CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Stormont-Vail Health Care	**Provider Cost Reimbursement Determination for Cost Reporting**
Provider	**Period Ending: 09/30/95**
vs.	
Blue Cross Blue Shield Association/ Blue Cross & Blue Shield of Kansas	**Review of: PRRB Dec. No. 2007-D6 Dated: November 30, 2006**
Intermediary	

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), as amended (42 USC 1395oo (f)). The Center for Medicare Management (CMM) and the Intermediary submitted comments, requesting reversal of the Board's decision. The Provider submitted comments requesting that the Administrator not review the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Provider subsequently submitted further comments requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

This case arises out of the settlement agreement entered into by the Provider and Department of Health and Human Services subsequent to the commencement of an action in the United States District Court for the District of Columbia. Stormont-Vail Health Care, Inc. v. Thompson, Case No. 1:02CV01917 (CKK)[1] The settlement

[1] Stipulation of Settlement and Dismissal, dated January 3, 2003.

agreement provides for the Hospital to submit additional information regarding Medicaid days and that the Intermediary is to promptly issue a revised notice of program reimbursement (NPR) for the fiscal year ending September 30, 1995, applying the provisions of HCFAR 97-2, and make payment. The settlement in particular states that:

> 4. After the Hospital receives notice of the reopening of its FY 1995 Medicare cost report, the Hospital shall submit any additional information that it believes is necessary for the Intermediary to apply the payment provisions of HCFAR 97-2 to the Hospital's FY 1995 Medicare DSH payment. Because the additional information that the Hospital plans to submit to the Intermediary is expected to include information from other entities, including the State of Kansas, the Hospital shall have the time necessary to obtain the information that it plans to submit to the Intermediary.
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> 5. After the Intermediary receives the additional information from the Hospital, to the extent that any additional FY 1995 DSH payment is due to the Hospital under the payment provisions of HCFAR 97-2, the Intermediary shall promptly: (a) recalculate the Hospital's FY 1995 Medicare DSH payment; b) issue a revised notice of program reimbursement reflecting the recalculated DSH payment for the Hospital's FY 1995; and (c) pay to the Hospital the additional amount due for the Hospital's FY 1995.
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> 6.The Hospital shall have the right to challenge the intermediary's final determination of the Hospital's FY 1995 DSH payment under 97-2.

Pursuant to the settlement agreement, the Provider submitted to the Intermediary a request to add 202 qualifying days by cover dated June 23, 2003 (Intermediary Exhibit I-5) to the DSH calculation and requested a sum certain payment amount. The Intermediary promptly issued a revised NPR showing the inclusion of the additional 202 days submitted by the Provider on July 25, 2003 and payment of the Provider's requested amount.

The Provider subsequently appeals the revised NPR to the Board by letter dated January 25, 2004, challenging the Intermediary's failure to include "as Medicaid-eligible days services to patients for Medicaid as well as patients eligible for general assistance days." By letter dated August 20, 2004, to the Board, the Provider requested to add and transfer to group appeals certain other DSH issues involving MediKan days and spend down days." By letter dated September 2, 2004, to the Intermediary, the Provider requested that the Intermediary reopen the cost report

and reflect additional days involving Medicaid Secondary payor days based on recent documentation from the State of Kansas.[2] The parties agreed that the Intermediary declined to reopen the cost report to include these days.[3]

The Intermediary challenged the Board's jurisdiction over the revised NPR asserting that it did not disallow any of the DSH days claimed by the Provider when the Intermediary reopened its cost report. The additional days the Provider now sought to include in the DSH calculation were days the Provider failed to request during the implementation of the settlement agreement. Consequently, the Intermediary asserted that there was no adverse determination over which the Board had jurisdiction.

The Board held that it had jurisdiction over the inclusion of the number of Medicaid eligible days in the DSH calculation under 42 CFR 405.1869. This regulation, the Board maintained, gives it jurisdiction to affirm, modify, reverse a determination of an intermediary with respect to a cost report and to make other modifications to the cost report even when those matters were not considered by the intermediary. The Board found that the Intermediary was to effectuate a settlement agreement and was specifically directed that it was not to impose deadlines for submission of information.

ISSUE AND BOARD'S DECISION

The issue before the Board was whether the Intermediary's revised Notice of Program Reimbursement (NPR) issued on July 25, 2003, that increased the Provider's Disproportionate Share Hospital (DSH) payment, included all Medicaid eligible days that would qualify for inclusion under HCFA Ruling 97-2.

After concluding that it had jurisdiction in this case, the Board held that the Provider's DSH payment must be increased to include all additional days that can be verified as having met the criteria of HCFAR 97-2. As such, the Board remanded the matter to the Intermediary to determine the number of days that should be included in

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[2] See, e.g.., Intermediary Exhibit I-10. Provider's letter dated September 2, 2004 to the Intermediary indicating that it had received information regarding unpaid Medicaid days which had not been accepted until eligibility was verified by the State of Kansas. It does not appear that the State documentation was included in the record by either party.

[3] It does not appear such correspondence was made a part of the record.

the determination of Provider's DSH payment and to recalculate the DSH payment accordingly.

SUMMARY OF COMMENTS

CMM commented requesting that the Administrator reverse the Board's decision. Specifically, CMM stated that the Intermediary should not reopen the Provider's revised NPR in order to include additional days submitted by the Provider for purposes of DSH. The Intermediary acted in accordance with the settlement agreement and did not impose any time limit on the Provider to submit additional Medicaid eligible days before the Intermediary issued a revised NPR. Essentially, CMM stated that the Provider is not "dissatisfied" with any decision of the Intermediary, as that term is used by the Medicare Act to define actions that give rise to Board jurisdiction.

The Provider commented requesting first that the Administrator not review the Board's decision and, later, that the Administrator affirm the Board's decision. The Provider stated that the Board's decision reflects and is fully consistent with the Stipulation of Settlement and Dismissal between the Provider and the Secretary of the Department of Health and Human Services and the Intermediary. The Provider asserted that there is no dispute that the total number of Medicaid eligible days total 952, but due to a delay in receiving data from the State of Kansas, the Provider only submitted 202 Medicaid eligible days.

The Provider argued that the Settlement Agreement grants the Provider the right to "challenge the Intermediary's final determination." Therefore, since the revised NPR at issue is the Intermediary's final determination, the Provider has the right to appeal and challenge that decision. The Provider also argues that the Board has jurisdiction to review the appeal of the revised NPR since it has met all the criteria and is dissatisfied with the Intermediary's DSH adjustment computation.

The Intermediary submitted comments requesting that the Administrator vacate the Board's decision and dismiss the appeal for lack of jurisdiction. The Intermediary argued that the revised NPR is final and contained all the Medicaid eligible days submitted by the Provider. The Provider was not under any deadline to make any submission to the Intermediary and had the opportunity to submit complete and accurate data for inclusion in the revised NPR. Therefore, the Provider has no issue to dispute or dissatisfaction that triggers an appeal of the revised NPR, since there was no disallowance made to the Provider.

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.[4]

Section 1878(a) of the Social Security Act and the regulations at 42 C.F.R. § 405.1835 set forth the certain requirements for Board jurisdiction. A provider may obtain a hearing before the Board with respect to its fiscal intermediary's determination of its cost report, inter alia, only if: the provider is dissatisfied with a final determination of its fiscal intermediary as to the amount of reimbursement due the provider for the period covered by such report; there is $10,000 or more in controversy; and the provider filed a request for a hearing within 180 days after the notice of the intermediary's final determination.[5] Further, Section 405.1801(a)(3) states that for purposes of appeal to the Board, "intermediary determination" is synonymous with "final determination of the Secretary." Such an intermediary determination is referred to as a notice of program reimbursement or "NPR."

Certain procedures not contemplated by the statute are set forth in the regulation. The regulation found at 42 C.F.R. §405.1885(a) allows for a reopening of a determination or an NPR if "made within 3 years of the date of the notice of the intermediary determination." In addition, the regulation found at § 405.1889 provide that:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a

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[4] The Provider states that review of jurisdiction by the Administrator would be inappropriate as the notice of review did not specifically identify that issue. However, the notice was broadly drafted as a review of the Board's decision of which jurisdiction was a component and the Provider acknowledged and responded to the comments submitted by Intermediary and CMM that raised the issue of jurisdiction. Therefore, the Provider had notice of, and responded to, this issue in its comments and such review is not prohibited by the Administrator.

[5] The Board may also take jurisdiction of late-filed appeals "for good cause shown" (42 C.F.R. § 405.1841(b)).

> separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 405.1877 are applicable.[6]

The right to appeal a revised NPR is strictly a regulatory right under 42 CFR 405.1889. The regulation at 42 CFR 405.1889 specifically incorporates 42 CFR 405.1835, which also in turn references 405.1841(a)(1). Notably, 42 CFR 405.1841(a)(1) specifies that "such request for Board hearing must identify that aspects of the determination with which the provider is dissatisfied...." Consequently, the regulatory right to appeal under 42 CFR 405.1889 as referenced in 405.1841(a)(1) requires a provider to meet a dissatisfaction requirement in order for Board jurisdiction to be met.

The Administrator, after reviewing the record and the relevant law, regulations, and governing criteria, finds that the Board acted improperly in accepting jurisdiction as the additional days the Provider now wants to include in the DSH calculation were not at issue in the revised NPR. The Administrator finds that 42 C.F.R. §405.1889 bars the Provider from using the revised NPR as the vehicle for an appeal to now include those days. The regulation at 42 C.F.R. §405.1889 provides that "such revision shall be considered a separate and distinct determination" for which the Provider has a right to a hearing, but only those matters adjusted in such a determination.

In accordance with the terms of the settlement agreement, the Provider submitted its list of Medicaid eligible, unpaid days on June 23, 2003. The Intermediary, also in accordance with the settlement agreement, on July 25, 2003 promptly issued a revised NPR making payment for all the days requested in the Provider's submission. The Intermediary's reopening of the Provider's cost report in order to include all of the additional Medicaid days that the hospital submitted in 2003, and its issuing of a revised NPR based on the inclusion of those additional days constitutes a separate and distinct determination which granted the Provider the full relief it requested without any disallowances. The matter of the additional days was never raised or requested by the Provider prior to the issuance of the revised NPR and, likewise, was not addressed by the Intermediary's determination as reflected in the revised NPR. Thus, these days were not part of the separate and distinct determination which comprises the revised NPR that is basis for any Board review.

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[6] See also §2932B of the Provider Reimbursement Manual.

In addition, there is no disallowance reflected by the revised NPR that causes Provider "dissatisfaction" with any decision of the Intermediary, as that term is used by the regulation to define actions that give rise to Board jurisdiction. Rather, the Provider's "dissatisfaction" stems from the Intermediary's subsequent decision not to reopen the revised NPR and include the additional Medicaid days. There is no adverse Intermediary action contained in the revised NPR that would allow for review by the Board since the Intermediary gave the Provider all the Medicaid eligible, unpaid days that it requested.[7] Further, to the extent the Provider's appeal can be interpreted as an intent to appeal the Intermediary's decision not to reopen the previously issued NPR, that decision is not subject to review.[8] Finally, contrary to the Provider's contentions, the language in the settlement agreement did not modify, limit, or expand the controlling regulation with respect to the appeal of a revised NPR under 42 CFR 405.1889. Subsequently, the Board's jurisdiction in this case is properly evaluated under the criteria set forth in that regulation.

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[7] While the terms of the settlement agreement are not properly before the Board, even assuming arguendo that they were, the Administrator notes that the Intermediary's application of the agreement appears consistent with the paragraph (5) requirement that the Intermediary "promptly" issue a revised NPR and make payment upon the Hospital's submission of "the" additional information. That is, under the agreement, the submission of the additional information by the Hospital "triggers" the responsibility of the Intermediary to promptly act and issue a revised NPR and make payment. The Provider fails to reconcile its interpretation of the agreement (that the Provider may make several open-ended submissions of additional information) with the requirement that the Intermediary "promptly" issue a revised NPR and make (final) payment once "the" additional information is submitted.

[8] *See* Your Home Visiting Nurse Services v. Shalala, 525 U.S. 449 (1999).

DECISION

Accordingly, the Administrator vacates the Provider Reimbursement Review Board decision consistent with this opinion. The Provider's request for a hearing before the Board is dismissed for lack of jurisdiction.

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

Date: 1/26/07

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