MAC analyzed the September 6, 1986 Federal Register commentary, and concluded that the Provider was in fact required to make a formal claim for DSH, and the eligible days issue should be reviewed the same as other unclaimed costs under *Bethesda*, whereas if you could have claimed a cost (in this case days), you were required to do so, and if you fail to, you fail to meet the dissatisfaction requirements of 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840.

The MAC argues that the Provider has failed to demonstrate the existence of a practical impediment that prevented it from identifying and claiming the days now in question prior to the settlement of the cost report or as part of the reopening revised NPR.[10]

DSH-SSI%

The MAC asserts that the SSI% was subject to CMS Ruling 1498 and the Provider received an updated SSI% in a reopening dated August 17, 2012.[11] Therefore the Board should dismiss this issue from the

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[7] Transferred to Case No. 09-2333G on December 21, 2010. Remanded pursuant to CMS Rule 1498-R and closed on March 7, 2012.
[8] Transferred to Case No. 09-1003G on December 21, 2010. Remanded pursuant to CMS Rule 1498-R and closed on February 6, 2014.
[9] *See* MAC's Jurisdictional Challenge, Exhibit I-13.
[10] *See* MAC's Jurisdictional Challenge at 6-7.
[11] *See* MAC's Jurisdictional Challenge at 8.

subject appeal.

Provider's Contentions:

DSH-Medicaid Eligible Days

The Provider argues that the Board does have jurisdiction over its appeal because the MAC specifically adjusted DSH on its cost report and is dissatisfied with its DSH reimbursement.

The Provider contends that, in spite of performing the eligibility process, it was unable to include all eligible days in the cost report for various reasons outside its control.[12] The Provider argues that it is not privy to the inner working of the State's Medicaid system and furthermore, the State of Connecticut's eligibility vendor experienced issues providing accurate data.

The Provider further argues that it could not have been reasonably expected to predict all of the Medicaid eligible days properly includable without additional data, such as documentation of eligibility from the state.[13] The Provider explains that it took efforts to include the most accurate count of paid and eligible days on its as-filed cost report, and should not be penalized and barred from appealing days to which it could not have identified at the time of filing.

DSH-SSI%

The Provider states that the DSH-SSI% was adjusted on its cost report and the Board should grant jurisdiction.

Board Decision:

DSH-Medicaid Eligible Days

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835 – 1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is filed within 180 days after the date of receipt by the provider of the intermediary 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 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

[12] *See* Provider's Alert 10 Response at 15.
[13] *Id.* at 16.

covered by this report.

Consistent with its decision in in *Barberton Citizens Hosp. vs. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015)("*Barberton*"),a Provider must establish a practical impediment in regards to its Medicaid eligible days in order for the Board to find that the Provider has met the dissatisfaction requirements set forth in42 U.S.C. §1395oo(a). In *Barberton* the Board states "pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction of 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."[14]

In the instant appeal, the Provider filed its cost report with 11,152 Medicaid paid days and 10,290 Medicaid eligible days, for a total of 21,442 Medicaid days.[15] The Provider submitted revised listings to the MAC prior to the issuance of the NPR, to which the Medicare Contractor made audit adjustments to increase days in total by 231.[16] The Provider has documented that there was a practical impediment in filing all matched days on the as-filed cost report. However, the Provider has not documented a practical impediment that prevented it from requesting the days it now seeks, in the revised listings it provided to the Medicare Contractor at audit in 2009, three years after the Provider's fiscal year end.

The Board finds that it lacks jurisdiction on the Medicaid eligible days issue in the subject appeal. The facts of this appeal are distinguishable than those in Barberton, as in Barberton the MAC did not provide the Provider an opportunity to present additional Medicaid days on audit, and it was only on appeal that the provider was able to supply the additional days it could not have compiled on the as-filed cost report. In this appeal, the Provider was able to supply the additional days it could not document on the as-filed appeal on audit (three years after the Providers' FYE), but are unable to document how, on appeal, they have demonstrated it is dissatisfied with the determination made by the Medicare Contractor. The Medicare Contractor gave the Provider the exact number of days Medicaid days it requested on audit, and is now still requesting additional days to which there was not previous dissatisfaction.

DSH-SSI%

The Medicare Contractor challenged jurisdiction over the DSH-SSI% issue. However, this issue was properly transferred to Case No. 09-1003G on December 10, 2010. Case No. 09-1003G was remanded and closed on February 6, 2014. Therefore, the DSH-SSI% issue is not pending in the subject case.

DSH-SSI Realignment

The DSH-SSI Realignment issue is still pending in the subject appeal. The Board finds this issue is moot due to the remand of the SSI% to the MAC. When the Provider receives a new SSI% in a revised NPR it can request realignment at that time. Therefore, the Board dismisses the SSI realignment issue from the subject appeal.

In summary, the Board denies jurisdiction over the last issues pending in the subject appeal, DSH Medicaid Eligible Days and SSI realignment issues. The Board hereby closes Case No. 11-0090.

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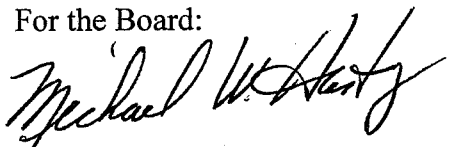
[14] *Barberton* at 4.
[15] Medicare Contractor's final position paper, I-11 at 1.
[16] *Id* at 4.

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

For the Board:



Michael W. Harty
Chairman

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

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

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Refer to:

CERTIFIED MAIL

OCT 22 2015

Provena Health
Sandy Cosler
System Director, Reimbursement
9223 West Saint Francis Road
Frankfort, IL 60423

RE: Jurisdictional Decision – on revised NPR appeal for
Provena Mercy Center, Provider No. 14-0174, FYE 12/31/2005 (participant 1)

As a participant in Provena Health 2006-2007 DSH/Labor Room Days CIRP Group,
PRRB Case No.: 10-0366GC

Dear Ms. Cosler:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced common issue related party (CIRP) group appeal which is subject to CMS Ruling 1498-R. The Board notes an impediment to jurisdiction over one of the participants in the group. The background and the Board's jurisdictional determination are set forth below.

Background

Provena Mercy Center was issued a revised Notice of Program Reimbursement (RNPR) on February 23, 2010. On August 20, 2010 the Provider filed a Model Form E – Request to Join an Existing Group Appeal: Direct Appeal From Final Determination, joining the subject group appeal. The Representative did not provide copies of the documentation (workpapers) required to support an adjustment to Labor Room Days on the RNPR.

Board's 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 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, and the request for hearing is received by the Board within 180 days of the date of receipt of the intermediary's final determination. However, before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over Provena Mercy Center's RNPR appeal. The applicable regulations explain that a revised NPR is considered a separate and distinct

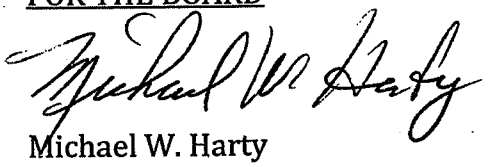
determination, and, the issue on appeal must have been specifically revised as a prerequisite for Board jurisdiction.[1] In this case, the documentation is not sufficient to document that Labor Room Days were revised for Provena Mercy Center.

Therefore, Provena Mercy Center (Participant 1) is hereby dismissed from case number 10-0366GC. 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.

Enclosed, please find a Standard Remand of DSH Labor Room Days Under CMS Ruling CMS-1498-R for the remaining participants in the group.

Board Members Participating
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

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 Labor Room Days Under CMS Ruling CMS-1498-R
Schedule of Providers

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

[1] 42 C.F.R. § 405.1885, 1889 (2009); *see also Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014) (holding that an "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered).

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Refer to: 09-1944GC

CERTIFIED MAIL OCT 22 2015

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

RE: Request for Reconsideration of Denial of Bifurcation Request
Daughters of Charity 2003 DSH Dual Eligible Days CIRP Group
Provider No.: Various
FYE: Various
PRRB Case Nos.: 09-1944GC

Dear Mr. Knight,

The Provider Reimbursement Review Board (Board) has reviewed the Providers' Request for Reconsideration of Denial of Bifurcation Request in case number 09-1944GC. The Board hereby denies the request for reconsideration; its decision is set forth below.

BACKGROUND

The Providers requested to establish this group appeal on June 23, 2009. On July 15, 2010, the group representative submitted a consolidated position paper for this appeal and others, which included a listing of the dual eligible days categories the Providers were appealing. The Board later received a request from Toyon Associates, Inc., the group representative, entitled, "Request for Case Bifurcation, Expedited Judicial Review for Part A Dual Eligible Days and for a Consolidated Hearing for Dual Eligible Part C Days." The Board denied the bifurcation request and the group representative subsequently filed this request for reconsideration of that denial.

REQUEST FOR RECONSIDERATION ARGUMENTS

The Providers argue that the Board should grant reconsideration and bifurcate the dual eligible exhausted Part A and Part C days issues. The Providers argue that their intent at the time they filed the appeal of the dual eligible days issue was to appeal all categories of dual eligible days. They argue that the factual and historical context in which the Providers appealed the dual eligible days issue supports their assertion that their intent was to appeal all categories of dual eligible days. First, the Providers argue that the 1986 DSH rule allowed dual eligible days in the Medicaid fraction numerator when Medicaid paid for the days, such as when no Medicare

payment was made because Part A benefits were exhausted. Second, the Providers argue that after CMS Ruling 97-2, CMS asserted that all dual eligible days must be excluded from the numerator of the Medicaid fraction based on the patient's status as a beneficiary. Furthermore, the Providers state that when they filed the group appeal, hospitals were contesting the exclusion of all dual eligible days that were not entitled to payment of benefits under Part A for any reason.

The Providers further argue that their intent to appeal the "whole dual-eligible issue" was expressed in the appeal and transfer language of the various Providers.[1] According to the Providers, the Board erred in assuming that the group issue statement was not intended to encompass the dual eligible days issue and in assuming that several Providers abandoned the dual eligible days issue. Finally, the Providers argue that the notice-pleading rules in effect when the group appeal was established did not require a specific description of the "exact nature of all aspects of the issue in dispute."[2]

BOARD'S DECISION

The Board hereby denies the Request for Reconsideration of Denial Bifurcation Request in case number 09-1944GC. In making its original decision regarding bifurcation of this appeal as well as with regard to this request for reconsideration, the Board has considered the record before it in its entirety, including all individual and group appeal requests, transfer requests, and position papers. The Board has determined that these documents together are not sufficient to establish that the Providers intended the Part C days to be an issue in this group appeal.

Toyon acknowledged in its reconsideration request that the issue statement for case number 09-1944GC did not specifically raise the Medicare Part C issue. It also acknowledged that the three Providers it included in the reconsideration request transferred the dual eligible days issue "in its entirety" but again did not specifically raise the Medicare Part C issue. The Board rules and regulations in effect at the time the group appeal was established and at the time the Providers requested to transfer the dual eligible days issue to this group appeal, both require a certain level of specificity for issue statements. 42 C.F.R. § 405.1835(b)(2) (2009) provides that an appeal request must include:

> An explanation (for each **specific item at issue** . . .) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal" (emphasis added).

Effective August 21, 2008, PRRB Rule 8 states:

> Some issues may have multiple components. To 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 . . . (emphasis added).

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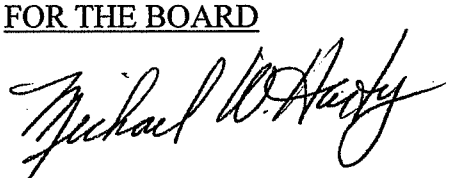
[1] Request for Reconsideration at 5 (July 16, 2015).
[2] *Id.* at 7.

The Board has determined that the Providers' group appeal request and transfer requests did not **specifically** identify the Part C days as an issue as required its rules and regulations. The Board affirms its previous decision and denies the Providers' request for reconsideration of the issue bifurcation. The Board has already reviewed all of the relevant documents when it made its original decision to deny bifurcation of the appeal. It determined that the documents did not establish that the Providers intended the Part C days to be an issue in this group appeal and upon a second review for this request for reconsideration the Board has reached the same conclusion. Therefore, the Board hereby denies the Request for Reconsideration of Denial of Bifurcation Request in case number 09-1944GC. The appeal remains closed.

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

cc: Darwin San Luis
Noridian Administrative Services, LLC
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

Wilson C. Leong, Esq., CPA
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Refer to:

CERTIFIED MAIL

OCT 28 2015

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

RE: QRS Empire Health Services 2005-2008 SSI CIRP Group, PRRB Case No. 09-2071GC

Dear Mr. Nord:

The Provider Reimbursement Review Board ("Board") has reviewed the subject group appeal on its own motion and has noted a jurisdictional impediment. The pertinent facts with regard to this case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

QRS filed the request for a common issue related party ("CIRP") group appeal on July 28, 2009 for the Supplemental Security Income ("SSI") ratio issue. The Board acknowledged the group appeal and assigned Case No. 09-2071GC.

The first participant used to form the group was Valley Hospital Medical Center ("Valley Hospital") (Provider No. 50-0119) for FYE 12/31/2006. Subsequently, QRS added multiple fiscal years for this provider as well as multiple years for Deaconess Medical Center ("Deaconess") (Provider No. 50-0044), thus resulting in the following participants:

	Provider	FYE	Date Filed	Source	Final Determination Cited
1	Deaconess	12/31/2007	11/25/2009	Direct Add	NPR dated 7/30/2009
2	Valley Hospital	12/31/2005	12/13/2010	Transfer from 08-0905	NPR dated 9/19/2007
3	Valley Hospital	12/31/2006	07/14/2009	Transfer from 09-0109[1]	Notice of Program Reimbursement (NPR) dated 4/5/2008
4	Valley Hospital	12/31/2007	9/10/2012	Direct Add	Publication of SSI % on web[2]
5	Valley Hospital	9/30/2008	9/10/2012	Direct Add	Publication of SSI % on web[3]
6	Deaconess	9/30/2008	9/10/2012	Direct Add	Publication of SSI % on web[4]
7	Deaconess	12/31/2006	1/07/2013	Direct Add	NPR dated 8/14/2012
8	Valley Hospital	12/31/2006	6/12/2013	Direct Add	Revised NPR dated 2/15/2013
9	Valley Hospital	12/31/2007	6/17/2013	Direct Add	NPR dated 7/19/2012

[1] The Provider's transfer request dated July 14, 2009 was sent separately from the group appeal request which was dated July 17, 2009. The group request was not received by the Board until July 28, 2009.
[2] The cover letter indicates the basis for the appeal was the issuance of the SSI percentages as published on CMS' website on March 16, 2012.
[3] *Id.*
[4] *Id.*

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.

Appeals from the Publication of SSI Ratios

On March16, 2012, the Centers for Medicare & Medicaid Services ("CMS") posted revised ratios for the Medicare disproportionate share hospital ("DSH") calculation for fiscal years 2006 through 2009.[5] Since the DSH adjustment is based on a hospital's cost reporting period, final determination of a hospital's eligibility for, and amount of, any DSH adjustment will be made by the Medicare Contractor at the time of the year-end settlement of its cost report.[6]

The Board finds that the publication of updated SSI ratios on the CMS website is not a final determination as contemplated by the Board's jurisdictional statute at 42 U.S.C. §1395oo(a) and, therefore, the appeals raised from the publication of SSI percentages are premature.[7] Accordingly, the Board does not have jurisdiction over Valley Hospital (FYE 12/31/2007 and FYE 9/30/2008) or Deaconess Medical Center (FYE 9/30/2008) based on the appeals from the publication of the SSI ratios and dismisses these providers (Participants 4, 5, 6) from the group.

CMS Ruling 1498-R – Pre-Ruling/Post-Ruling SSI Ratio Issues

On April 28, 2010, the CMS Administrator issued CMS Ruling CMS-1498-R ("Ruling") to address three specific Medicare DSH issues, including the "data matching process" used to calculate the SSI ratio.[8]

The three initial participants, Deaconess (FYE 12/31/2007) and Valley Hospital (FYE 12/31/2005 and FYE 12/31/2006), raised appeals based on NPRs issued prior to the issuance of the Ruling. For these participants, the Ruling requires that Board remand each qualifying appeal of this issue to the appropriate Medicare contractor to recalculate each provider's DSH payment.

However, the final three participants, Valley Hospital (FYE 12/31/2006 from Revised NPR and FYE 12/31/2007) and Deaconess (FYE 12/31/2006) appealed from NPRs that were issued after the effective date of CMS Ruling 1498-R. These providers have received the updated SSI ratios and are not subject to a remand under the Ruling. Therefore, the pre-Ruling SSI issue initially raised in the group appeal is a different legal issue than the post-Ruling SSI issue currently being raised by these final participants.

Consequently, the Board is bifurcating Case No. 09-2071GC to separate the remaining final determinations in dispute. Enclosed, please find a Notification of Bifurcated CIRP Group assigning Case No. 16-0075GC to the newly formed case, the QRS Empire Health 2006-2007 Post-Ruling 1498 SSI

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[5] *See* http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html (last visited Oct. 21, 2015).
[6] Medicare Program; Changes to the Inpatient [PPS], 51 Fed. Reg. 31,454, 31,458 (Sept. 3, 1986).
[7] Valley Hospital and Deaconess have since received NPRs in which these revised SSI ratios were utilized and have filed new appeal requests. Specifically, Valley Hospital (FYE 12/31/2007) filed a request to be directly added to this group on June 17, 2013. Valley Hospital and Deaconess (both FYE 9/30/2008) transferred the SSI Percentage issue to Case No. 15-3126GC, the QRS Empire Health 2008 SSI Percentage NPR Based CIRP Group.
[8] CMS Ruling No. 1498-R at 4-7 and 29-30. *See* https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS1498R.pdf (last visited Oct. 21, 2015).

Percentage Group. The Board is transferring the post-Ruling providers (Participants 7, 8, 9) to this newly formed group:

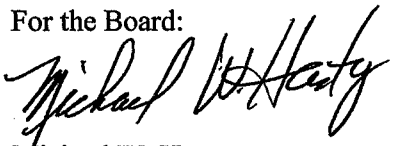
Deaconess Medical Center (50-0044), FYE 12/31/2006;
Valley Hospital Medical Center (50-0019), FYE 12/31/2006; and
Valley Hospital Medical Center (50-0019), FYE 12/31/2007.[9]

Case No. 09-2071GC will remain pending for participants that received NPRs prior to the issuance of the Ruling (Participants 1, 2, 3) as these participants are subject to remand. Enclosed, please find a Standard Remand of the SSI Fraction pursuant to CMS Ruling 1498-R.

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
Notification of Bifurcated CIRP Group for Case No. 16-0075GC
Standard Remand of the SSI Fraction under CMS Ruling 1498-R with Schedule of Providers for Case No. 09-2071GC

cc: Byron Lamprecht, Wisconsin Physicians Service (w/enclosures)
Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

[9] Direct Add Requests were received January 7, 2013; June 12, 2013; and June 17, 2013, respectively.

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Refer to:

CERTIFIED MAIL

OCT 28 2015

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

Re: **Catholic Health System NY 2002 Dual Eligible CIRP Group Bifurcation to Part A Non-Covered/Exhausted Benefits Days and Part C Days**
PRRB Case No.: 09-0143GC

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 will be adjudicated in Case No. 16-0085GC, Catholic Health System NY 2002 Part C Days CIRP Group.[1] If the Board finds 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 in 2008, framed the issue as follows:

> Whether the Providers' [Medicare Contractors] correctly excluded from the Providers' Medicaid percentages all days of care that were rendered to dual eligible patients. . . .[2]

The Representative identified four categories of days, including Medicare Part A (exhausted benefit days); Medicare Secondary Payer days; Days Denied as Medically Unnecessary or Custodial Care; and Medicare Part C days.

The initial appeal request included two providers, Mercy Hospital of Buffalo (33-0279) and Sisters of Charity (33-0078). On October 2, 2009, the Representative advised that the group was complete and that there would be no additional participants added.

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[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.
[2] *See* Group hearing request, Tab 2: Statement of the Group Issue at 1, Oct. 16, 2008.

On May 31, 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.[3] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[4] McKay wrote that it determined that " . . . each of the group appeals . . . challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[5]

Board Determination on Bifurcation

The Board hereby grants the bifurcation request regarding the Dual Eligible days issue into two groups:

(1) Dual Eligible Exhausted Benefits days and
(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."[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 2008 group appeal request.

Board Determination on Jurisdiction

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

The Board finds that Mercy Hospital of Buffalo (participant 1) properly added the Dual Eligible days issue to its individual appeal and specifically raised the sub-issue of Part C days on October 17, 2008 (prior to the October 21, 2008 deadline for adding issues) prior to transferring to the subject group appeal. The other provider in the group, Sisters of Charity Hospital (participant 2)

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[3] *See* Case Management Plan Letter, May 31, 2013.
[4] *See* Bifurcation Letter, Aug. 30, 2013.
[5] *Id.* at 1.
[6] 42 C.F.R. § 405.1837(a)(2) (2003).

transferred the Dual Eligible days issue from an optional group (case no. 06-0859G) for which the group issue statement was framed as

> Is the [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 who received Part C benefits correct?[7]

The request to transfer Sisters of Charity from the optional group to the subject CIRP group was filed on October 17, 2008. Although the transfers for both Providers occurred after the 2008 regulation change, which limited the ability to add issues to an open appeal, the original appeals included the issue prior to the regulatory change. 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 deems the "transfer" of the "Dual Eligible days component" a transfer of Dual Eligible Exhausted Benefits days and an "add/transfer" of the Dual Eligible Part C days issue. The Board finds that the group appeal to which the providers were transferring explicitly defined the issue under appeal as including the Part C days component.

The Parties will receive correspondence regarding the applicability of CMS Ruling 1498-R with regard to the Dual Eligible Days issue under separate cover.

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

For the Board:
Michael W. Harty
Chairman

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

[7] 06-0859G Group Request for Hearing at 2, Jan. 12, 2006.

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Refer to: 04-1053

OCT 28 2015

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Trinity Health System
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Manager, Reimbursement
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Wisconsin Physicians Service
Byron Lamprecht
Cost Report Appeals
P.O. Box 1604
Omaha, NE 68101

RE: Jurisdiction Challenge – St. John's Health System
Provider No.: 15-0088
FYE: 06/30/2001
PRRB Case No.: 04-1053

Dear Mr. Tomkovich and Mr. Lamprecht,

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

Background

The Provider submitted a request for hearing on March 11, 2004, based on a Notice of Program Reimbursement (NPR) dated September 17, 2003. On August 23, 2011, the Medicare Administrative Contractor (MAC) challenged the Board's jurisdiction over the Disproportionate Share Hospital (DSH) – Medicaid eligible days issue. On August 29, 2011, the Provider submitted a responsive brief.

The Board finds that it lacks jurisdiction over St. Johns Health System for FYE 6/30/2001) as the Provider was unable to establish they faced a practical impediment in gaining Medicaid eligibility data prior to the submission of the initial cost report.

Intermediary's Position

The MAC asserts that the Board does not have jurisdiction over the DSH – Medicaid eligible days issue because there was no final determination for this issue. The MAC argues that it gave the Provider a deadline during the audit process to submit an additional listing of Medicaid days, and they failed to submit a listing by the deadline. There was no adjustment made on the settled cost report for the issue of Medicaid days and the Provider was not precluded from claiming the additional payment for which it is now claiming in their initial cost report.

Provider's Postion

The Provider contends that the Board should accept jurisdiction consistent with numerous other court decisions requiring both paid and unpaid days be included in the DSH Medicaid fraction, and also cites *Bethesda Hospital et al. v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*"), in which the Supreme Court dealt with the Board's authority to hear appeals on matters that were not included on the cost report and were not he subject of an adverse intermediary determination. The Provider states that they did submit additional Medicaid days to the MAC for review during the audit process (albeit one day late), and therefore has shown that they exhausted their administrative remedies to resolve this issue. The Provider states that the parties worked together for years to administratively resolve this issue, and believed that resolution was imminent until the MAC filed its jurisdictional challenge.

Board's Decision

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835 – 1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is filed within 180 days after the date of receipt by the provider of the intermediary 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 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.

The Board finds that, pursuant to the rationale in *Barberton Citizens Hosp. vs. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015)("*Barberton*"), the Provider was not able to establish a practical impediment in regards to their Medicaid eligible days.

In *Barberton* the Board states "pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction of 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."[1]

While the Provider went to lengths describing the submission of additional documentation to the MAC at audit and during the appeals administrative resolution process, the fact remains that the

1 *Barberton* at 4.

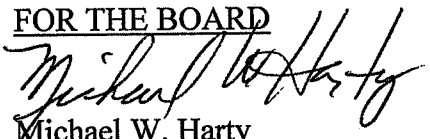
days in dispute were not included on the cost report. The Provider received reimbursement for the number of days it claimed on its as-filed cost report. Although it has given the MAC additional listings of days during the audit and appeals process, the MAC is not required by regulation or statute to review such documentation (listing provided at audit was after deadline).

The standard set forth in Barberton requires the Provider to document why they did not initially claim the Medicaid days at issue on their as-filed cost report. The Provider did not document how there was a practical impediment from obtaining the days, therefore, the Board finds they lacked the practical impediment needed for Board jurisdiction of an item not claimed on the as-filed cost report. The Provider's burden for Board jurisdiction is to document their required statutory dissatisfaction with the MAC's determination in the NPR. However, as the Provider failed to make a valid claim in the cost report for the days they are now requesting, nor was there a practical impediment documented to make such a claim, the Provider has not documented they are "dissatisfied" with the reimbursement they received in the NPR for Medicaid days.

As the Board lacks jurisdiction over the Medicaid eligible issue, the issue is dismissed from this appeal. As Medicaid eligible days was the sole remaining issue in this appeal, the appeal is now 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
Michael W. Harty
Charlotte Benson, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

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