CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Western Reserve Care System **Provider** **vs.** **Blue Cross Blue Shield Association/ AdminaStar Federal, Inc.** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Year Ending: December 31, 1999 (2003 Wage Index)** **Review of:** **PRRB Dec. No. 2007-D20** **Dated: February 23, 2007**

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 mandated in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The Intermediary and the Center for Medicare Management (CMM) submitted comments requesting review of Issue No. 1. In addition, comments were timely received from the Provider requesting review of Issue No. 2. The parties were notified of the Administrator's intention to review Issue No. 1 and Issue No. 2 in the Board's decision. Subsequently, the Provider submitted additional comments regarding Issue No. 1 and Issue No. 2. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is a general acute care hospital located in Youngstown, Ohio that is subject to the inpatient Prospective Payment System (IPPS). The Provider included contract labor costs for perfusionist and pharmacy services on its cost report for Federal fiscal year (FFY) 1999. The Intermediary made no adjustment to the costs associated with the contract services during its audit of the cost report but excluded these costs for purposes of calculating the Provider's FFY 2003 wage index.

Specifically, Issue No. 1 concerned contracted perfusionist services. The Provider contracted with Allegheny General Hospital (Allegheny) to secure perfusionist services for their cardiothoracic and vascular surgery program. The contract required the Provider to pay for the services of the perfusionists on a fee-per-case basis that varied based on volume and type of service rendered.[1] The fee included compensation for the perfusionists' time, benefits, continuing education, travel and communication expenses. The Provider included the full amount of the contracted services in the data that was used to calculate its wage index.[2] The Intermediary found that the amount claimed for contracted perfusionist services included indirect costs that are not allowable under the regulations and excluded all of the contract labor costs and hours from the wage index calculation.

Issue No. 2 involved contracted pharmacy services. The Provider executed a pharmacy management agreement with Owen Healthcare, Inc. (Owen). The contract required the Provider to provide registered pharmacists and support personnel, while Owen provided pharmacy inventory and management personnel. The Provider determined that a portion of the amount paid under the agreement related to personnel costs and reported that portion as contract labor.[3] The Intermediary considered the Owen agreement a contract for management services and excluded 100 percent of the claimed contracted labor costs and hours from the wage index calculation.

ISSUES AND BOARD'S DECISION

Issue No. 1 concerned whether the Intermediary's refusal to include the Provider's cost for contracted perfusionist services in its wage index calculations was proper.

The Board found that all of the costs incurred by the Provider for perfusionist services pursuant to the contract with Allegheny were personnel costs and "wage related" for wage index purposes. The Board noted that §2118 of the Provider Reimbursement Manual (PRM), recognizes payments for services that are related to patient care and rendered under a fee-for-service arrangement as an allowable cost for Medicare purposes. In addition, PRM 15-2, §3605.2, Part II, instructs providers to include the payment for services furnished under contracts for direct patient care in the provider's wage index calculations.[4] In addition, the Board noted that CMS

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[1] See Provider's Revised Position Paper Exhibit P-9, Appendix B.
[2] Form CMS-2552-96, Worksheet S-3, Part II, line 8.
[3] Form CMS-2552-96, Worksheet S-3, Part II, line 9.
[4] PRM 15-2, §3605.2, Part II – Wage Index Information; Form CMS-2552-96; Instructions for line 9.

instructions direct the provider to "report only personnel costs associated with these contracts."[5]

The Board considered the agreement between Allegheny and the Provider the controlling source for determining the services contracted and paid.[6] The Board found, upon examining the agreement and the itemized compensation amounts, that the amounts paid by the Provider and included as contract labor costs were incurred for the express purpose of placing the perfusionists in a position to provide patient services. Thus, the Board concluded that the contracted perfusionist services were personnel costs of the contract and "wage related" for wage index purposes. Further, the Board found that PRM 15-2, §3605.2 does not require any further breakdown of the costs incurred by Allegheny to provide these personnel services claimed under the agreement, and concluded that such a breakdown is beyond Medicare requirements. Accordingly, the Board found that the total cost incurred for contracted perfusionist services was properly included in the Provider's wage index calculation.

Issue No. 2 involved whether the Intermediary's refusal to include the Provider's costs for contracted pharmacy services in its wage index calculations was proper.

The Board found that the agreement between the Provider and Owen for pharmacy services was a management services contract subject to exclusion under PRM 15-2, §3605, and that its costs may not be included in the wage index calculation. The Board observed that PRM 15-2, §3605.2, Part II, specifically excludes from the calculation payments for management and consulting contracts or any other payments not directly related to patient care.[7]

The Board considered the agreement between Owen and the Provider the controlling source for determining the services contracted and paid.[8] The Board's examination of the agreement indicated that Owen was delegated the authority to manage and supervise the operation of the pharmacy, and the Provider would provide full-time, registered pharmacists and other full-time personnel. Accordingly, the Board concluded that the agreement between the Provider and Owen was a management services contract that was not directly related to patient care. Thus, the Board found that the cost of the pharmacy service contract is subject to exclusion under PRM 15-2, §3605, and its costs may not be included in the wage index calculation.

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[5] Id.
[6] See Provider's Position Paper, Exhibit P-9.
[7] PRM 15-2, §3605, Part II – Form CMS-2552-96-06-03; Instructions, line 9.
[8] Provider Exhibit P-14.

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Administrator review Issue No. 1 in the case. The Intermediary argued that PRM 15-2, §3605 provides instructions for completion of the wage index information, under which only amounts paid for direct patient care services and management under contract are to be entered on line 9 of the worksheet. The Intermediary further noted that costs for equipment, supplies, travel expenses and other miscellaneous or overhead items are not to be included. The Intermediary argued that the Provider's contract for perfusionist services included costs of cell phones, travel and other miscellaneous costs that could not be carved out because the billings were on a per-case fee. The Intermediary maintained that the wage index was intended to reflect only costs of wages paid for hospital services, not other miscellaneous costs. The Intermediary concluded that the PRRB decision on Issue no. 1 is incorrect because the result is that non-wage related costs, which the instructions clearly indicated should be removed, end up in the wage index data.

CMM commented and requested that the Administrator review and reverse Issue No. 1 in this case. Although the Board ruled that all of the costs incurred by the hospital for perfusionist services pursuant to its contract with Allegheny were "wage-related" personnel costs for the purpose of the area wage index calculation, CMM agrees with the Intermediary's exclusion of such costs. CMM noted that these costs were excluded because the Provider failed to provide sufficient documentation to support that the reported amount did not include indirect costs that are not allowed in the wage index calculation. CMM argued that the Board erred in its determination that the PRM 15-2, §3605.2 does not require any further breakdown of the contract perfusionist cost to exclude indirect costs. CMM noted that the Provider acknowledged to the Board that indirect costs are included in the contract perfusionist cost.

CMM further argued that it is the hospital's responsibility to maintain and furnish the intermediary sufficient documentation for a proper determination of costs payable under the program, pursuant to 42 CFR §413.20 and §413.24. CMM stated that, in the absence of sufficient documentation that distinguishes the personnel cost from the indirect cost, the Intermediary correctly eliminated the total contract cost to ensure that claimed costs did not overstate the area's wage index. Thus, CMM maintained that the Intermediary's exclusion of the total cost associated with the Provider's contract perfusionist services was appropriate because the Provider failed to exclude the associated indirect cost from its wage costs and did not provide sufficient documentation to enable the Intermediary to adjust the hospital's wages to exclude the indirect cost.

The Provider commented, requesting that the Administrator affirm Issue No. 1. The Provider noted that CMS has a duty to properly calculate the wage index for the Provider,

and must include all wage-related costs that the Provider incurred. The Provider argued that the Intermediary's initial adjustment disallowed 100 percent of the expense the Provider incurred for the cost of perfusionists who provided direct patient care services, and it would be an abuse of discretion for CMS to uphold the adjustment. The Provider argued that it provided sufficient documentation to support its claim. It further noted that the instructions require the reporting of personnel costs, and in this case, it was the cost of providing the personnel. How Allegheny arrived at its per case compensation is irrelevant, because the services it provided and the compensation the Provider paid is totally for personnel. Thus, the Provider argued that it is not paying for anything other than wages and wage-related costs of Allegeny's personnel. The Provider agreed with the Board's conclusion that the contracted perfusionist services were personnel costs of the contract and "wage related" for the wage index purposes, and argued that it is supported by the language of the Perfusion Services Agreement.

The Provider commented requesting that the Administrator review Issue No. 2 in the case. The Provider maintained that the PRRB's decision on Issue No. 2 was not in accordance with the undisputed facts in evidence, nor with the applicable laws, regulation and other applicable authorities. The Provider believed that the Board erred in excluding the personnel costs associated with pharmacy personnel provided by Owen Healthcare. The Provider acknowledged that the Pharmacy Agreement encompassed services beyond personnel. Accordingly, for purposes of reporting its wage index data, the Provider determined that portion of the amounts paid under the Pharmacy Agreement relating to personnel costs. The Provider argued that the Board expressed no concern with the calculation of the personnel-related costs, rather, it's sole basis for disallowing any amount paid to Owen was that it found "nothing in the agreement that calls for Owen to work directly with patients."[9] However, the Provider noted that pharmacists in hospitals do not work directly with patients.

The Provider maintained that it chose to operate its pharmacy in part through the Pharmacy Agreement with Owen, and the employees Owen provided must be included in the Provider's wage index determination as contract labor. The Provider argued that the Intermediary's characterization of Owen's services as exclusively "management" is contradicted by the express language of the Pharmacy Agreement setting forth the services rendered by Owen. The Provider argued that there is no evidence to support the finding that Owen's three full-time employees provided exclusively management services. Rather, the record confirms that Owen provided pharmacists to provide pharmacy services for the Provider's patients. Accordingly, the Provider urged the Administrator to reverse the Board's decision on Issue No. 2.

[9] PRRB Dec No. 2007-D20, p. 6.

DISCUSSION

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

I. Medicare Law and Policy

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorized the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with statute, the regulation at 42 CFR §413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare, pursuant to 42 CFR §413.20. The regulation at 42 CFR §413.24 requires that providers receiving payments on the basis of reasonable costs must provide adequate cost data. This data must be based on the financial and statistical records which must be capable of verification. The fiscal 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). 42 CFR §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the PRRB within 180 days of the issuance of the NPR. 42 USC §1395oo(a); 42 CFR §405.1835.

II. Prospective Payment System and Wage Index

Title VI of the Social Security Amendments of 1983 added §1886(d) to the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services provided to Medicare beneficiaries.[10] Under this system, hospitals are reimbursed their inpatients operating costs on the basis of prospectively determined national and regional rates for each discharge according to a list of diagnosis-related groups.[11] The Secretary is required to adjust the standardized amounts "for area

[10] Pub. Law 98-21.

[11] See Social Security Act, §1886(d)(3)(E).

differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." The rates are average standardized amounts that are divided into a labor-related share and a non labor-related share. The labor-related share is adjusted by the wage index applicable to the geographic area wherein the hospital is located. The wage index is calculated by dividing the average hourly wage paid by hospitals in that area by the national average hourly hospital wage.

Section 1886(d)(3)(E) of the Act also requires CMS to update the wage index annually and bases the annual update on a survey of wages and wage related costs taken from cost reports filed by each hospital paid under PPS. The survey measures, to the extent feasible, the earnings and paid hours of employment by occupational category, and must exclude the wages and wage-related costs incurred in furnishing skilled nursing services. Based on the substantial amount of time that is needed for providers to compile and submit cost reports and for intermediaries to review these reports, there is generally a four-year lag between the reporting of wage data and the date when the wage index is published.

On August 1, 2002, CMS issued the final rule for the development of the Federal fiscal year (FFY) 2003 wage index update, which required the use of fiscal year (FY) 1999 wage data.[12] In computing the wage index, data was used from cost reports beginning during the most recent Federal fiscal year for which there is a complete set of data. For the FY 2003 wage index, that is cost reports that began during FY 1999. Adequate time is needed for the hospitals to complete and submit their cost reports to their intermediaries, for intermediaries to perform a separate, detailed review of all hospitals' wage data and submit the results to CMS, and for CMS to compile a complete set of all hospitals' wage data from a given Federal fiscal year.[13] The current dispute centers on the elimination of some elements of the Provider's FY 1999 costs from the wage index calculations. Thus, the issue is not whether the costs are allowable or related to patient care, but rather whether certain costs are properly included in the calculation of the wage index.

The final FY 2003 wage index included the following categories of data associated with costs paid under the hospital inpatient prospective payment system: [14]

- Salaries and hours from short-term, acute care hospitals;
- Home office costs and hours;
- Certain contract labor costs and hours; and

[12] 67 Fed. Reg. 49982, 49984 (August 1, 2002).
[13] 67 Fed. Reg. 31434 (May 9, 2002).
[14] 67 Fed. Reg. 50021 (August 1, 2002).

- Wage-related costs.

The wage index also continued to exclude the direct and overhead salaries and hours for services such as skilled nursing facility services, home health services, and other subprovider components that are not paid under the hospital inpatient prospective payment system.

III. Contracted Services

Improvements in the wage data have allowed for easier identification of contract labor costs and hours. As a result, effective with the FY 1994 wage index, costs for direct patient care contract services were included in the wage index calculation. With the FY 1999 wage index, costs for certain management contract services were also included in the wage index calculation.[15] The definition of contract labor was expanded for purposes of determining the hospital wage index to include the personnel costs and hours associated with certain contract management personnel. Contract management services would be limited to individuals working in the top four positions in the hospital: the Chief Executive Officer/Hospital Administrator, Chief Operating Officer, Chief Financial Officer, and Nursing Administrator. For cost reporting periods beginning on or after October 1, 2000, contract pharmacy and laboratory costs furnished under contract could be included in the calculation.

The PRM 15-2, §3605, allows providers to enter amounts paid for services furnished under contracts, rather than by employees, for direct patient care, and management services. The Worksheet S-3, Part II consists of detailed information for use in the hospital wage index including contract labor for direct patient care services. In the instructions for completing this worksheet, contract labor costs and hours are limited to labor-related payments and hours attributable to direct patient care contract services. Specifically, hospitals are instructed to exclude indirect patient care contract services (for example, management and housekeeping services), nonlabor-related expenses (equipment and supplies), and any contract services for which labor-related payments and hours could not be accurately determined. The instructions emphasize that providers are not to include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. The Instructions for line 9 explicitly state, in pertinent part, that:

> Direct patient care services include nursing, diagnostic, therapeutic, and rehabilitative services… report only personnel cost associated with these contracts… Eliminate all supplies, travel expenses, and other miscellaneous items… Direct patient care contracted labor, for the

[15] 61 Fed. Reg. 46181 (August 30, 1996).

> purposes of this worksheet, does not include… management and consultant contracts… or any other service not directly related to patient care.

IV. Management Services

Management services furnished under contract rather than by employees may be included under limited circumstances but only those personnel costs associated with the contract can be reported. Providers are instructed to eliminate all supplies, travel expenses, and other miscellaneous items. The contract management services are limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The Instructions at line 9 go on to state that:

> For purposes of this worksheet, contract management services do not include… other management or administrative services… consultative services… physician services… or any other services other than the management contracts.

The amounts paid for pharmacy services furnished under contract, rather than by employees may also be reported, but cannot include services paid under Part B, management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Providers are to report only personnel costs associated with contracts, and exclude all indirect costs.

Issue No. 1: Contracted Perfusionist Services:

Generally, PRM 15-1, §2118 recognizes payments for services that are related to patient care and rendered under a fee-for service arrangement as an allowable cost for Medicare purposes. However, PRM 15-2, §3605.2, Part II, instructs the providers to include only the payment for services furnished under contracts for direct patient care in the provider's wage index calculations. The provider is instructed to report only personnel costs associated with these contracts.[16] For the purposes of calculating the wage index, personnel costs are not to include supplies, travel expenses and other miscellaneous items.

Pursuant to the service agreement between Allegheny and the Provider, Section 3.1 sets the scope of services to be furnished under which Allegheny is required to "provide the services of qualified cardiovascular Perfusionists to provide services at NSH [Provider]

[16] PRM 15-2, §3605.2, Part II – Wage Index Information; Form CMS-2552-96; Instructions for line 9.

for operation of the cardiopulmonary bypass equipment for open heart surgery procedures."[17] Section 3.13 further established the compensation for the services and, under its terms, Allegheny accepted as payment in full for the Perfusionist services provided "… reimbursement of all costs associated with Perfusionists' employment." (Emphasis added). The agreement itemized the compensation amounts at its Appendix B, which detailed the perfusionist service fee to be charged per case and/or per service. It also outlined the perfusionist expenses that are included in the determination of these service fees: hour rates, benefits percentage, annual allowance for continuing education and recertification expenses, travel expense rate per mile, communication expenses for cellular telephones and pagers, and cost of living and merit increases.[18] The Provider also submitted an Analysis of Purchased Services-Perfusionists and invoices to support the perfusion services rendered by Allegheny.[19] The analysis and supporting invoices determine the hourly rate for perfusionists services that includes non-wage related perfusionist costs. This hourly rate is therefore based on a per perfusion service amount that is inflated due to the inclusion of non-wage costs.

Of particular relevance to this case, the PRM 15-2, §3605.2, line 9 instructions specifically state that hospitals must "report only personnel costs associated with the contract" and must "eliminate all supplies travel expenses, and other miscellaneous or overhead items." The instructions for completion of the wage index information explicitly state that only amounts paid for direct patient care services and management under contract are to be entered on line 9 of the worksheet. Accordingly, the costs for equipment, supplies, travel expenses and other miscellaneous or overhead items are not to be included. This section also indicates that a breakdown of the contract cost is required in order to insure the exclusion of any indirect cost.

The Administrator finds that the Provider failed to properly eliminate all the travel expenses and miscellaneous items from the total cost reported for contracted perfusionist services and thus, these extrananeous items were improperly included in the Provider's wage index calculation. The Provider's contract for perfusionist services included costs of cell phones, travel and other miscellaneous costs that could not be carved out because the billings were on a per-case fee. Due to the fact that the wage index was intended to reflect only costs of wages paid for hospital services, and not other miscellaneous costs, the Intermediary's exclusion of the total cost associated with the hospital's contract perfusionist services was appropriate. Otherwise, non-wage related costs, which the instructions clearly indicated should be removed, would be used in calculating in the wage index.

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[17] See Provider's Position Paper, Exhibit P-9.
[18] Id.
[19] See Provider's Position Paper, Exhibit P-10.

Furthermore, it is the Provider's responsibility to maintain and furnish the intermediary sufficient documentation for a proper determination of costs payable under the program, pursuant to 42 CFR §413.20 and §413.24. In the absence of sufficient documentation that distinguishes the personnel cost from the indirect cost, the Intermediary cannot ensure that it has correctly eliminated those costs which tend to overstate the area's wage index. In addition, due to the fact that the wage index is applied in a budget neutral manner, an overstatement of an area's wage index would increase program payments to hospitals in that labor market area and decrease payments to all other hospitals in the country. The Administrator finds that, for the foregoing reasons, it is proper for an intermediary to exclude the total costs associated with a hospital's contract services if a hospital fails to exclude the associated indirect costs from its wage costs and does not provide sufficient documentation to enable the intermediary to adjust the hospital's wage costs to exclude these indirect cost.

Thus, contrary to the Board's findings, the Administrator finds that the principles governing the construction of the wage index, Medicare documentation rules, and the PRM 15-2, §3605.2 requires further breakdown of the costs incurred by Allegheny to provide these personnel services claimed under the agreement. As the Provider did not provide information that removes the non-wage portion of the perfusionist cost, the adjustment to remove contracted perfusion services for the wage index calculation is correct.

Issue No. 2: Contracted Pharmacy Services:

The Medicare program recognizes payments for patient care services rendered under a fee-for-service arrangement as an allowable cost and requires their inclusion in wage index calculations. However, the PRM 15-2, §3605.2, Part 2, specifically excluded from the calculation payments for management and consulting contracts or any other payments not directly related to patient care.[20] Pursuant to the agreement between Owen and the Provider, Owen was to "own the inventory and manage a pharmacy service on behalf of the hospital for the purpose of exclusively supplying hospital pharmacy items including, but not limited to, pharmaceuticals, drugs, IV solutions and sets, dietary, albumin a plasma protein, but not including, radiologicals, Rhogam, dialysis fluid, pumps or controllers, to hospital to be administered to hospital's

[20] PRM 15-2, §3605, Part II; Form CMS-2552-96-06-03; Instruction, line 9. As noted, the only exception for excluding management contract services is with respect to the four designated positions.

patients…".[21] Section 2 delegates the authority to manage and supervise the operation of the pharmacy to Owen and states that Owen will advise and assist the Provider in strategic planning, protocol development and staff development.[22] Additionally, section 5.2 of the agreement provides that the Provider supply 18.63 full-time, registered pharmacists and 26.44 full-time personnel for the operation of the pharmacy while assigning all management and supervisory responsibilities of any "Hospital Employee" working in the Pharmacy to Owen.[23] This language explicitly provides that all direct patient care activities are performed by hospital employees.

Although CMS Form 2552-96 permits the inclusion of "the amount paid for pharmacy services furnished under contract, rather than by employees," the cost report instructions form CMS 2552-96(T4), Worksheet S-3 identify the allowable types of management services that may be included, and the pharmacy management services are not included. The agreement between the Provider and Owen explicitly states that there are 18.63 full-time equivalent pharmacists on the hospital staff and that the hospital assigns all management rights to Owen for any hospital employee working in the pharmacy. This includes the right to supervise, evaluate and take appropriate disciplinary actions.

Furthermore, there is nothing in the agreement that obligates Owen to work directly with patients. The hospital provided the pharmacists who provided services to patients, and Owen's functions are limited to management, oversight, and consulting. Thus, the agreement between the Provider and Owen is correctly classified as a "management contract" because the services rendered were limited to supervising staff, strategic planning and developing policies/procedures.

Based on the CMS 2552-96(T4) cost report instructions and no documentation to support the Provider's contention that the employees provided by Owen did not provide management services, the removal of the contracted pharmacy services was appropriate. Accordingly, the Administrator affirms the Board's decision that the cost of the Pharmacy service contract is subject to exclusion under PRM 15-2, §3605 and its costs may not be included in the wage index calculation.

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[21] See Provider's Position Paper, Exhibit P-14.

[22] Id.

[23] Id.

DECISION

Issue No. 1:

The Administrator reverses the decision of the Board for Issue No. 1 in accordance with the foregoing opinion.

Issue No. 2:

The Administrator affirms the decision of the Board for Issue No. 2 in accordance with the foregoing opinion.

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

Date: 4/24/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services

DECISION

Issue No. 1:

The Administrator reverses the decision of the Board for Issue No. 1 in accordance with the foregoing opinion.

Issue No. 2:

The Administrator affirms the decision of the Board for Issue No. 2 in accordance with the foregoing opinion.

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

Date: _____ _____

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services