CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

IN THE CASE OF:	CLAIM FOR:
Marion General Hospital **Provider** **vs.** **Blue Cross and Blue Shield Assn.** **TriSpan Health Services** **Intermediary**	**Medicare Reimbursement** **Cost Year Ending: 09/30/99** **REVIEW OF:** **PRRB Decision No. 2007-D8** **Dated: December 8, 2006**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the 60-day period mandated in §1878(f) (1) of the Social Security Act (Act) [42 USC 1395oo (f) (1)], as amended. The Provider submitted comments requesting that the Administrator reverse the Board as to Issue No. 2. The Administrator notified the parties of his intent to review Issue Nos. 1 and 2. The Intermediary submitted comments requesting that the Administrator vacate the Board's decision as to Issue No. 1 and affirm the Board's decision as to Issue No. 2. The Provider submitted further comments requesting that the Board's decision be upheld with respect to Issue No.1 and reversed with respect to Issue No. 2. Accordingly, the Board decision is now before the Administrator for final administrative review.

ISSUES AND BOARD DECISION

Issue No. 1 is whether the Board may grant jurisdiction for the adjustment included in the Provider's initial Notice of Program Reimbursement (NPR) pursuant to a revised NPR.

The Board majority stated that the issue is whether it may accept jurisdiction for the amount of the adjustment made in the original NPR for September 30, 1999,

when no appeal was filed. The Board concluded that jurisdiction may be granted. The Majority stated that the Intermediary was aware that the issue of unliquidated liabilities was not resolved at the time it issued the original NPR. The original statement made in the NPR constituted a partial determination and it operated as an interim settlement. The Intermediary's revised NPR reopened the cost report for the same issue of unliquidated liabilities. The reopening included a reassessment of the initial adjustment to the debt and increased the amount of the disallowance. The Board concluded that the revised NPR concerned the same issue and same adjustment as the initial NPR. The Board noted that the Provider's appeal includes the combined $425,773 disallowance ($297,259 adjustment on initial NPR, plus $128,414 adjustment on the revised NPR).

One Board member dissented stating that the grant of jurisdiction over the original NPR for September 30, 1999, was in error. The Provider filed a request for an extension of time to pay certain of its accrued liabilities. During the review of the extension request, the Intermediary became aware that $297,359 of the accrued liabilities would never be paid, because they had been forgiven by the creditor. These costs were disallowed when the 1999 cost report was settled and the initial NPR was issued, which was never appealed. The Intermediary granted an extension for the liquidation of the remaining accrued liabilities that related to debts incurred during 1999. When the Provider failed to liquidate the liabilities within that three-year period, the 1999 cost report was reopened, and the unliquidated liabilities were disallowed, and a revised NPR was issued. When the Provider appealed the revised NPR, it included the $297,359 in costs that had been disallowed in the initial NPR.

The Dissenter found that the revised NPR did not address, nor did it adjust, the forgiven costs eliminated in the initial NPR. The notice of reopening did not list the forgiven costs among the items to be addressed in the said reopening. Since the Intermediary's decision regarding the disallowance of the "forgiven costs" was not appealed within the time frame allowed for at 42 CFR 405.1841, the Provider missed its opportunity to object to the treatment of those costs. Since the Intermediary made no determination regarding the forgiven costs in the revised NPR, the Board does not have jurisdiction over that NPR.

Issue No 2 involved whether the Intermediary's adjustment to remove unliquidated liabilities in the year incurred was proper. The Board found that the substantive issue was whether the Provider's accrued costs that remained unliquidated at the end of the three year extension period should be disallowed either in the year they were incurred and accrued or in the cost reporting year at the end of the extension period. The Board found that it was undisputed that the unliquidated liabilities are non-allowable costs and that the regulations at 42 CFR 413.100 and the Provider Reimbursement Manual at section 2305 are controlling.

The Board found that, under the regulation and manual, short-term liabilities must be liquidated timely and, generally, to be timely liquidated, short-term liabilities must be liquidated within one year after the end of the cost reporting year of the accrual. Where a liquidation does not meet these requirements, the cost is generally disallowed in the year of the accrual. Neither the regulation, nor Manual, provides for a separate timetable where an extension has been granted. In the absence of a discrete rule regarding the treatment of extended liabilities, the Board concluded that the language of 42 CFR 413.100(c)(2) was controlling and required that the liabilities be disallowed in the cost reporting period in which they were accrued. The Board also found that the Provider could not rely on the Administrator decision in Jewish Hospital as that case was vacated. Consequently, the Board found that the Intermediary properly disallowed these costs in the cost reporting period ended September 30, 1999.

SUMMARY OF COMMENTS

The Provider requested that Issue No. 1, as to jurisdiction, be affirmed and that Issue No. 2 be reversed. The Provider pointed out that the Administrator is to review this decision in light of prior Administrator decision. Regarding Issue No. 1, the Provider referred to St. Mary's Hospital, Admin. Dec. issued May 5, 1983. Under facts similar to this case, pursuant to 42 CFR 405.1841(a), the Administrator allowed the provider to expand the appeal, where it was dissatisfied with a later NPR treating the same issue so long as the expanded appeal did not cause any surprise or administrative inconvenience. The Provider stated that the St. Mary's decision supports the Board's granting of jurisdiction under the circumstances involved in this case.

With respect to Issue No. 2 and the disallowance of short-term liabilities, the Provider argued that they should be removed in 2002, the third year of the extension, rather than 1999, the year originally accrued. The Provider referred to an Administrator decision in support of its position. The Administrator in Jewish Memorial Hospital, PRRB Dec. No. 89-D75, found that when the allowability of a cost incurred in a prior year depends upon actions taken, or not taken, by a provider in a subsequent period, the adjustment for that cost is properly made in the subsequent period. In that case, there was conditional reimbursement dependent upon subsequent events. While the Board here noted that case had been vacated and could not be relied upon, the Provider pointed out that a stipulation and order implies that the case was settled or dismissed and there was no final decision on the merits. Therefore, the case has no precedential value to determine the current issue and the Administrator should rely upon the holdings in Jewish Memorial as the correct policy for determining the year in which the costs should be disallowed.

The Intermediary commented, requesting reversal of the Majority's decision as to Issue No. 1 and affirmation of the Board as to Issue No. 2. With respect to the jurisdictional issue, the Intermediary argued that the Provider did not appeal the initial NPR adjustment within the 180-day requirement. Therefore, only the adjustments made in the revised NPR that are timely appealed are properly before the Board. With respect to the Board's decision on Issue No. 2, the Intermediary argued that the Provider's position is without merit and the Intermediary properly followed the regulations requiring the removal of the costs in the year in which they were incurred, i.e., 1999.

DISCUSSION AND EVALUATION

The record furnished by the Board has been examined, including all correspondence, position papers and exhibits submitted by the parties. The Board's decision has been reviewed by the Administrator. All comments received after entry of the Board's decision have been made a part of the record and have been considered.

ISSUE NO. 1

After review of the record and applicable law and policy, the Administrator finds that the Board's granting of jurisdiction for that aspect of the Provider's appeal involving the "forgiven" debt adjustment made pursuant to the original NPR must be vacated for lack of jurisdiction.

With respect to a Board hearing, §1878(a) of the Act provides, inter alia, that any provider of services which has filed a required cost report may obtain a hearing with respect to such cost report by the Board:

> (1) if such provider --
> (A)(1) Is dissatisfied with the final determination of the intermediary as to the amount of total program reimbursement ... for which payment may be made under this title for the period covered by such report...
> …
> (2) The amount in controversy is $10,000 or more, and
> (3) Such provider files a request for a hearing within 180 days after the notice of the intermediary's final determination....

Under 42 CFR 1841(a)(1), the request for a Board hearing must be filed in writing within 180 days after the notice of the intermediary's determination was mailed to the provider.

However, the regulation at 42 CFR 405.1885 allows for a cost report to be reopened under certain limited circumstances. The regulation at 42 CFR 405.1889 addresses the effects of reopening and revising an NPR, stating that:

> Where 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 separate and distinct determination or decision to which the provision of §§405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

Under the regulation, if a specific reimbursement matter is reopened and revised, the provider's appeal rights are limited to the particular matter that is revised, and does not extend to other matters that were adjusted in the initial NPR.

In this case, the Provider accrued costs for cost reporting year ending September 30, 1999, for short-term liabilities. The Provider did not liquidate all of its accrued liabilities within one year of having filed the cost report and requested an extension of the liquidation period set forth at §2305.1, of the PRM, by letter dated September 22, 2000.[1] The Intermediary, by letter dated July 24, 2002, responded to the Provider's request and granted a partial extension of the time for liquidating the FYE 1999 accruals.[2]

A subsequent settlement of liabilities relating to the Wesley Health Systems billing, reduced the amount owing by $297,359.[3] The Intermediary issued the Provider's original NPR on August 12, 2003, for cost reporting period ending September 30, 1999, which included the adjustment in the amount of $297,359 representing the portion of the Wesley Health Systems accruals that had been "forgiven." The Provider did not appeal that original NPR.[4]

By notice dated April 2, 2004, the Intermediary reopened the Provider's cost reporting period ending September 30, 1999[5] to reflect adjustments as a result of the "proposed changes to: (1) Non-allowable expenses due to untimely liquidation

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[1] Provider's Exhibit P-7.
[2] Intermediary Exhibit I-8.
[3] Transcript of Oral Hearing (Tr.). at pp. 176-178.
[4] Tr. at p. 119.
[5] Provider Exhibit P-1.

of liabilities...." The Intermediary issued a revised NPR, dated July 1, 2004, which adjusted approximately $128,414 in unliquidated short-term liabilities.[6] The Provider filed a request for hearing on December 31, 2004, which was within 180 days of the date of the revised NPR,[7] but well beyond 180 days of the date of the original NPR. The Provider's request for a hearing showed the appeal amount of the adjustment as $425,773.[8]

The Administrator finds that the record demonstrates the Provider did not file its request for a hearing within 180 days of the initial NPR, but rather within 180 days of the revised NPR. The Administrator finds that the initial NPR was a final determination with respect to the $297,395 for the adjustment made pursuant to the forgiveness of debt. The Administrator finds that the revised NPR was a final determination of the Intermediary with separate and distinct appeal rights only involving the adjustment of approximately $128,414 with respect to the unliquidated liabilities. The revised NPR did not address, nor did it adjust, the forgiven liabilities which had previously been adjusted pursuant to the initial NPR.[9] Thus, the Administrator finds that the Provider's appeal rights are limited to matters adjusted on the revised NPR. i.e., the balance of the liabilities for which an extension had been allowed and which were subsequently disallowed for untimely liquidation pursuant to an issue- specific reopening and adjustment on the revised NPR.

The Provider refers to St. Mary's Hospital (Administrator Decision issued May 5, 1983) where the Board consolidated a provider's appeal of its initial NPR for FY 1979, with its appeal of a revised NPR for FY 1978. The Administrator allowed the Provider to expand its appeal of the revised NPR to include a cost item that was not at issue in the reopening, but that was identical to the cost item it challenged in the initial NPR for FY 1979. The Administrator first finds that in this case, the issue involved in the initial and revised NPRs are not identical: the initial NPR involved the amount of the incurred liability as a result of a portion of the debt having been forgiven, while the revised NPR involved the timeliness of the liquidation balance of the debt. As the Ninth Circuit Court of Appeals noted in French Hospital, 89 F.3d 1411, 1420 (9\th/ Cir. 1995) the "narrowness of [CMS] ruling in St. Mary's Hospital, coupled with the Secretary's longstanding issue-specific interpretation, refutes the hospital claim of inconsistency." Likewise, the Administrator finds that the facts of this present case are distinguishable from the

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[6] Intermediary Exhibit I-1, I-5 (see, e.g., note 1-column entitled "amt to be removed")

[7] Provider Exhibit P-3.

[8] Id.

[9] Regardless of when the Intermediary challenged jurisdiction in this case, jurisdiction cannot be waived and may be raised at any time.

St. Mary's facts. In addition, since this singular decision was issued, the Administrator has restated, many times, the longstanding the issue-specific appeal rights allowed under 42 CFR 405.1889.

Consequently, the Administrator finds the Board improperly accepted jurisdiction over the forgiven debt adjustment made on the original NPR.[10]

ISSUE NO. 2

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 therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the 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. Generally, with respect to cost finding, 42 CFR 413.24(a)(1998) states that:

> Providers receiving payment on the basis of reimbursable costs must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.[11]

The regulation at paragraph (b)(2) further explains that:

> *Accrual basis of accounting*. As used in this part, the term accrual basis of accounting means that revenue is reported in the period in which it is earned, regardless of when it is collected; and expense is

[10] The Board's characterization of the adjustment on the initial NPR as an interim settlement, fails to address how the Provider would have appealed the forgiven debt if it had timely liquidated the balance of the liabilities. It also incorrectly suggests that, when a provider is granted an extension of time to liquidate a liability any adjustment made in the initial cost report is always interim and not final.

[11] As noted in Shalala v. Guernsey Mem'l Hosp., 514 U.S. 87, 94-95 (1995) "generally accepted accounting principle (GAAP) is not the only form of accrual accounting and 42 CFR 413.24 does not, simply by its accrual accounting requirement, bind the Secretary of Health and Human Services to make reimbursements according to GAAP."

> reported in the period in which it is incurred regardless of when it is paid (see 413.100 regarding limitations on allowable accrued costs in situations in which the related liabilities are not liquidated timely.)[12]

The regulation at 42 CFR 413.100(a) sets forth special treatment of certain accrued costs as described in 42 CFR 413.24 (b)(2), repeating that expenses are reported in the period in which they are incurred and explaining that: "In the case of accrued costs described in this section, for Medicare payment purposes the costs are allowable in the years in which the costs are accrued and claimed for Medicare payment only under the conditions set forth in paragraph (c) of this section." That paragraph explains that:

> (c) *Recognition of accrued costs.* (1) *General*. Although Medicare recognizes in the year of the accrual, the accrual of costs for which a provider has not actually expended funds during the current cost reporting period, for purposes of payment Medicare does not recognize the accrual of costs unless the related liabilities are liquidated timely.
> (2) *Requirements for liquidation of liabilities*. For accrued costs to be recognized for Medicare payment in the year of the accrual, the requirements set forth below must be met with respect to the liquidation of related liabilities. <u>If liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual, except as specified in paragraph (c)(2)(ii) of this section.</u>
> (i) *A short-term liability*.
> (A) Except as provided in paragraph (c)(2)(i)(B) of this section, a short-term liability, including the current portion of a long-term liability (for example, mortgage interest payments due to be paid in the current year), must be liquidated within 1 year after the end of the cost reporting period in which the liability is incurred.
> (B) If, within the 1-year time limit, the provider furnishes to the intermediary sufficient written justification (based upon documented evidence) for nonpayment of the liability, the intermediary may grant an extension for good cause. The extension may not exceed 3 years beyond the end of the cost reporting year in which the liability was incurred. (Emphasis added.)

In response to comments to this rule, the Secretary repeated that:

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[12] <u>See also</u> Section 2302.1 of the Provider Reimbursement Manual (PRM) regarding "Accrual Basis of Accounting."

> This rule will result in a clearer statement in the regulations of our policy precluding Medicare payment for expenses in a cost reporting period for which the associated liability is not liquidated timely. If the liability is not liquidated timely, Medicare will recover payment it made for the year of accrual. (Generally, recovery is applicable to the actual year of accrual, although it could apply to a later period in some cases, such as for vacation pay.) Should the liability thereafter be liquidated and our policy provides for Medicare payment in that subsequent period, there will be a Medicare outlay for that period. In cases in which the liability is never liquidated, Medicare does not share in the cost, in the current period or a later period.[13]

Also consistent with the regulations, Section 2305 sets forth the interpretative rules regarding the recognition of expenses under the Medicare program relating to the liquidation of liabilities. Section 2305 requires that a short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. Section 2305.1 allows for an exception to the one-year time limit for good cause. Section 2305.1 states that:

> If within one year following the end of a provider's cost reporting period, the provider furnishes to the intermediary sufficient written justification (based upon documented evidence) for the nonpayment of the liability, the intermediary may grant an extension for good cause. This extension may not extend beyond three years after the end of the cost reporting period in which the liability was incurred. Examples of valid justification, i.e., good cause, would include, but are not limited to insufficient cash flow, or accounting error in receipt and processing of bills for the costs of goods and services.

A review of the record shows that the Provider failed to liquidate the short term liabilities within the three year period. Moreover, both the regulations and Manual illustrate that under accrual accounting, the accruals are to be claimed in the year incurred. Likewise, the preamble to the rule clarifying the accrual policy restated that, except under special circumstances set forth in the regulation, if the accruals are not timely liquidated, the accruals are disallowed in the year originally claimed. Thus, the Administrator finds that the Intermediary properly disallowed the untimely liquidated liabilities in the year originally claimed.

However, the Provider also refers to the Administrator decision in Jewish Hospital, Admin Dec. No. 89-D75, for support of the proposition that the adjustment to

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[13] "Medicare Program; Clarification of Medicare's Accrual Basis of Accounting Policy", 60 Fed. Reg. 33126, 33130 (June 27, 1995).

disallow the costs in question should be made in the third year of the extension (in this case 2002), not the year in which the costs were incurred (1999). The Administrator in that case seemed to believe that to require the disallowance in the year the costs were incurred, when a three year extension was allowed was possibly in conflict with the three year reopening rules at 42 CFR 405.1885. The Administrator concluded that there was a likelihood that the limitation on reopening would occur before the failure of the provider to liquidate the liability would be discovered by the intermediary. The Administrator believed that it created a situation by the very terms of the requirement, that Medicare would be unlikely to recover the funds.

By stipulation and order dated July 6, 1990, the United States District of the Southern District of New York, ordered the case remanded to the Secretary for the sole purpose of vacating the Administrator decision and reinstating the September 29, 1989, decision of the PRRB. The Administrator's order vacating his decision of November 27, 1989, and reinstating the PRRB decision in PRRB No. 89-D75, was dated September 12, 1990.

Notably, neither the Board, nor the Administrator decisions, are precedential and binding outside the four corners of the particular decision. In this particular case, the Administrator's decision was vacated and the Board's decision reinstated. Further, a review of the applicable provisions shows that the Administrator's holding in Jewish Hospital, that perceived a conflict between the three year extension for liquidation of liabilities and 42 CFR 405.1889, was based on an erroneous assumption as to the underlying timeframes. For example, where a intermediary has granted an extension for liquidation of a liability, the intermediary should have followed up with a contact to the provider for proof of liquidation by no later than the extension deadline. The three year period for liquidation begins with the end of the reporting year in which the liability is claimed. In contrast, the three year reopening provision begins with the date of the NPR, which is always after the cost reporting period ends and the cost report is submitted and audited. Therefore, these separate three year periods are not running concurrent with each other and the time for reopening is always going to fall well after the date the liabilities must be liquidated when an extension is allowed. Therefore, not only was the decision vacated, but the premise of the decision was also incorrect.

In sum, after a review of the facts, the applicable policy, regulations and prior decisions, the Administrator finds that the Intermediary properly disallowed the untimely liquidated liabilities for the Provider's cost reporting period ending September 30, 1999.

DECISION

ISSUE NO. 1

Regarding Issue No. 1, the Board's decision is vacated with respect to the forgiven debt adjusted on the Provider's original NPR. The Administrator finds that there is no Board jurisdiction over that adjustment pursuant to the appeal of the revised NPR.

ISSUE NO. 2

Regarding Issue No 2, the Board decision is affirmed with respect to upholding the Intermediary's adjustment for untimely liquidation of the short term liabilities made pursuant to the revised NPR.

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

Date: 2/12/07

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