PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D14

PROVIDER –
Norwalk Hospital
Norwalk, CT

Provider No.: 07-0034

Cost Reporting Period Ended:
September 30, 2005

vs.

CASE NO.: 09-0704

INTERMEDIARY –
Blue Cross Blue Shield Association/
National Government Services, Inc.

INDEX

ISSUE:

Whether the Provider Reimbursement Review Board has jurisdiction over Medicaid eligible days for which there was no adjustment made by the Intermediary within the Notice of Program Reimbursement.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended (Act),[1] to provide health insurance to the aged and disabled. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulation, and interpretative guidelines published by CMS.[3]

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the inpatient prospective payment system for operating costs.[4] Similarly, the capital-related costs of inpatient hospital services are reimbursed by Medicare generally through the prospective payment system for capital-related costs.[5] Collectively, these prospective payment systems will be referred to as the inpatient prospective payment system (IPPS).

A Medicare Disproportionate Share Hospital (DSH) payment is an adjustment to the IPPS payment rates.[6] The DSH payment is based on whether a hospital meets certain criteria (*e.g.*, number of beds, geographical location) and whether it treats a threshold number of low income patients. As a proxy for the number of low income patients, the statute uses the sum of two fractions, the Medicare and Medicaid fractions. That sum is known as the "disproportionate patient percentage." The Medicare fraction (also known as the SSI fraction) utilizes the number of days of inpatient care for Medicare patients who are eligible for Supplemental Security Income (SSI). The Medicaid fraction is derived from inpatient hospital days for patients entitled to medical assistance under Title XIX of the Act,[7] which established the Medicaid program. The greater the disproportionate patient percentage exceeds the relevant threshold eligibility for a DSH adjustment, the greater the payment to the hospital.

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[1] 42 U.S.C., Chapter 7, Subchapter XVIII.

[2] FIs and MACs are hereinafter referred to as intermediaries.

[3] *See* Social Security Act (Act) §§ 1816 and 1874A, 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

[4] *See* § 1886(d) of the Act, 42 U.S.C. § 1395ww(d); 42 C.F.R. § 412.1(a).

[5] *See* § 1886(g) of the Act, 42 U.S.C. § 1395ww(g); 42 C.F.R. § 412.1(a).

[6] *See* § 1886(d)(5)(F) of the Act, 42 U.S.C. § 1395ww(d)(5)(F); 42 C.F.R. § 412.106.

[7] 42 U.S.C., Chapter 7, Subchapter XIX.

Providers are required to submit cost reports annually, with reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[8] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR).[9]

A provider dissatisfied with the intermediary's final determination of total reimbursement (*i.e.*, the NPR) may file an appeal with the Provider Reimbursement Review Board (Board) provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[10]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Norwalk Hospital (Provider) is a Medicare certified acute care hospital located in Norwalk, Connecticut. National Government Services, Inc. (Intermediary) is the Provider's Medicare fiscal intermediary.

The Provider submitted a timely request for hearing on January 23, 2009, based on an NPR dated August 15, 2008. The Provider raised multiple issues in its appeal request; however, per the proposed joint scheduling order dated September 30, 2009 and the Provider's final position paper dated January 27, 2011, the sole unresolved issue is DSH – Medicaid Eligible Days. The Provider has described this issue as follows:

> Whether the numerator of the "Medicaid fraction" properly includes all "eligible" Medicaid days, regardless of whether such days were paid days.[11]

The Intermediary challenged the Board's jurisdiction over the DSH – Medicaid Eligible Days issue by filing a jurisdictional brief dated April 13, 2011. The Provider submitted a responsive jurisdictional brief dated May 11, 2011. Pending the Board's jurisdictional decision in this case, the parties submitted a stipulation of facts dated March 14, 2012, and agreed that 7,597 Medicaid eligible, both paid and unpaid, days should be allowed after a review of documentation submitted by the Provider.[12]

The Provider was represented by J.C. Ravindran of Quality reimbursement Services. The Intermediary was represented by Arthur E. Peabody, Jr., Esq. of Blue Cross Blue Shield Association.

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[8] *See* 42 C.F.R. § 413.20.

[9] *See* 42 C.F.R. § 405.1803.

[10] *See* § 1878(a) of the Act, 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835.

[11] Provider's Final Position Paper at 3.

[12] *See* Stipulations dated March 14, 2012, ¶9.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that there was no adverse finding meeting the requirements of 42 C.F.R. §§ 405.1801(a) and 405.1803. The Intermediary did not adjust the number of Medicaid days reported on the as-filed cost report; rather, it used the number of Medicaid paid and unpaid days reported by the Provider. The Provider has had ample time since the issuance of HCFA Ruling 97-2 to either establish a method for accumulating its own Medicaid eligible paid and unpaid days or to timely make a request to its state agency for the data prior to submission of its cost report. In its Jurisdictional Brief, the Intermediary cites Maple Crest Care Center v. Mutual of Omaha Insurance Company, PRRB Decision 2003-D4 (Nov. 7, 2002), in which the Board ruled that it lacked jurisdiction over issues of unclaimed costs where "[t]here was nothing in the statute, regulations or manual provisions that prevented the Provider from making the cost report elections in the manner it requested through the reopening request."[13]

The Intermediary also requests the Board review its prior interpretation of 51 Fed. Reg. 31454, 31457 (Sept. 3, 1986).[14] The Intermediary argues that this Federal Register cite only applies to interim payments and, therefore, does not apply to the final DSH payment calculation. The Provider has the responsibility to submit complete and accurate data on its filed cost report, including the number of eligible Medicaid days to be used in calculating the DSH payment at final settlement. The Intermediary does not accumulate cost report data for the Provider, but rather is responsible for the review of the data submitted by the Provider and for verification that this data meets regulatory requirements.

PROVIDER'S CONTENTIONS:

The Provider believes jurisdiction can be found under Bethesda Hosp. Ass'n v. Bowen, 485 U.S. 399 (1988), and the Board's prevailing rules since the DSH – Medicaid Eligible Days issue was self-disallowed. The Provider asserts that the Medicaid eligible days (including those at issue) are often not available from the State in time for the Provider to include them on the cost report prior to the cost report filing deadline. The Provider then relies on previous Board jurisdiction decisions that indicated "the practical difficulties in getting [State] information combined with the Secretary's statement it is not necessary for hospitals to formally apply for a DSH adjustment create circumstances in which a provider may demonstrate that it is dissatisfied with the Intermediary's determination of reimbursement despite not having made a claim on the cost report."[15]

Finally, the Provider cites to 42 C.F.R. § 412.106 which sets forth the DSH classification criteria and asserts that § 412.106 predetermined that it would not have qualified for DSH. As a result, the Provider self-disallowed Medicaid eligible days in the cost report in accordance with PRRB Rule 7.2(A). In this regard, the Provider contends that the Provider can qualify for DSH under § 412.106 only as a result of the additional Medicaid days at issue.

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[13] *Available at* http://www.cms.gov/PRRBReview/downloads/2003D4.pdf (last visited Mar. 16, 2012).

[14] *See* Intermediary's Jurisdictional Brief at 3-4 and Exhibit I-7.

[15] Provider's Jurisdictional Brief at 1-2 (no citations provided).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

Absent the jurisdictional issue before the Board, the parties have agreed through stipulation of facts that a total of 7,597 Medicaid eligible days are allowable in the Provider's DSH calculation. However, the Intermediary challenges the Board's jurisdiction over the DSH issue on the ground that the Intermediary did not make an adjustment to the Medicaid eligible days in the NPR at issue. Rather, the Provider simply failed to claim on its cost report, the Medicaid days which it now requests on appeal.

CMS promulgated regulations to implement the DSH statute via an interim final rule published on May 6, 1986 (the May 1986 Interim Final Rule).[16] CMS later finalized these regulations in the final rule published on September 3, 1986 (the September 1986 Final Rule).[17] In the preamble to the September 1986 Final Rule CMS states:

> It is *not necessary* for hospitals serving a disproportionate number of low income patients ... *to formally apply for a disproportionate share adjustment.* The Medicare fiscal intermediaries have been given instructions to make a determination concerning each hospital's eligibility for an adjustment under § 412.106(b)(1) based on Medicaid data from the hospital's latest available cost report and the Supplemental Security Income (SSI)/Medicare percentages that have been supplied by HCFA central office....
>
> As we stated in the interim final rule (51 FR 16777), hospitals may submit additional Medicaid and total patient day data to their fiscal intermediaries if they believe that their latest cost report does not accurately reflect these data. However, *additional data supplied are subject to intermediary review and verification.*
>
> *We are evaluating the need to publish regulations to outline procedures and requirements for hospitals to follow in applying for a disproportionate share adjustment* based on the patient revenue criteria under section 1886(d)(5)(F)(i)(II) of the Act, as set forth in regulations at § 412.106(b)(2).[18]

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[16] *See* 51 Fed. Reg. 16772 (May 6, 1986).

[17] *See* 51 Fed. Reg. 31454 (Sept. 3, 1986).

[18] *Id.* at 31457 (emphasis added). Similarly, in the May 1986 Interim Final Rule, CMS states:

> The process we will use for making payments to hospital that serve a disproportionate share of low-income patients will be similar to the process we use to make the additional payment for the indirect medical education costs: that is, we will make interim payments *based on the latest available data subject to a year-end settlement on a cost reporting period basis.* For purposes of making these interim payments, the initial determination of a hospital's eligibility for this payment will be made by the hospital's Medicare fiscal intermediary based on Medicaid statistical data as reported on the hospital's most recent cost report and the SSI and Medicare data to be supplied by HCFA central office. *If a hospital disagrees with the intermediary's determination of its Medicaid patient days, it will be the hospital's responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied.* Medicaid data submitted by

Thus, at the outset of implementing the DSH adjustment, CMS made clear that providers need not "formally apply" for a DSH adjustment because the information on which the intermediary's decision is based is readily available to intermediaries. Specifically, the intermediary would base its decision to make a DSH adjustment on the relevant SSI information supplied by CMS and the Medicaid days information supplied by the provider as part of the cost reporting process.

The Board concludes that: (1) while it is not necessary for a hospital to formally apply for a DSH adjustment, the hospital does have an obligation to submit Medicaid days information as part of the cost reporting process; and (2) this obligation is separate and distinct from the DSH adjustment decision process handled by the intermediary.

First, the above excerpt confirms that hospitals are required to submit the Medicaid days data as part of the normal cost reporting process and that this information is subject to the normal cost report audit and settlement process.[19]

Second, the addition of the DSH adjustment in 1986 did not alter the hospital's obligation to submit Medicaid days data and, thus, that obligation was not subsumed into the DSH adjustment decision process (*i.e.*, that obligation remained separate and distinct from the DSH adjustment decision process). In the preamble to the September 1986 Final Rule, CMS stated that its interpretation of the Medicaid days as used in the Medicaid percentage of the DSH calculation was "consistent with the way we require Medicaid days to be reported on the Medicare cost report."[20] CMS explained that CMS' initial interpretation was based, in part, on CMS' belief that Congress did not intend "an additional reporting mechanism, possibly tied to State eligibility records, be developed to obtain Medicaid statistics on noncovered patient days."[21] As a result, CMS' initial interpretation did not substantively change the scope of hospitals' then-existing obligation to report Medicaid days on the cost report.[22]

Finally, in the preamble to the May 1986 Interim Final Rule, CMS states that the intermediary's findings on the Medicaid patient days are a "determination" in and of itself (*i.e.*, separate and distinct from the DSH adjustment decision process):

> *If a hospital disagrees with the intermediary's determination of its Medicaid patient days*, it will be the hospital's responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied. Medicaid data submitted by the hospital, whether on the cost report

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the hospital, whether on the cost report or furnished subsequently, are subject to intermediary audit to ensure their accuracy.

51 Fed. Reg. at 16777 (emphasis added).

[19] *See supra* note 18.

[20] 51 Fed. Reg. at 31460.

[21] *Id.*

[22] *See also* 56 Fed. Reg. 43358, 43379 (Aug. 30, 1991) (cross-referencing the September 1986 Final Rule discussion of CMS' interpretation of Medicaid days being based, in part, on how Medicaid days was then-currently being reported as part of the normal cost reporting process).

> or furnished subsequently, are subject to intermediary audit to ensure their accuracy.[23]

Based on the above, if a hospital is dissatisfied with the intermediary's determination of its Medicaid days, the hospital can exercise its appeals rights in accordance with the regulations set forth in 42 C.F.R. Part 405.[24]

Legal challenges to CMS' initial interpretation of Medicaid days eventually resulted in CMS issuing HCFA Ruling 97-2. In HCFA Ruling 97-2, CMS accepted that "eligible" as well as "paid" Medicaid days should be included in the Medicaid fraction. The data needed to determine eligibility for Medicaid came from the states. Notwithstanding, HCFA Ruling 97-2 maintains the hospitals' responsibility for collecting and reporting eligible Medicaid days data as part of the cost report:

> Pursuant to this Ruling, Medicare fiscal intermediaries will determine the [DSH] amounts due and make appropriate [DSH] payments through normal procedures. Claims [for DSH adjustments] must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed [Medicaid] days. The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. *Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.*[25]

Significantly, HCFA Ruling 97-2 specifies that a hospital cannot report Medicaid days data from its own records on the cost report if such Medicaid data "cannot be verified by State records." As a result, hospitals are limited to reporting *only* Medicaid days data that have been verified by State records.

Historically, the data needed by providers from the State to verify Medicaid eligibility during a specific fiscal year often has not been available for months or even years after the cost report

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[23] 51 Fed. Reg. at 16777 (emphasis added).

[24] *See* 51 Fed. Reg. at 31458-31459. *See also* Board Rule 8.2; *see generally* Board Rule 8. Board Rule 8.0 addresses how to frame issues for adjustments involving multiple components and Board Rule 8.2 describes a DSH adjustment as the type of adjustment that may involve multiple issue components. Board Rule 8.1 specifies that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in [Board] Rule 7." Similarly, the Board Rules in effect from March 1, 2002, to August 21, 2008, specified the following in Part I.B.II.a: "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."

[25] (Emphasis added.)

filing deadline for that fiscal year. This lack of availability and/or access to State data created a practical impediment to reporting all eligible Medicaid days (both paid and unpaid) for a given fiscal year at the time of the relevant cost report filing deadline. Specifically, it created situations where none (or only a portion) of the relevant Medicaid days data for a fiscal year was available from the State prior to the cost report filing deadline for that fiscal year. In those situations, as required by HCFA Ruling 97-2, hospitals could report only those Medicaid days that were verified by State records.

In the final rule published on July 31, 1998, CMS conformed the DSH regulations located in 42 C.F.R. § 412.106 "to the new statutory construction issued in HCFA Ruling 97-2."[26] In particular, as part of this final rule, CMS incorporated the hospital's obligation to provide Medicaid days data into regulation § 412.106(b)(4)(iii).[27]

In 2003, Congress addressed a hospital's access to information needed to calculate the DSH Medicare and Medicaid fractions, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).[28] Specifically, MMA § 951 requires CMS to "*arrange to furnish* to subsection (d) hospitals ... the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year."[29] CMS has stated, "[W]e interpret section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records ..., in the case of the Medicaid fraction, against the State-Medicaid agency's records."[30]

CMS maintains that it has satisfied its § 951 obligation under this interpretation because the current mechanisms in place allow hospitals to obtain access to this Medicaid days data and these mechanisms are sufficient.[31] Moreover, CMS stated that "it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on hospitals because, since they have provided inpatient care to these patients for which they billed the relevant payers, including the State Medicaid plan, they will necessarily already be in possession of much of this information."[32]

Significantly, in implementing HCFA Ruling 97-2 and MMA § 951, CMS has not addressed how the practical impediment described above (*i.e.*, the fact that only Medicaid days verified by the State can be claimed and that the data needed to verify Medicaid eligibility may not be available) may affect a hospital's appeal rights.[33] The Board concludes that this practical

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[26] *See* 63 Fed. Reg. 40954, 40984-40985 (July 31, 1998).

[27] *Id.*

[28] Pub. L. No. 108-173.

[29] (Emphasis added.)

[30] 70 Fed. Reg. 47278, 47438 (Aug. 12, 2005).

[31] *Id.* at 47442.

[32] *Id.*

[33] The Board is not aware of CMS ever revisiting its 1986 evaluation of "the need to publish regulations to outline procedures and requirements for hospitals to follow in applying for a disproportionate share adjustment based on the patient revenue criteria." 51 Fed. Reg. at 31457. *See supra* note 18 and accompanying text.

impediment is similar to the legal impediment in Bethesda Hosp. Ass'n v. Bowen, 485 U.S. 399 (1988)[34] that the Supreme Court found sufficient for Board jurisdiction under § 1878(a) of the Act.[35] In Bethesda, the Supreme Court states:

> We agree that, under subsection (a)(1)(A)(i) [of § 1878 of the Act[36]], 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*. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the fiscal intermediary. Providers know that, under the statutory scheme, the fiscal intermediary is confined to the mere application of the Secretary's regulations, that the intermediary is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the intermediary to do otherwise would be futile. 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. *We conclude that petitioners could claim dissatisfaction, within the meaning of the statute, without incorporating their challenge in the cost reports filed with their fiscal intermediaries.*[37]

Similarly, the Board concludes that, if a hospital did not claim certain Medicaid days on a cost report because the relevant information to verify such Medicaid days with the State was not available (through no fault of the hospital) prior to the relevant cost report filing deadline, then the hospital could claim dissatisfaction regarding those Medicaid days.

The Board recognizes that CMS recently promulgated regulatory provisions to address Bethesda situations in the final rule published on May 23, 2008.[38] Specifically, CMS promulgated new regulatory provisions at 42 C.F.R. § 405.1835(a)(1) describing how a provider can preserve its right to claim dissatisfaction and to pursue a Board hearing:

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[34] Significantly, the Supreme Court issued Bethesda subsequent to interim final and final rules issued on May 6, 1986, and September 3, 1986, respectively. As a result, these rules do not take into account the Bethesda decision.

[35] 42 U.S.C. § 1395oo(a).

[36] 42 U.S.C. § 1395oo.

[37] Bethesda, 485 U.S. at 404-405 (footnote omitted) (emphasis added).

[38] 73 Fed. Reg. 30190 (May 23, 2008).

> (a) *Criteria.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if—
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> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).[39]

Significantly, CMS describes the new § 405.1835(a)(1)(ii) as "more akin simply to a presentment requirement" than "an exhaustion requirement."[40]

Section 405.1835(a)(1)(ii) states that the "presentment requirement" is not applicable to FYs that end prior to December 31, 2008 and, thereby, is not applicable to this case. Nevertheless, the regulatory history indicates that CMS anticipated that a hospital may self-disallow claims where the cost is unknown and still have appeal rights. In the preamble to the May 23, 2008, final rule, CMS recognized that providers can appeal certain situations where the provider is uncertain about a cost and does not have access to the underlying data to verify such cost. Specifically, in connection with "Provider Hearing Rights," CMS states the following in the preamble:

> In § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i), we proposed that a provider would be required to explain its dissatisfaction with the amount of Medicare payment for the specific item(s) at issue by stating why Medicare payment is incorrect for each disputed item. *We acknowledge that there may be instances in which a provider may be uncertain as to whether Medicare payment is incorrect because it does not have access to underlying data (for example, data from a State agency).* Accordingly, we have revised § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i) to allow a provider to explain why it is unable to determine whether payment is correct as a result of not having access to underlying information.[41]

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[39] *Id.* at 30249 (italics in original).

[40] *Id.* at 30196-30197.

[41] *Id.* at 30194 (emphasis added) (quoting from Section II.D entitled "Provider Hearing Rights (§ 405.1803(d), § 405.1811, and § 405.1835)").

This discussion is consistent with Board Rule 7, entitled "Issue Statement and Claim of Dissatisfaction" which also does apply to this case. Board Rule 7.1 describes what is required for issue statements addressing "NPR or Revised NPR Adjustments" and recognizes in Paragraph B that there may be situations where a provider may not have access to data:

> **B. No Access to Data:** If the Provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.[42]

Similarly, Board Rule 7.2 describes what is required for issue statements addressing "Self-Disallowed Items" and recognizes in Paragraph B that there may be situations where a provider may not have access to data:

> **B. No Access to Data**
>
> If the Provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.[43]

The Board believes that, despite recent improvements in the availability of data, some hospitals still experience delays in obtaining access to this state data (*e.g.*, some states will not accept requests until after the cost report filing deadline).

In this case, the Provider contends that "its finalized cost report did not accurately reflect its Medicaid paid and unpaid but eligible days. The information obtained from the State of Connecticut agencies did not reconcile with the Provider's underlying records. The finalized Medicaid days total did not include paid and eligible days adjudicated and processed after the cutoff date, used by the Intermediary, and did not include all out of State paid and eligible days."[44] The Board finds that, in the cost report as filed, in accordance with the HCFA Ruling 97-2 and the regulation, the Provider used the Medicaid days verified by the State and is dissatisfied that such days did not match its own records.[45] Because HCFA Ruling 97-2 prohibited the reporting of days for patients that could not be verified by State records, the Board finds that jurisdiction is available under Bethesda for the difference being disputed.

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[42] (Emphasis in original.)

[43] (Emphasis in original.)

[44] Provider's Model Form A – Individual Appeal Request at Tab 3, Issue 2.

[45] As § 405.1835(a)(1) as amended on May 23, 2008 is not applicable to this case, the Board specifically declines to address whether the Provider under the facts of this case complied with the new "presentment requirement" under § 405.1835(a)(1). *See supra* notes 40 - 43 and accompanying text.

DECISION OF THE BOARD:

The Board concludes it has jurisdiction over the DSH – Medicaid Eligible Days issue. The Intermediary is directed to revise the Provider's DSH calculation to reflect a total of 7,597 allowable days set forth in the stipulation of facts.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, CPA
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: MAR 19 2012