CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Sisters of Charity Hospital **Provider** **vs.** **Blue Cross/Blue Shield Association** **Empire Medicare Services** **Intermediary**	**Provider Reimbursement for** **Cost Reporting Period Ending:** **12/31/99** **Review of:** **PRRB Decision 2006-D46** **Dated: September 7, 2006**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act). The parties were notified of the Administrator's intent to review the Board's decision and of their right to submit comments during the course of this review. Comments were received from the Intermediary, requesting reversal of Board's decision. Comments were also received from the Provider, requesting affirmation of the Board's decision. Accordingly, the Board's decision is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue on the merits was whether the Intermediary properly calculated the Provider's indirect medical education (IME) reimbursement.

As a preliminary matter, the Majority of the Board found that it had jurisdiction over the Provider's appeal of this issue for FYE December 31, 1999. The Majority determined that although the Intermediary did not adjust the Provider's bed count, it did adjust other components of the Provider's intern and residents to available beds ratio (IBR). The Majority stated that, under the statute, the Board has the authority to revise any cost incurred by a provider during the period covered by a

cost report, regardless of whether the cost had been claimed, or whether the matter was considered by the intermediary. With respect to this case, the Majority noted that intermediaries were required to recalculate provider's 1998 IRB ratios as they related to the determination of IME payment for 1999. The Intermediary made such adjustments to the Provider's 1998 IRB ratio. The Notice of Program Reimbursement (NPR) at issue constitutes the Intermediary's final determination regarding the Provider's IME payment for 1999, and incorporates a determination of an IRB ratio derived, in part, from the 1998 cost reporting period. The Majority explained that the IME payment calculation for 1999, including the 1998 IRB ratio, is a matter covered by the properly appealed 1999 cost report. Thus, the Majority concluded that the Board does have jurisdiction over the appealed IRB ratio issue.

On the merits, the Majority held that the Intermediary's calculation of the Provider's IME reimbursement was improper. The Majority noted that, as mandated by the statute, the IRB ratio for cost reporting periods beginning on or after October 1, 1997, is compared to the IRB ratio derived from the immediately preceding cost reporting period, and limits reimbursement to the lower of the two ratios. In this case, the Intermediary considered the stipulated revised bed count appropriate to calculate the 1999 ratio, but inappropriate to recalculate the 1998 ratio for use in the fiscal year 1999 IRB comparisons. The Majority found that the stipulated bed counts for both 1998 and 1999 are the appropriate counts to be used for the 1999 ratio analysis. The Majority noted, however, that the Provider's 1998 cost report had been settled and is not the subject of any challenge or appeal. Thus, the Majority ordered that calculation of the Provider's IME reimbursement be remanded to the Intermediary for incorporation of those counts.

Two Board members dissented with respect to the Majority's jurisdictional decision. The Dissenters stated that the count of available beds is a component of the IBR computation that is uniquely within the Provider's knowledge and control. In addition, the Dissenters noted that adjustments made by the Intermediary to other aspects of the IBR ratio did not affect the bed count itself. The Dissenters also noted that nothing in the law, regulation, or program instruction about the number of beds that could be claimed encumbered the Provider's claim. Thus, the Dissenters concluded that since the Provider failed to meet its burden to properly report an accurate number of available beds and, the Provider could not demonstrate dissatisfaction.

COMMENTS

The Intermediary commented, requesting reversal of the Majority's decision. The Intermediary argued that the Majority's decision to take jurisdiction is erroneous. The Intermediary pointed out that the dissenting opinion represented a correct analysis of jurisdictional policy and should be adopted.

The Provider commented, requesting affirmation of the Majority's decision. The Provider objected to the Administrator's review due to insufficient notice of the particular issues being reviewed. With respect to the merits of the case, the Provider argued that the Majority Board's decision is correct for all the reasons stated in the decision, for the reasons stated in the Provider's briefs and position papers, and based on evidence in the record.

CMM commented, requesting reversal of the Majority's jurisdictional decision. CMM noted that the dissenting opinion directed attention to the compelling evidence that the Provider did not have a right to appeal the bed counts of the relevant years to the Board.

With respect to the merits of the Provider's case, CMM explained that subject to the caps provided by the Balanced Budget Act of 1997 (BBA), Medicare makes IME payments to hospitals using the intern and resident to bed ratio (IRB ratio) and the intern and resident to bed cap (IRB cap). The IME payment each year is based on the number of full-time equivalent residents and interns training at the hospital and the number of beds at the hospital (i.e., the IRB ratio). The IRB ratio is then compared to the IRB cap, which is the IRB ratio from the previous year. In effect, the IRB cap is a rolling cap with current year IME payments dependent on the lower of either the current year's or previous year's IRB ratio.

CMM noted, at issue in this case, are the bed counts used to determine the Provider's 1998 and 1999 IRB ratios and the application of the IRB cap policy in the 1999 year. The bed count used in this case for both years was the bed count reported by the Provider on its 1998 and 1999 settled cost reports. While the Provider filed a timely appeal of its 1999 cost report, the Provider did not file a timely appeal of its 1998 cost report and, thus, the 1998 cost report is beyond the three-year period for reopening. CMM argued that although the Majority agreed that the bed count on the settled 1998 cost report may not be revised, it incorrectly instructed the parties to disregard the 1998 cost report bed count for purposes of calculating IME payments in 1999. CMM asserted that since the 1998 cost report is no longer subject to appeal, the bed count from the cost report is definitive and

final. Thus, the Intermediary is obligated to use the bed count finalized in the 1998 cost report to calculate the 1998 IRB ratio even for the purpose of calculating IME payments in 1999.

Finally, CMM explained that regarding the 1999 IRB ratio (not the IRB cap), but for the jurisdictional issue, the use of the stipulated bed count for the 1999 year is acceptable and appropriate for calculating the 1999 IRB ratio.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

A provider may request a hearing before the Board if certain criteria are met. Under section 1878(a) of the Act, the Board's jurisdiction is limited to a provider's request for review of a "final determination" of the Intermediary or the Secretary for which the provider is "dissatisfied." That section states, in relevant part, that:

> Any provider of services which has filed a required cost report within the time specified in 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…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 title for the period covered by such report….
> (ii) is dissatisfied with a final determination of the Secretary as to the amount of payment under subsection (b) or (d) of section 1866,
> (2) the amount in controversy is $10,00 or more, and
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i)….[1] (Emphasis added.)

[1] The Board may also take jurisdiction of late-filed appeals "for good cause shown" (42 CFR 405.1841(b)).

A "final determination" is not defined in the Act, but is defined in regulation 42 CFR 405.1801. Section 405.1801(a)(3) states that for purposes of appeal to the Board, "intermediary determination" is synonymous with "intermediary's final determination," and "final determination of the Secretary," as those latter two terms are used in section 1878(a) of the Act. Section 405.1801(a)(1) defines "intermediary determination," with respect to the cost reimbursement system, as:

> [A] determination of the amount of total reimbursement due the provider, pursuant to §405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

Further, 42 CFR 405.1801(a)(2) explains that intermediary determination means, with respect to a hospital that receives payments for inpatient hospital services under the prospective payment system, (part 412 of this chapter):

> [T]he total amount of payment due the hospital, pursuant to 405.1803 following the close of the cost reporting period, under that system for the period covered by the determination.

Hence, an "intermediary's final determination," is represented by the Notice of Program Reimbursement or NPR which is issued after the close of the provider's cost reporting period and the provider's submission of a timely cost report.

As reflected in the statute, a criterion for Board jurisdiction is that the provider is "dissatisfied" with the amount of program reimbursement. With respect to the first criterion for Board jurisdiction, the Supreme Court in Bethesda stated 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."[2] However, the Supreme Court recognized the distinction between a provider that self-disallowed a claim pursuant to a Medicare regulation that it intended to challenge before the Board and a provider that failed to claim all reimbursement it was entitled to under the regulations. The Court stated, with respect to the provider in Bethesda, that:

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[2] The Supreme Court in Bethesda, 485 U.S. 399 (1988), addressed the issue of "dissatisfaction" as set forth in section 1878 of the Act. The provider in Bethesda "self disallowed" certain claims on the cost report submitted to its intermediary, in order to comply with a Medicare regulation that it intended to challenge before the Board.

> Thus, petitioners stand on different grounds 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.

This language in Bethesda recognizes that a hospital that does not request reimbursement for all of the costs which it is entitled to be reimbursed in its cost report, cannot then request such costs before the Board.

In this case, with respect to the cost report under appeal, the Provider filed its cost report showing a total of 398 beds for its fiscal year 1999. Pursuant to the assettled cost report, no adjustment was made to the 398 claimed beds.[3] The Provider appealed its IME payment adjustment pursuant to the 1999 FYE NPR. The Provider sought to add a claim for a lower bed count as an issue to other appealed issues. The Provider discovered that it had overstated its 1999 bed count as well as its 1998 bed count, and that these bed counts impacted its IBR for 1999. The Provider contended that for FYs 1998 and 1999, the proper bed counts were 270 and 262 beds, respectively, and that these bed counts should be used in the IBR calculation for purposes of an IME payment for FY 1999. The Provider acknowledged that there were no audit adjustments to the bed count for IME. However, the Provider argued that there were several "unreported" adjustments to the IME payment calculation and that the Board has jurisdiction to review all aspects of the cost report. The Majority concluded that the adjustments to the other IBR components opened up any component, specifically the bed count, to appeal for FY 1999, including the 1998 IRB ratio, and that the Board had jurisdiction over all matters covered by the cost report.

Applying the above law to the facts of this case, the Administrator finds that the Provider, in this instance, is unable to demonstrate that under the applicable rules it meets the dissatisfaction requirement necessary for Board jurisdiction of the bed count issue. The record demonstrates that the Intermediary made no adjustment to the Provider's reported number of beds. An "unreported" adjustment to other components of the IME payment calculation does not confer Board jurisdiction over the bed count issue. The number of beds, while a component of the IBR, is independently claimed and reported on the cost report and used for various purposes other than the IME payment. Thus, the Board Majority incorrectly assumed jurisdiction over the bed count issue in this case.

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[3] See, Intermediary Exhibit I-2, Worksheet S-3, Part 1.

Under the statute, the Provider cannot demonstrate that it is dissatisfied with the intermediary's final determination reflected in this NPR, issued pursuant to the originally filed cost report, by pointing to its erroneously reported bed count. The Administrator notes that Medicare regulations did not prohibit the Provider from claiming the correct bed count for IME purposes on its originally filed FY 1999 cost report. Thus, Board jurisdiction does not extend over that issue as a self-disallowed claim under Bethesda.

Moreover, the Administrator notes the Majority's opinion that section 1878(d) of the Act delineates the broad scope of the Board's power to review and revise any cost incurred by the provider during the period encompassed by a cost report, even if the cost had not been claimed for reimbursement. However, the Majority's decision fails to recognize the place that paragraph (d) occupies in the statutory structure of section 1878 of the Act. The Supreme Court noted that section 1878(d) does not confer jurisdiction, but rather sets forth the Board's powers and duties after its jurisdiction has properly been invoked under section 1878(a) of the Act.[4] Thus, section 1878(d) of the Act cannot be used to confer Board jurisdiction of an untimely challenge or claim to section 1878(a) appeal. Therefore, the Administrator vacates the determination of the Majority that it has jurisdiction to address the Provider's appealed bed count issue in this case.

However, even assuming arguendo that there was Board jurisdiction over the Provider's appealed bed count, the Board's decision on the merits is flawed. The Provider contended that the stipulated bed counts for FY 1998 and 1999 should be used in calculating the Provider's IME for FY 1999. Under the Balanced Budget Act of 1997 (BBA), the IME payment each year is based on the number of full-time equivalent residents and interns training at the hospital and the number of available beds at the hospital (i.e., the IRB ratio) compared to the IRB ratio for the prior year. Thus, a provider's IME payment for a particular year is dependent, inter alia, on the lower of either the current year or previous year IRB ratio.[5]

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[4] See, Bethesda, 485 U.S. at 406 (emphasis added) where the court stated:

> This [Section 1878(d)] language allows the Board, once it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary.

[5] Pub. L. 105-33. Section 1886(5)(B)(vi) of the Act.

In this case, while the Intermediary preserved its jurisdictional challenge, the Intermediary also stipulated to the following bed counts: for FY 1998 the bed count is 291.35 beds and for FY 1999, the bed count is 272.97 beds.[6] The Majority determined that the stipulated bed counts for both FY 1998 and FY 1999 are the appropriate counts to be used in the FY 1999 IRB ratio analysis and applied to the calculation of the Provider's IME reimbursement for FY 1999.

However, the Administrator notes that the Provider did not file a timely appeal of its FY 1998 cost report and the FY 1998 cost report is beyond the three-year period for reopening. Although the Majority agreed that the bed count on the settled 1998 cost report may not be revised, it incorrectly instructed the parties to disregard the 1998 cost report bed count for purposes of calculating IME payments in 1999. The Administrator finds that the 1998 cost report is no longer subject to appeal, and that the bed count from the cost report is definitive and final. The Board in this instance had no jurisdiction over any part of FY 1998 cost year. Thus, even if one assumed jurisdiction over the FY 1999 bed count issue, the Board lacked the authority to instruct the Intermediary to use an alternative FY 1998 bed count for purposes of determining the Provider's FY 1998 IRB ratio to be used in calculating the Provider's FY 1999 IME payment. Were the Board to have jurisdiction over the FY 1999 bed count issue, the Intermediary would still be obligated to use the bed count finalized in the FY 1998 cost report to calculate the FY 1998 IRB ratio for the purposes of comparison with the FY 1999 IRB ratio in the calculation of IME payments in FY 1999.

[6] See Stipulations of the Parties.

DECISION

The Administrator vacates, for lack of jurisdiction, the decision of the Board Majority, consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 11/06/06

/s/
Leslie V. Norwalk, Esq.
Acting Administrator
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