CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Winn Parish Medical Center **Provider** **vs.** **Wisconsin Physicians Service** **Intermediary**	**Cost Reporting Periods Ending: December 31, 2001; December 31, 2002; December 31, 2003; December 31, 2004; December 31, 2005; March 31, 2007; and March 31, 2008** **Review of: PRRB Dec. No. 2011-D33** **Dated: June 15, 2011**

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 U.S.C. § 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting that the Administrator affirm the Board's decision. The Intermediary commented, requesting that the Administrator reverse the Board's decision. CMS' Center for Medicare (CM) commented, requesting that the Administrator overturn the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

Winn Parish Medical Center (Provider) is a general acute care hospital located in Winnfield, Louisiana. The Provider sought Medicare Dependent Hospital (MDH) status through reopening requests. The Intermediary denied these reopening requests. The Provider appealed the Intermediary's denial of the MDH status.

ISSUE AND BOARD DECISION

The issue, according to the Board, was whether the Provider is eligible to be classified and reimbursed as a Medicare Dependent Hospital (MDH) for the fiscal years ending (FYEs) 12/31/01, 12/31/02, 12/31/04, 12/31/05, 03/31/07, and 03/31/08. The Board concluded that the Provider qualifies for MDH payments for FYEs 12/31/01, 12/31/02, 12/31/04, 12/31/05, 03/31/07, and 03/31/08. However, the Board noted that since the reopening request was made more than three years after the date of the Notice of Program Reimbursement (NPR) for the FYE 12/31/01, it cannot be reopened and no MDH payment may be made for that year.

The Board noted that, in reaching its decision, it had to decide: 1) Whether the Provider could qualify under the original method for determining MDH status; and 2) When the MDH status becomes effective. The Board found that the statutory language in effect for all the years under appeal made it clear that there are two options to qualify for MDH status: option 1, based on fiscal year 1987 data, or option 2, based on two of the three most recently audited/settled cost reporting periods. The Board further found that option 1 was not amended or superseded by the new option, but continues to be a valid basis on which to qualify for MDH status. The Board noted that this conclusion is supported by the Federal Register publications which implement the regulatory changes required by the statutory addition of option 2.[1]

The Board stated that historically, providers which qualified under MDH criteria (option 1) had their payments adjusted as of the first day of the fiscal year that they qualified. The Board found that the original criteria had not changed, and is still valid for providers qualifying under option 1, and that the additions to the regulations (option 2) did not change the process for option 1. The Board found that it was uncontested by the Intermediary and the evidence in the record that the Provider met all of the original (option 1) criteria for qualifying for MDH status for the fiscal years under appeal.

Finally, the Board noted that it stood by its previous findings on jurisdiction for all fiscal years, noting that the Provider believed in good faith that it would be allowed reimbursement under MDH status for its FYE 2001 even though the NPR for that year was issued more than three years prior to the date the request for MDH status was filed, and that this good faith belief met the requirement for amount in controversy for jurisdiction.[2] However, while the Board found that the Provider met the amount in controversy for jurisdiction and the Medicare cost report is the proper mechanism to be used to implement payment for MDH adjustments, the cost report for FYE 12/31/01 was

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[1] *See, e.g.*, 67 Fed. Reg. 50,062 (Aug. 1, 2002), and 66 Fed. Reg. 32,175 (June 13, 2001).

[2] The Board cited to *Russell-Murray Hospice, Inc. v. Sebelius*, F.Supp.2d 43 (D.D.C. 2010).

beyond the three year reopening period when the request for MDH status was made, and therefore, the MDH payment adjustment cannot be implemented.

SUMMARY OF COMMENTS

The Provider commented, urging the Administrator to affirm Board's decision. The Provider argued that the Board's decision as to the issue, as well as to jurisdiction, was correct. The Provider noted that it was not required to qualify for MDH status based on the newer, optional method of reviewing Medicare utilization in two of the three most recently audited cost reporting periods, but rather that it qualified under the original, mandatory methodology. Regarding jurisdiction, the Provider stated that the MDH regulation expressly allows for Board review of MDH denials outside of the cost reporting or Notice of Program Reimbursement (NPR) context. In particular, 42 C.F.R. §412.108(b)(9) provides for Board review of an intermediary's "initial and ongoing determination" of MDH status. The Provider argued that the Board correctly determined that the Provider was requesting MDH status, and that it was not relevant that the requests and denials reference "reopenings". The Provider further claimed that, since MDH status is mandatory, the Administrator should hold that even for 2001, the MDH request was timely and that MDH reimbursement should be made to the Provider.

The Provider stated that CMS recognized that there would be few newly qualified MDHs under the original mandatory criteria, but that some new MDHs could qualify if they had met all of the original criteria except bed size.[3] The Provider argued that a final determination is to be made each year based on a provider's average number of beds during the cost reporting period,[4] and that the Intermediary was clearly on notice of the Provider's reduced bed size based on the as-filed cost reports for each of the years under appeal. The Provider argued that it did not need to notify the Intermediary, as CMS had noted that hospitals did not need to take action to qualify for the MDH adjustment.[5]

The Provider made a point of noting that it was not trying to, nor was it required to, qualify as an MDH under the new, optional criteria established in 2000, and stated that the new criteria did not replace the original criteria. The Provider argued that the requirement for providers to submit a written request for MDH status applies only to the new, optional qualification, which analyzes Medicare utilization in the three most recently audited cost reports. The Provider stated that, since it was not attempting to qualify under this option, it should not be subject to the procedural rule requiring a written request to qualify.

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[3] 63 Fed. Reg. 26,327 (May 12, 1998).
[4] 55 Fed Reg. 15,150, 15,155 (Apr. 20, 1990).
[5] Id.

The Provider disagreed with the comments submitted by CM that suggested that all of 42 C.F.R. §412.108(b) applies to both the original method of qualifying for MDH status, and the newer, optional method of qualifying for MDH status. The Provider noted that this contention is contrary to the plain language of the regulation and the applicable regulatory history. The Provider argued that prior to 2000, there was no requirement to submit a written request for MDH status. The Provider claimed that nothing in the May 9, 2002 *Federal Register* discussion, nor in the August 1, 2002 Final Rule suggests that CMS had changed its interpretation of the MDH statutue or was attempting to make the 30-day effective date apply to MDH status under the original mandatory qualifying criteria. Thus, the Provider argued, subsections (b)(3) and (b)(4) of 42 C.F.R. §412.108 follow directly and solely from subsection (b)(2) and apply only to MDH requests under the new, optional method of qualifying.

The Intermediary commented, recommending that the Administrator reverse the decision of the Board. The Intermediary contended that the Provider is not entitled to be designated as an MDH. The Intermediary stated that the Board made an erroneous interpretation of the regulation, and that there are also jurisdictional issues which preclude the Provider's right to a Board hearing. The Intermediary also noted that the Board's decision circumvents the Intermediary's discretion regarding reopening cost reports.

First, the Intermediary noted that the Board made an erroneous interpretation of the regulation at 42 C.F.R. § 412.108. The Intermediary argued that subsection (b)(2) requires the provider to make a written request for MDH status, and further requires the provider to submit with its request qualifying documentation. Subsection (b)(4) establishes that a provider's MDH status will go into effect 30 days after the date the fiscal intermediary provides written notification to the hospital. The Intermediary stated that in this case, the provider did not make a written request for MDH status, nor did it submit any qualifying documentation. Thus, the Intermediary argued, the Board's decision circumvents the regulation and allows the provider to qualify for MDH payments retroactively.

The Intermediary also argued that the Provider should not be allowed to be designated as an MDH in that the Provider did not file its appeal in accordance with the regulations at 42 C.F.R. §405.1835. The Intermediary noted that it did not make a determination of the provider's MDH status, but rather, the only decision it made was not to reopen the Provider's cost reports. The Intermediary stated that this refusal to reopen is the basis the Provider uses to file its appeal, and that, furthermore, the Provider uses the date of the Intermediary's letters refusing to reopen to meet the 180 day time limit. The Intermediary argued that a timely appeal must be made within 180 days of a determination, and that its letter refusing to reopen should not be considered a determination. Using the date of the NPR, the Providers filed appeals late for all of the cost reporting periods under review, except for 2007. Additionally, for the 2008 cost report year, a final determination was not issued at the time the Provider filed its appeal.

Finally, the Intermediary argued that the Board's decision circumvents the Intermediary's exclusive right to make the decision to reopen or not reopen a cost report. The Intermediary noted that this is contrary to the opinion of the United States Supreme Court in *Your Home Visiting Nurse Services, Inc. v. Shalala*.[6] In this case, the Supreme Court held:

> The Board does not have jurisdiction to review a fiscal intermediary's refusal to reopen a reimbursement determination. The regulations do not confer such jurisdiction, so petitioner must establish it on the basis of the Act. Section 1395*oo*(a)(1)(A)(i) authorizes a provider to obtain a hearing before the Board if the provider "is dissatisfied with a final determination of … its fiscal intermediary … as to the amount of total program reimbursement due the provider … ." The Secretary's reading of §1395*oo*(a)(1)(A)(i)–that a refusal to reopen is not a "final determination … as to the amount of … reimbursement" but only a refusal to make a new determination–is well within the bounds of reasonable interpretation…

CMS' Center for Medicare (CM), commented, recommending that the Administrator overturn the Board's decision. Regarding the Provider's FYE 12/31/01, CM noted that it agreed with the Board that the Provider should not receive MDH status, but for a reason in addition to the Board's stated rationale. CM also stated that it did not believe that the Provider should be granted MDH status for its FYEs 12/31/02, 12/31/04, 12/31/05, 03/31/07, and 03/31/08.

CM noted that when the MDH program was initially implemented for cost reporting periods beginning on or after April 1, 1990, the Provider did not qualify as an MDH because it had more than 100 beds. The Provider continued to operate with more than 100 beds through FY 2000. CM stated that, while the Provider began operating with 100 or fewer beds beginning with its FYE 12/31/01, it was not until August 24, 2007 that the Provider notified its Intermediary that it qualified for MDH classification and requested that the Intermediary classify and reimburse it as an MDH.

CM pointed out that while fiscal intermediaries initially were required to review all hospitals at the start of the MDH program to determine which hospitals qualified, that was a one-time review to capture all hospitals that initially qualified as an MDH. The criteria were static until FY2002, when the MDH qualifying criteria changed and allowed hospitals to qualify based on cost reporting periods other than those beginning in FY 1987. However, CM noted, during the time that the criteria did not change, it is not reasonable that the fiscal intermediaries would continuously review the hospitals that did not qualify as an MDH initially to see if there might be a change in a hospital's circumstances that would allow it to qualify as an MDH. CM noted that if a provider's circumstances

[6] 525 U.S. 449 (1999).

changed such that it believes it now may qualify as an MDH, it is the provider's responsibility to pursue that with their intermediary. CM pointed out that the Provider in this case did this, but requested MDH status retroactively.

CM stated that when the MDH criteria changed, effective FY 2002, allowing a provider to now qualify as an MDH based on two of three of their most recent, settled cost reports, rather than only on their cost reporting period beginning in FY 1987, the codified regulations at 42 C.F.R. §412.108 were revised to incorporate that change and to detail the process. However, the provisions at 42 C.F.R. §412.108(b)(4) are not necessarily limited to MDHs that qualify based on data from two of three most recent, settled cost reporting periods. The paragraph at 42 C.F.R. §412.108(b)(4)(i) was added to codify existing policy to require a provider to notify its fiscal intermediary if there is a change to the circumstances that affects its qualification as an MDH. Thus, 42 C.F.R. §412.108(b)(4), which provides that a determination of MDH status is effective 30 days after the date the fiscal intermediary provides written notification to the hospital, applies equally to any determination made by an intermediary regarding MDH status after the initial 1990 intermediary initiated determinations. Thus, when the qualifying criteria changed to allow hospitals to qualify as an MDH based on two of their three most recent, settled cost reports, the regulations were expanded to incorporate not only the additional criteria, but to detail the existing application process, the effective date for approved applications, and the withdrawal of status if a provider no longer meets the MDH criteria.

Thus, CM noted, after review of the statute, regulations, and policy regarding MDHs discussed during the rule-making process in the *Federal Register*, that a provider may qualify as an MDH based on its cost reporting period beginning in FY 1987, after the initial review and designation of MDHs based on the FY 1987 cost reports by the fiscal intermediaries at the start of the MDH program. However, it became the provider's responsibility to notify its fiscal intermediary of a change to its circumstances that may now allow it to qualify as an MDH, and the provider must request MDH status. The regulations also specify that status is only effective 30 days after the date of the approval letter from the fiscal intermediary to the provider. Since the Provider requested MDH status for cost reporting periods that had already passed, there should be no MDH designation or payment for those retroactive periods.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. Comments timely submitted have been included in the record and have been considered.

The Medicare program was established to provide health insurance to the aged and disabled. The Centers for Medicare and 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS.[7]

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 portion of those costs to be allocated to Medicare.[8] 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).[9]

Section 1878(a)(1) of the Social Security Act provides that any provider of services, which "has submitted such reports within such time as the Secretary may require in order to make payment under such sction" may obtain a hearing with respect to such cost report by the Board if the provider:

> (A) (i) is dissatisfied with a final determination of the [intermediary] as to the amount of total program reimbursement due the provider ... 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 the payment under subsection (b) or (d) of section 1886.
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> (2) the amount in controversy is $10,000 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).

According to 42 C.F.R. § 405.1801(a), an "intermediary determination" means the following:

> (1) With respect to a provider of services that has filed a cost report under §§ 413.20 and 413.24(f) of this chapter, the term means 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.

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[7] Section 1816 of the Act, 42 C.F.R. §§413.20(b) and 413.24(b).
[8] 42 C.F.R. §413.20.
[9] 42 C.F.R. §405.1803.

> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the determination.
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> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases ''intermediary's final determination'' and ''final determination of the Secretary'', as those phrases are used in section 1878(a) of the Act.

Thus a provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) if it files a request for a hearing within 180 days after notice of the intermediary's determination, and meet the amount in controversy:[10]

The Medicare regulations at 42 C.F.R. §405.1885(a)(2007)[11] also provide that an intermediary may reopen a previous determination with respect to findings on matters at issue in a cost report. Such a reopening must be made within three years of the date of notice of the intermediary determination.[12] No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d)[13] and (e)[14] of this section. Notably, 42 C.F.R. §405.1885(c) provides that jurisdiction for reopening a

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[10] 42 C.F.R. §405.1835. The language of this regulation changed effective October 1, 2008. The Provider filed a request for a hearing for four out of the seven appeals prior to this language change, and after the language change for the remaining three cost reporting periods. However, the requirements remained substantially the same.

[11] The Provider's requests for a Board hearing, for the respective denials of the reopening requests, were filed both before and after a 2008 revision to the PRRB regulations. However, such revisions were related to clarifying language to the provisions at issue and did not make any substantive changes to 42 C.F.R. §405.1885. See 73 Fed. Reg. 30,266.

[12] 42 C.F.R. §405.1885(b).

[13] Paragrah (d) states that: "Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision."

[14] Paragraph (e) states that: "Notwithstanding an intermediary's discretion to reopen or not reopen an intermediary determination or an intermediary hearing decision under paragraphs (a) and (c) of this section, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section."

determination rests exclusively with the administrative body that rendered the last determination.[15] Thus, the Board does not have jurisdiction over the appeal of an Intermediary's denial of reopening.[16] A determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision within the meaning of this subpart and is not subject to further administrative review or judicial review.[17] Moreover, regarding the effects of any revision, the regulation at 42 C.F.R. §405.1889 (2007) states 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 Sec. 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.[18]

By letter dated August 24, 2007, the Provider requested reopening for the fiscal years ending (FYEs) 12/31/01, 12/31/02, 12/31/03 and 12/31/04, to be classified and reimbursed as an MDH. By letter dated September 13, 2007, the Intermediary responded with a "Notice of Denial-Reopening Request." The Intermediary's denial stated that:

> We determined the cost report settlements should not be reopened to reimburse the hospital as a Medicare Dependent Hospital. Our determination is in accordance with 42 CFR 412.108(b) the regulations require a hospital to submit a written request along with qualifying documentation to the intermediary for a determination of the MDH status. the determination of the

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[15] *See* 42 CFR 405.1885(c)(2008) which clarified the regulation to state that: "(c) Jurisdiction for reopening. Jurisdiction for reopening an intermediary determination or intermediary hearing decision rests exclusively with the intermediary or intermediary hearing officer(s) that rendered the determination or decision (or, when applicable, with the successor intermediary), subject to a directive from CMS to reopen or not reopen the determination or decision. Jurisdiction for reopening a Secretary determination, CMS reviewing official decision, a Board decision, or an Administrator decision rests exclusively with CMS, the CMS reviewing official, Board or Administrator, respectively.

[16] *See e.g. Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449 (1998). 42 CFR 405.1885(a)(6) (2008).

[17] *See e.g.* 42 CFR 405.1885(a)(6) (2008).

[18] The regulation at 42 C.F.R. §405.1889 (2008) was revised to state that: "(b)(1) Only those matter(s) that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decisions.(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.".

> intermediary is effective 30 days after a written notification to the hospital, In so much as the cost reporting periods listed above have been previously settled and there is no evidence that the provider was ever approved as a MDH hospital so we will not revise the cost report determinations.

By letter dated October 2, 2007 the Provider re-submitted its request for reopening of cost reporting period for FYEs 12/31/01, 12/31/02 12/31/03 and 12/31/04 which included a copy of the letter the consultant had supplied claiming that the denial incorrectly relied upon 42 CFR 412.108(b)(2) and 42 CFR 412.108(a)(1)(iii)(C). In this request the provider included documentation of its bed size and utilization from S-3 of its most recently audited cost reports. The Provider's consultant wrote that the request was based on 42 CFR 412.108(a)(1(iii)(A) and, therefore, the timeframes of paragraphs (b)(2), (3) and (4) are not applicable.. The Intermediary by letter dated November 2, 2007 responded to the Provider's request for reconsideration of the denial of reopening for FYEs 12/31/2001, 12/31/2002, 12/31/2003 and 12/31/2004. The Intermediary found that the request for reopening for FYE 2001 was filed more than three years after the initial NPR and the request was not related to any of the revised NPRs for that year. The Intermediary found that, regarding the other FYEs, based on the regulation in effect for these cost reporting periods, a cost report reopening to allow retroactive MDH reimbursement is not permitted.

By letter dated October 1, 2008, the Provider requested reopening of the FYEs 12/31/05, 12/31/06, 03/31/07, and 03/31/08 cost reporting periods to be classified and reimbursed as an MDH. By letter dated October 9, 2008, the Intermediary responded with a “Notice of Denial-Reopening Request.” The Intermediary's denial stated that:

> We determined the cost report settlements should not be reopened to reimburse the hospital as a Medicare Dependent Hospital. Our determination is in accordance with 42 CFR 412.108(b) the regulations require a hospital to submit a written request along with qualifying documentation to the intermediary for a determination of the MDH status. the determination of the intermediary is effective 30 days after a written notification to the hospital, In so much as the cost reporting periods listed above have been previously settled (except for the March 31, 2008) and there is no evidence that the provider was ever approved as a MDH hospital so we will not revise the cost report determination. The March 31, 2008 cost report has not been settled in final yet and is not eligible for reopening.

The Provider's requested reconsideration of the reopening denial by letter dated October 29, 2008 for FYEs 12/31/2005, 12/31/2006, 03/31/2007, 03/31/2008 and also requested MDH status for “all future years discharges.” The request for MDH status was “in accordance with the regulations at 42 CGFR 412.108(b)(2 that “it qualifies as an [MDH] under 42 CFR 412.108(a)(1)(iii)(A) and 42 CFR 412.108(a)(l(iii)(C). The Intermediary

responded to the reconsideration request for FYEs 12/31/05, 12/31/06, 03/31/07 and 03/31/08 by letter dated January 19, 2009. The Intermediary stated that: "we have reviewed your request for reconsideration of retroactive MDH status in accordance with the Code of Federal Regulations, Title 42 Chapter IV section 412.108. We have determined that Winn Parish Medical Center does not qualify for MDH status during the above stated periods for the reasons described in or previous denial letter dated October 9, 2008." The Intermediary, by letter dated January 12, 2009, granted the Provider MDH "Initial status" with the approval effective February 11, 2009 for FYE 03/31/09.

The Provider subsequently appealed the denials of reopening within 180 days of the respective Intermediary letters. However, the Provider's request for a Board hearing was more than 180 days after NPRs were issued for the FYEs 2001, 2002, 2003, 2004, 2005, 2006 cost years. The Provider appealed within 180 days of the NPR for the FYE 03/31/2007 and so the "Individual Appeal" request showed the type of determination being appealed as an "NPR" and "other-Intermediary rejection of Medicare Dependent Hospital determination." An NPR had not been issued for FYE 2008 when the Provider filed its appeal on March 18, 2009.

The Administrator finds that, the Board's jurisdiction letter, dated June 3, 2009, correctly noted that it does not have jurisdiction over Intermediary denials of reopening of cost reports. However, the Board found that the Provider was actually requesting classification as an MDH, not merely a cost report reopening, and that the concurrent request for reopening was incidental to the MDH request. The Board found that the Intermediary would have to reopen the cost report to implement the MDH classification. Thus, the Board held that the correspondence was not actually a reopening request, but rather a request to be classified as an MDH, and that the reopening request was incidental to the MDH classification request.

The Administrator disagrees with the Board's finding that these were not reopening requests, but rather requests to be classified as an MDH to which the reopening was incidental. Any revision to the Provider's classification for purposes of payment for those years is dependent upon the cost report being reopened. Reopening is not "incidental" to the Provider's request to be paid as an MDH. This fact is evident in the Board's finding that the FYE 2001 was beyond the three year period and therefore the appeal could not be considered for that year. Hence, the nature of the action being requested, reopening, still defines the legal relief that could be administratively granted and limits the scope of the Board's authority to review here. The August 24, 2007 letter,[19] which requested reopening of the FYE 12/31/01, 12/31/02, 12/31/03, and 12/31/04 cost reports, states, "We are requesting the reopening of the above noted cost reports to include the following issue:

[19] *See* Provider's Final Position Paper, Exhibit P-16.

To Classifiy and Reimburse the Hospital as a Medicare Dependent Hospital."[20] The letter specifically referenced 42 C.F.R. §405.1885, which provides that cost reports may be reopened within three years, and the Provider requested such a reopening to implement MDH status. Similarly, the October 1, 2008 letter,[21] which requested reopening of the FYE 12/31/05, 12/31/06, 03/31/07, and 03/31/08 cost reports, again requests reopening of the cost reports, and did not request classification as an MDH.[22] Rather, the record shows that it was not until October 29, 2008 that the Provider sent a letter, along with supporting documentation, requesting classification as an MDH.[23]

The Administrator finds that the August 24, 2007 letter, and the October 1, 2008 letter were first and foremost reopening requests for the aforementioned cost years.[24] The Intermediary denied these reopening requests on September 13, 2007,[25] and October 9, 2008,[26] respectively. The Provider appealed the denials of the respective cost years to the Board. Because jurisdiction for reopening an intermediary determination decision rests exclusively with the intermediary, the Board did not have jurisdiction over this appeal regarding the Intermediary's denial of the reopening requests.[27]

However, even assuming, *arguendo*, the Board did have jurisdiction over the MDH issue involved pursuant to the Provider's timely appeal of the FYE 03/31/2007 cost report, the

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[20] The Provider's letter noted that a third party consultant, hired by the Provider's parent company, had recently determined that the Provider met the qualifications to be classified as an MDH for the period of January 1, 2001 to December 31, 2004. However, the Provider did not request such status, and did not submit any additional documentation to show that it indeed qualified as an MDH contemporaneous with the cost years for which reopenings were requested.

[21] *See* Provider's Final Position Paper, Exhibit P-1.

[22] The Provider states that based on the requirements of 42 C.F.R. §412.108(a)(iii), it qualifies as an MDH for the period of January 1, 2005 to March 31, 2008. No additional documentation was submitted to substantiate this claim, and no request for such classification was made.

[23] *See* Provider's Final Position Paper, Exhibit P-3.

[24] The Administrator's finding that these were reopening requests, rather than request to be classified as an MDH, also precludes the Provider's contention that 42 C.F.R. §412.108(b)(9) provides for PRRB review of the intermediary's "initial and ongoing determination" of MDH status as the matter being appealed are the Intermediary's denials of reopening.

[25] *See* Provider's Final Position Paper, Exhibit P-17.

[26] *See* Provider's Final Position Paper, Exhibit P-2.

[27] As the Intermediary had not ruled on the merits of the request, the Board action ruling in the first instance on MDH status for the related cost years on the merits is also improper.

Board still reached an incorrect conclusion in this case. [28] Notably the MDH classification and payment under Medicare has been subject to incremental legislation. That is, unlike other payments and classifications which are enacted and procedures are set forth effective for a date certain going forward, the MDH provision has been authorized through discrete and separate legislation acts, for set closed cost report or discharge periods, which included a period in time for which the MDH status was allowed to lapse. Consequently, as a result of the piecemeal legislative actions, CMS procedures for processing MDH status itself did not remain static for those hospitals that did not qualify for MDH status initially.

The MDH program was originally created in section 6003(f) of the Omnibus Budget Reconciliation Act of 1989,[29] which added section 1886(d)(5)(G) to the Act. As set forth in section 1886(d)(5)(G) of the Act, in order to be classified as an MDH, a hospital was required to meet all of the following criteria:

- The hospital is located in a rural area.
- The hospital has 100 or fewer beds.
- The hospital is not classified as an SCH (as defined at § 412.92).
- In the hospital's cost reporting period that began during FY 1987, not less than 60 percent of its inpatient days or discharges were attributable to inpatients entitled to Medicare Part A benefits.

As provided by the law, MDHs were eligible for a special payment adjustment under the prospective payment system, effective for cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993. Hospitals classified as MDHs were paid using the same methodology applicable to SCHs, that is, based on whichever of the following rates yielded the greatest aggregate payment for the cost reporting period:

- The national Federal rate applicable to the hospital.
- The updated hospital-specific rate using FY 1982 cost per discharge.

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[28] The Administrator notes that, with the exception of the Provider's FY 3/31/07 cost report, the Provider's requests for hearing filed with the Board were all filed more than 180 days from the date of issuance of the NPRs and, thus, cannot be construed as appeals of the NPRs themselves. The Provider's request for a Board hearing for the FYE 3/31/07 appeal was made within 180 days of the corresponding NPR and included a challenge to MDH status although the cost report did not make any claims for payment as an MDH, nor had the Provider alerted the Intermediary to a change in its bed status and hence possible MDH status during or prior to this period. In addition, the request for hearing for FYE 3/31/08 was filed prior to the issuance of the NPR and thus would be premature for an NPR appeal.

[29] Pub. L. 101-239.

- The updated hospital-specific rate using FY 1987 cost per discharge.

With respect to Hospital's meeting qualifications initially for cost reporting periods beginning on or after April 1, 1990 ending on or before March 31, 1993, the Secretary stated in the final rule that:

> Hospitals do not need to take any action to qualify for this adjustment. *The fiscal intermediary will determine for each cost reporting period which hospitals meet the criteria to qualify as MDHs prior to the start of the hospital's first cost reporting period beginning on or after April 1, 1990.*
>
> * * * * * * * * * * *
>
> Whether the intermediary determines a hospital's classification as an MDH based on its own data or after a hospital's request, the classification will be effective with the start of the cost reporting period in which the hospital first meets all the qualifying criteria effective with the first cost reporting period that begins on or after April 1, 1990.
>
> Each MDH will be informed of its FY 1987-based hospital-specific rate within 180 days after it qualifies as an MDH. That is, any hospital that the intermediary identifies as qualifying for MDH status will be notified of its hospital-specific rate within 180 days after the start of its cost reporting period beginning on or after April 1, 1990. However, any hospital that is identified as an MDH by the intermediary after the start of its cost reporting period will be notified of its hospital-specific rate within 180 days after the intermediary determines that it meets the qualifying criteria. (Emphasis added.) [30]

Thus, at the time of the Secretary's announcement, the MDH criteria was only applicable for the limited time frame of cost reporting periods beginning on or after April 1, 1990 and ending on or before March 31, 1993 and the responsibility of the Intermediary to make determinations on qualification for the MDH status was only for this limited prescribed period.

Section 13501(e)(1) of the Omnibus Budget Reconciliation Act of 1993[31] extended the MDH provision through FY 1994 and provided that, after the hospital's first three 12-month cost reporting periods beginning on or after April 1, 1990, the additional payment to an MDH whose applicable hospital-specific rate exceeded the Federal rate was limited to 50 percent of the amount by which the hospital-specific rate exceeded the Federal rate.

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[30] 55 Fed. Reg. 15,150, 15,155 (Apr. 20, 1999)
[31] Pub. L. 103-66.

The MDH program then was allowed to lapse for cost reporting periods beginning on or after October 1, 1994 until October 1, 1997. Section 4204(a)(3) of the Balanced Budget Act (BBA) of 1997[32] reinstated the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001, but did not revise either the qualifying criteria for these hospitals or the payment methodology.[33] The final rule promulgated to reinstate the MDH provision for the discrete period involving discharges occurring on or after October 1, 1997 and before October 1, 2001. CMS stated:

> For the purpose of implementing section 4204 of Pub. L. 105–33, we consider that a hospital that meets the criteria above and that was classified as an MDH on September 30, 1994 is reinstated as an MDH. We have identified 414 hospitals that were classified as MDHs on September 30, 1994…We will provide fiscal intermediaries with a list of the hospitals we have identified; therefore, *hospitals that meet the criteria for classification as an MDH and that were classified as an MDH on September 30, 1994 do not need to take any action in order to be reinstated as an MDH.* At the time the year-end settlement is made, the fiscal intermediary will determine for each cost reporting period which hospitals meet the criteria to qualify as MDHs. In addition, the intermediary will determine for each cost reporting period which of the payment options yields the highest rate of payment to a hospital that qualifies as an MDH. (Emphasis added). [34]

This period in which the MDH program was allowed to lapse and then be reinstated, *inter alia*, allowed CMS the opportunity to change how it was implementing the MDH program. In the May 12, 1998 "Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates; Final Rule", the Secretary responded to the recommendations that it establish a process for identifying those hospitals that did not qualify previously. The Secretary stated that:

> Since section 4204 of the BBA did not revise the criteria for classification as an MDH, it is unlikely that there will be new hospitals that qualify except for those hospitals that met all of the original criteria except bed size. We have instructed our fiscal intermediaries to review their records to determine

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[32] Pub. L. 105–33.

[33] *See* Congressional Record Senate S1738 (Feb. 27, 1997). Senator Grassley, who introduced the bill in the Senate, noted: "My legislation would not extend the program as it was originally enacted by the Omnibus Budget Reconciliation Act of 1989. Rather, it would reinstate for 5 years the provisions contained in the Omnibus Budget Reconciliation Act of 1993. It would not have retroactive effect, however. The program would be revived for fiscal year 1998, and would terminate at the end of fiscal year 2002."

[34] 62 Fed. Reg. 45,966, 46,000 (Aug. 29, 1997).

> if there are any hospitals that did not meet the criteria in 1994 and that do now [i.e., FY 1998]; for example, a hospital that had more than 100 beds in 1994 and now has 100 or fewer beds. In addition, as discussed in the August 29, 1997 final rule (62 FR 46000), at the time of a hospital's year-end cost report settlement, the fiscal intermediary will determine if the hospital met the criteria to qualify as an MDH. *Although the fiscal intermediaries are making every effort to identify and notify all affected hospitals, any hospital that believes it meets the criteria for MDH status but has not received notification should contact its fiscal intermediary.* (Emphasis added.) [35]

Thus, for FFY 1998, to reenact the MDH program, intermediaries were instructed to reinstate MDH status and, for FFY 1998, attempt to identify hospitals that did not meet the criteria in 1994: however CMS alerted providers that hospitals also had the responsibility to notify intermediaries of any changes. CMS also never indicated that, under this renewed authority, there would be ongoing automatic review on a yearly basis by intermediaries for all hospitals that did not initially qualify the first year or qualify for MDH status in FFY 1998, the first year the MDH program was reinstated.

Section 404(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999[36] extended the MDH provision to discharges occurring after October 1, 2001 and before October 1, 2006. In addition, effective with cost reporting periods beginning on or after April 1, 2001, § 212 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000[37] provided hospitals an option to base eligibility for MDH status on two of the three most recently audited cost reporting periods, for which the Secretary has a settled cost report, where at least 60 percent of a hospital's inpatient days or discharges were attributable to Medicare Part A beneficiaries.

The interim final rule at 66 Fed. Reg. 32,175 (June 13, 2001) also noted that a hospital must notify its fiscal intermediary to be considered for MDH status under this new provision, and stated that any hospital that believed it met the criteria to qualify as an MDH, based on at least two of the three most recently audited cost reporting periods, must submit a written request to its intermediary within 180 days from the date of the NPR for the cost reporting period in question. The Intermediary would then make its determination and notify the hospital within 180 days from the date it received the hospital's request and all of the required documentation.

The final rule published at 66 Fed. Reg. 39,883 (Aug. 1, 2001), CMS also addressed concerns that requiring a hospital to apply within 180 days from the date of the NPR would result in a lengthy period of time, perhaps two to four years, while the cost report

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[35] 63 Fed. Reg. 26,318, 26,327 (May 12, 1998).
[36] Pub. L. 106–113.
[37] Pub. L. 106-554.

settlement and process were completed. Thus, CMS deleted the requirement that a hospital request MDH status within 180 days of the issuance of the NPR, allowing a hospital to request MDH status as soon as it qualified, even if no NPR had yet been issued. The purpose of this change was quite the opposite of that suggested by the Provider as it was to eliminate any undue delay and not to allow an open ended timeframe in which a provider could retroactively request MDH status. This is also apparent as CMS also changed the time in which the intermediary would make its determination from 180 days to 90 days from the date it receives the hospital's request and all of the required documentation. Further, the non-retroactive application of an MDH approval is plainly set forth effect for if a request is approved, MDH status and the associated payment adjustments *are effective 30 days after the date of written notification of approval from the intermediary to the hospital*.[38]

The final rule published at 66 Fed. Reg. 39,884, the Secretary specifically stated:

> We believe it is most appropriate, and consistent with procedures for SCH and rural referral center designation, to *require hospitals to request consideration as an MDH*, rather than placing this requirement with the fiscal intermediaries. We will further clarify the MDH policy and process, including the change noted above, through future Program Memoranda. (Emphasis added).[39]

While this new provision created a new option for hospitals to qualify as an MDH, the Secretary clarified that they were still subject to the other provisions in place for MDHs. The Secretary stated that:

> Under *existing* classification procedures at § 412.108(b), a hospital must submit a written request to its fiscal intermediary to be considered for MDH status based on at least two of its three most recently audited cost reporting periods for which the Secretary has a settled cost report (as specified in § 412.108(a)(1)(iii)(c)). The fiscal intermediary will make its determination and notify the hospital within 90 days from the date it receives the hospital's request and all of the required documentation. The intermediary's determination is subject to review under 42 CFR part 405, Subpart R. *MDH*

[38] However, in light of the timing of the enactment, Program Memorandum Transmittal A-01-144 (Dec. 20, 2001) provided that hospitals with cost reporting periods beginning on or after April 1, 2001 and before January 1, 2002, shall have approval of their MDH status effective as of the date of the beginning of the hospital's cost reporting period, if the hospital submitted a request to its fiscal intermediary prior to October 1, 2001.

[39] 66 Fed. Reg. 39,884 (Aug. 1, 2001).

> *status is effective 30 days after the date of written notification of approval.* (Emphasis added). [40]

Thus, the regulation at 42 C.F.R. §412.108 (2001)[41] noted:

> (b) *Classification procedures.* The fiscal intermediary determines whether a hospital meets the criterion in paragraph (a) of this section. A hospital must notify its fiscal intermediary to be considered for MDH status based on the criterion under paragraph (a)(1)(iii)(C) of this section. Any hospital that believes it meets this criterion to qualify as an MDH, based on at least two of the three most recent audited cost reporting periods, must submit a written request to its intermediary. The intermediary will make its determination and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation. If a hospital disagrees with an intermediary's determination, it should notify its intermediary and submit documentable evidence that it meets the criteria. The intermediary determination is subject to review under subpart R of part 405 of this chapter. *MDH status is effective 30 days after the date of written notification of approval.* The time required by the intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for such a review. (Emphasis added).[42]

In the August 1, 2002 final rule, CMS made numerous clarifications, and corresponding changes to the regulations, regarding MDH classification. CMS clarified that an approved classification as an MDH remains in effect unless there is a change in the circumstances under which the classification was approved. CMS also clarified that the fiscal intermediary will evaluate on an ongoing basis whether or not a hospital continues to qualify for MDH status. Finally, CMS adopted the proposal that if a hospital loses its MDH status, that change in status would become effective 30 days after the fiscal intermediary provides written notification to the hospital that it no longer meets the MDH criteria, and if the hospital would like to be considered for MDH status after another cost reporting period has been audited and settled, the hospital must reapply by submitting a

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[40] 67 Fed. Reg. 49,982, 50,062 (Aug. 1, 2002).

[41] The regulation at 42 CFR 412.108(b) (2000) stated that: "Classification procedures. The fiscal intermediary determines whether a hospital meets the criteria in paragraph (a) of this section. If a hospital disagrees with an intermediary's decision, it should notify its intermediary and submit documentable evidence that it meets the criteria."

[42] In a previous decision, the Board found "that the controlling regulation at 42 C.F.R. §412.108(b)(4) clearly states that the effective date for MDH status is 30 days after the date the fiscal intermediary provides written notification to the hospital." *Iroquois Memorial Hospital*, PRRB Dec. No. 2003-D49.

written request to its fiscal intermediary. However, it was noted that an MDH that continues to meet the criteria would not have to reapply. The Secretary stated:

> Concerning the commenter's request to not require hospitals to reapply for MDHs status since the intermediaries would already be reviewing that status on an annual basis, we wish to clarify that the *ongoing reviews would be of hospitals with existing MDHs status only*. Therefore, hospitals that had lost their MDH status would not be included in an automatic annual review to determine whether or not the hospitals continue to meet the eligibility criteria for MDH status. Instead, such hospitals must *reapply* for MDH status based on two of their three most recently audited cost reports. (Emphasis added). [43]

The regulation at 42 C.F.R. §412.108 was thus updated effective October 1, 2002 to state:

> (a) Criteria for classification as a Medicare-dependent, small rural hospital.
>
> (1) General considerations. For cost reporting periods beginning on or after April 1, 1990 and ending before October 1, 1994, or beginning on or after October 1, 1997 and ending before October 1, 2006, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in § 412.63(b)) and meets all of the following conditions:
>
> (i) The hospital has 100 or fewer beds as defined in § 412.105(b) during the cost reporting period.
>
> (ii) The hospital is not also classified as a sole community hospital under § 412.92.
>
> (iii) At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits during the hospital's cost reporting period or periods as follows, subject to the provisions of paragraph (a)(1)(iv) of this section:
>
> (A) The hospital's cost reporting period ending on or after September 30,1987 and before September 30, 1988.
>
> * * * * * *

[43] 67 Fed. Reg. 49,982, 50,063 (Aug. 1, 2002)

(C) At least two of the last three most recent audited cost reporting periods for which the Secretary has a settled cost report.

* * * * * * * * * * *

(b) Classification procedures.

(1) *The fiscal intermediary determines whether a hospital meets the criteria specified in paragraph (a) of this section.*

(2) A hospital must submit a written request along with qualifying documentation to its fiscal intermediary to be considered for MDH status based on the criterion under paragraph (a)(1)(iii)(C) of this section.

(3) The fiscal intermediary will make its determination and notify the hospital within 90 days *from the date that it receives the hospital's request and all of the required documentation*.

(4) *A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides written notification to the hospital.* An approved MDH status determination remains in effect unless there is a change in the circumstances under which the status was approved.

(5) The fiscal intermediary will evaluate on an ongoing basis, whether or not a hospital continues to qualify for MDH status. This evaluation includes an ongoing review to ensure that the hospital continues to meet all of the criteria specified in paragraph (a) of this section.

(6) If the fiscal intermediary determines that a hospital no longer qualifies for MDH status, the change in status will become effective 30 days after the date the fiscal intermediary provides written notification to the hospital.

(7) A hospital may reapply for MDH status following its disqualification only after it has completed another cost reporting period that has been audited and settled. The hospital must reapply for MDH status in writing to its fiscal intermediary and submit the required documentation.

(8) If a hospital disagrees with an intermediary's determination regarding the hospital's initial or ongoing MDH status, the hospital may notify its fiscal intermediary and submit other documentable evidence to support its claim that it meets the MDH qualifying criteria.

> (9) The fiscal intermediary's initial and ongoing determination is subject to review under subpart R of Part 405 of this chapter. The time required by the fiscal intermediary to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.

Finally, § 5003(a)(1) of the Deficit Reduction Act of 2005[44] extended and modified the MDH special payment provision which was previously set to expire on October 1, 2006, to include discharges occurring on or after October 1, 2006, but before October 1, 2011. Section 3124(a) of the Patient Protection and Affordable Care Act[45] amended sections 1886(d)(5)(G)(i) and 1886(d)(5)(G)(ii)(II) of the Act to extend the MDH program and payment methodology from the end of FY 2011 to the end of FY 2012, by striking ''October 1, 2011'' and inserting ''October 1, 2012''.

In this case, the Provider argues that as subsections (b)(3) and (b)(4) follow (b)(2) directly, they are only applicable to the optional method of qualifying. The Provider also argues that subsection (b)(9) is the basis for its appeal rights at any time.[46] The Administrator finds the Provider's contention that some of the subpoints of section (b) apply universally, while others apply only to the optional method of qualifying, is incorrect.

Subsection (b)(1) states that the fiscal intermediary determines whether a hospital meets the criteria to be classified an MDH. Subsection (b)(2) states that to be considered under option 2 (two out of the last three years audited cost reports), a hospital must submit a written request, along with qualifying documentation. Subsection (b)(3) states that the fiscal intermediary will make its determination and notify the hospital within 90 days from the date it receives the hospital's request. Thus, a request is required, and has been required since 1997. Subsection (b)(4) states that a determination of MDH status made by the intermediary is effective 30 days after the date the intermediary provides written notification to the hospital.

The Provider is correct that it is not required to qualify for MDH status under the newer, optional method of reviewing Medicare utilization in two of the three most recently audited cost reporting periods.[47] However, even though it is requesting qualification

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[44] Pub. L. 109–171.

[45] Pub. L. 111-148.

[46] *See* Provider's Comments to the Office of the Attorney Advisor. *See also* Board's jurisdiction letter.

[47] The law and regulation allows the provider to qualify under the regulation at 42 C.F.R. 412.108(a)(1)(iii)(C), and the original criteria, The previous versions of bills in the Senate and House would have made the new option mandatory, but those bills never passed. *See*, e,g, H.R. 953 and S. 1051, both entitled "The Medicare Dependent Hospital Relief Act of

under the original methodology, that methodology was allowed to lapse, along with its procedures. Section 4204(a)(3) of the Balanced Budget Act (BBA) of 1997 (Public Law 105–33) reinstated the MDH special payment for discharges occurring on or after October 1, 1997 and before October 1, 2001 and in doing so no longer provided for the intermediary's automatic annual review of the status of hospital's that had not before qualified. The Provider did not request, with documentation, that it be granted MDH status until October 29, 2008,[48] and the Intermediary granted this request, effective February 11, 2009.[49] Under the existing process effective for this period, the earliest the MDH status would be effective is in FFY 2009.[50] The Administrator finds that the Provider was required to request MDH status, and the regulation at 42 C.F.R. §412.108(b)(4) states that the effective date for MDH status is 30 days after the date the intermediary provides written notification to the hospital.

1993", that sought to amend 42 U.S.C. 1395ww(d)(5)(G)(iii)(IV) by striking "during the cost reporting period beginning during fiscal year 1987" and inserting "during at least 2 of the cost reporting periods beginning on or after October 1, 1986, and ending on or before September 30, 1990." *See also* S.832 and H.R. 1651, both entitled "The Medicare Dependent Hospital Relief Act of 1995" that sought to redefine "Medicare Dependent Hospital" as "any subsection (d) hospital…for which not less than 60 percent of its inpatient days were attributable to medicare beneficiaries during 2 of the last 3 preceding fiscal years for which data is available." Thus, Congress apparently intended this to be an additional avenue of qualification, rather than a replacement avenue to qualify as an MDH.

[48] See Intermediary's Final Position Paper, Exhibit I-5.

[49] *See* Intermediary's Final Position Paper, Exhibit I-7.

[50] The Provider also argues that intermediaries had the burden to annually review all providers for possible MDH status from 1990 onward. However, the regulation and preamble language do not support that intermediaries had the burden to automatically and annually check for changes in all providers' status for all years from 1990 onward including the 2007 cost year. In the alternative, the regulation, preamble language and general rules and timeframes for claiming, documenting, and paying of Medicare reimbursement do not support that the Provider could request MDH status anytime and have it be applied retroactively. Not only does the regulation require a written request for MDH status with supporting documentation, the record also does not support the Provider's argument that the Intermediary had been put on notice that the Provider's bed number had changed and that its 1987 Medicare utilization rate now qualified it for MDH status and thus the Intermediary should, sua sponte, have changed the Provider's status. For the cost reporting period 01/1/2001 through 12/31/2001, the Provider specifically listed that there were no changes to "total available beds from the prior cost reporting period." In addition, filing a cost report that might show the requisite bed size would not be sufficient alert of MDH eligibility as it would not also include the 1987 statistics. The Provider also did file any protested amount for example, alleging MDH status for the FYE 2007 cost report.

In sum, the Administrator finds that the Provider was requesting the Board to review the Intermediary's denial of reopening, and that the Board improperly found jurisdiction over the denials of reopening. Even assuming, *arguendo*, that Board jurisdiction was proper for FYE 03/31/2007, the Provider was required to request MDH status with appropriate documentation, and any approval would be effective 30 days after the date the intermediary provided written notification to the hospital. The record shows that no request was filed in a time period that would have been effective for FYE 03/31/2007 and therefore, the Provider did not qualify for a MDH payment during the FYE 03/31/2007.

DECISION

Consistent with the foregoing opinion, the decision of the Board is reversed. The Board lacks jurisdiction over the Provider's request for a Board hearing over the Intermediary's denials of reopening.

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

Date: 8/16/11 /s/

Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services