CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Baptist Memorial Hospital **Provider** **vs.** **Blue Cross /Blue Shield Association** **Riverbend Government Benefits** **Administrator** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 09/30/95** **Review of:** **PRRB Dec. No. 2007-D65** **Dated: August 30, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The Centers for Medicare and Medicaid Services (CMS) Center for Medicare Management (CMM) and the Intermediary submitted comments, requesting reversal of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Provider 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.

ISSUE AND BOARD'S DECISION

Issue No. 1

Issue No. 1 involves whether CMS properly denied the Provider's request for an exception to its Skilled Nursing Facility (SNF) Routine Service Cost Limits (RCL).

The Board held that CMS' denial of the Provider's request for an exception pursuant to the revised Notice of Program Reimbursement (NPR) was improper. The Board found no basis for CMS' limitation in the regulations found at 42 C.F.R. §413.30 (c) or the Provider Reimbursement Manual (PRM-I) at §2531.1.A. In reaching this determination, the Board relied on the fact that CMS limits a provider's TEFRA exception request to within 180 days after the date of the Intermediary's initial NPR.[1] The Board noted that the 42 C.F.R. § 413.30(c) did not make a distinction between types of NPRs. Therefore, absent a clause limiting the filing of an RCL exception request to an initial NPR, a provider should be allowed to make an exception request for the full amount pursuant to the issuance of a revised NPR.

Issue No 2

Issue No. 2 involves whether the Provider is entitled, under CMS Program Memorandum (PM) A-99-62, to include Social Security Act §1115 waiver days for expanded Medicaid population in the Medicaid component of its disproportionate share hospital (DSH) calculation.

With respect to Issue No. 2, the Board relied on its decision on the Provider's FYE 09/30/94 appeal involving the same parties and the same §1115 waive days issue.[2] The Board held that the Provider was entitled to include the §1115 waiver days in the Medicaid component of the Medicare DSH calculation for fiscal year ending (FYE) September 30, 1995. The Board ruled that the Provider had met the "hold harmless" requirements of PM-A-99-62 by filing a jurisdictional proper appeal prior to October 15, 1999 deadline. The Board disagreed with the Intermediary's contention that the Provider did not meet the filing requirements of PM A-99-62 and, therefore, was not entitled to the "hold harmless" provisions of PM-A-99-62. Therefore, the Board held that the Intermediary improperly excluded §1115 wavier expanded Medicaid population (TennCare) days from the numerator of the Medicaid fraction of the Medicare DSH calculation.

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[1] 42 C.F.R. §413.40(e)(1) (1995).

[2] *Baptist Memorial Hospital v. Blue Cross Blue Shield Ass'n/Riverbend Government Benefits Administrators*, PRRB Dec. No. 2007-D43 (June 29, 2007) Admin. Dec. (August 31, 2007) (Hereinafter, *Baptist I*).

SUMMARY OF COMMENTS

Issue No. 1: Exception to the SNF RCL

The Intermediary commented requesting that the Administrator reverse the Board's decision. The Intermediary agreed with the Board's determination that an RCL exception request based on a revised NPR was not, per se, jurisdictionally defective. However, the Intermediary contended that an award is limited to the impact of the revised NPR that triggered the request. Therefore, since the revised NPR did nothing more than lower the difference between total costs and the RCL, the amount of any possible exception had to be zero.

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider agreed with the Board's determination that a provider should be allowed to make an exception request for the full amount from any NPR in which the RCL is an issue. The Provider argued that there is nothing in the regulation, or the PRM, that limits the window in with to request and RCL exception to 180 days from the date of the initial NPR. The administrative record demonstrates that the Provider was over its RCL limits and the Provider has proven the elements required for an exception request based on atypical costs. The Provider maintained that it is entitled to the full exception request based on atypical costs, because the exception request related to costs (except direct nursing costs and time commitment employee health and welfare benefits) that the revised NPR adjusted. The fact that the costs were adjusted downward is immaterial as long as each of the costs included in the exception request continued to exceed the RCLs.

In the alternative, the Provider argued that, if the Administrator holds that the Provider's RCL exception request is limited to the revised NPR, the Administrator should direct the Intermediary to pay $386,950 in additional reimbursement. This was the correct amount specifically adjusted in the revised NPR.

Issue No. 2: Section 1115 Waiver Days

The Intermediary commented requesting that the Administrator reverse the Board's decision. Relying on the Administrator's decision in *Baptist Memorial Hospital*,[3] the Intermediary argued that the elements for qualifying for the hold harmless provisions of PM A-99-62 does not exist in this case because the Provider did not have a jurisdictional proper appeal before the Board on, or before, October 15, 1999. The Intermediary noted that the Administrator had vacated the earlier decision on grounds of *res judicata* because the Provider had participated in litigation which held that the TennCare §1115 waiver days should be excluded on the merits.

CMM commented requesting that the Administrator overturn the Board's decision. CMM incorporated by reference comments made in an earlier case involving the same issue and the same Provider.[4] CMM stated that the Provider had no expectation of being reimbursed for these days in its initial appeal. The Provider indicated in its appeal that the estimated financial impact of the days it was appealing was around $75,000; therefore it's apparent that the Provider intended to appeal days other than §1115 waiver days when it submitted its initial appeal.

CMM noted that the issue was not whether the Provider had prior knowledge of the hold harmless provisions of PM A-99-62 but whether the Provider filed a jurisdictionally proper appeal on the precise issue of §1115 wavier days on or before October 15, 1999. The Provider did not specifically identify §1115 waiver days as part of its appeal until it submitted it preliminary position paper on November 29, 1999. The Provider did not have a jurisdictionally proper appeal pending on the precise issue of §1115 waiver days on or before October 15, 1999. Therefore, the requirements necessary in order to include those days under PM A-99-62 have not been met.

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider argued that it is entitled to the hold harmless provisions of PM A-99-62 for FYE 09/30/95 based on the fact that the Board held that for FYE 09/30/94 it had a jurisdictional proper appeal before the Board on or before October 15, 1999.[5] The Provider also disagreed with CMM's comments that the Provider had no expectation of being reimbursed for these days in its FYE 09/30/94 appeal based on the Provider's statement that

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[3] Id.
[4] Id.
[5] Id.

the estimated financial impact of the days it was appealing was around $75,000. The Provider argued that it used $75,000 as a placeholder, to keep its claim alive and represented only a rough approximation of the amount in dispute in order to satisfy the Board's $10,000 threshold. By no means should the Administrator interpret the use of $75,000 to mean that the Provider's request for a hearing on audit adjustment no. 49 did not include a request on the §1115 wavier days issue.

Finally, the Provider disagreed with the Administrator holding in *Baptist Memorial Hospital*,[6] that the principles of *res judicata* foreclosed any determination of the hold-harmless issue on the merits. The Provider argued that Medicare's common-issue related-party (CRIP) rules require a provider that is part of a hospital chain to separately pursue issues that do not involve "common questions of fact or interpretations of law."[7] The Provider maintained that its challenge to the hold harmless provisions of PM A-99-62 is separate and distinct from the legal question of whether CMS' policy to exclude §1115 waiver days from the DSH calculation violates the Medicare statute. Therefore, it could not have raised its factual challenge under the PM and its legal challenge together in either an individual or a CIRP group appeal without waiving its right to pursue all proper avenue of appeal. Furthermore, the D.C. District Court's decision in *Baptist Memorial Hospital, et al. v. Leavitt*, CA No. 1:06-cv-00437-JR (June 27, 2007) did not implicate the principle of *res judicata*.

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.

Issue No. 1: Exception to the SNF RCL

Section 1878(a) of the Social Security Act (Act) and the regulations found at 42 C.F.R. § 405.1835 set forth the 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

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[6] Id.

[7] See 42 C.F.R. §§ 405.1837 and 405.1841(a)(2) and PRM-I §2920.

$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.[8]

The regulation found at 42 C.F.R. §405.1885(a) allows for a reopening of an intermediary determination or decision if "made within 3 years of the date of the notice of the intermediary determination." In addition, the regulation found at §405.1889 provides 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 separate and distinct determination or decision to which the provisions of §§405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

This provision is also set forth in §2932B of the Provider Reimbursement Manual (PRM). This section likewise refers to a revised NPR as a "separate and distinct determination" which gives a right to a hearing on the matters corrected by such determination. Thus, a revised NPR does not reopen the entire cost report to appeal. It merely reopens those specific matters adjusted by the revised NPR.

Relevant to the disputed cost in this case, with respect to the reimbursement of costs, § 1814(b)(1) of the Act specifies that, for cost years beginning prior to October 1, 1983, providers of inpatient hospitals services were entitled to payment of the lesser of the "reasonable cost" or the "customary charges" for covered services furnished to Medicare beneficiaries. Section 1861(v)(1)(A) of the Act defines "reasonable cost" as the cost actually incurred, excluding amounts not necessary to the efficient provision of health care. Section 222 of the Act of 1972 had amended §1861(v)(1)(A) to authorize the Secretary to set prospective limits on the cost reimbursed by Medicare. These limits are referred to as the "223 limits" or "routine cost limit" or "RCL", and were based on the costs found to be necessary in the efficient delivery of services. The Secretary implemented the cost limits at 42 C.F.R. §413.30 (formerly designated at 42 C.F.R. §405.460).

Pursuant to the statute, the Secretary may provide for exceptions and adjustments to the RCLs under certain circumstances. The exception criteria is set forth in the regulation at 42 C.F.R. §413.30. As set fort in the regulations at 42 C.F.R. §413.30, CMS may grant an exception to the RCL for a number of reasons, including atypical patient mix and extraordinary circumstances. Under the RCL process, the Secretary may grant such

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

exceptions and adjustments "only to the extend the costs are reasonable, attributable to the circumstances specified, separately identified by the provider and verified by the intermediary."[9] The regulation at 42 C.F.R. §413.30(c) provides that such a request must be timely and sets forth in detail the procedural requirements governing review of the request by the intermediary, CMS and the Board. In particular the regulation provides that:

> The provider's request must be made to its intermediary within 180 days of the date on the Intermediary's notice of program reimbursement. The intermediary makes a recommendation on the provider's request to [CMS], which makes the decision. [CMS] responds to the request within 180 days from the date [CMS] receives the request from the intermediary. The intermediary notifies the provider of [CMS'] decision. The time required for [CMS] to review the request is considered good cause for the granting of an extension of the time limit to apply for a Board review, as specified in §405.1841 of this chapter. [CMS'] decision is subject to review under subpart R of part 405 of this chapter.

By letter, dated September 21, 1998, the Intermediary issued the original NPR for FYE 09/30/95.[10] Under 42 C.F.R. §413.30(c) the approximate 180 day deadline was March 25, 1999. No exception request was filed by the Provider within that timeframe. By letter, dated September 27, 2000, the Provider was advised through a reopening notice that its cost report for FYE 09/30/95 would be revised to implement the results of a review of its home office cost report.[11] On November 6, 2001, the Intermediary issued the revised NPR.[12] Within 180 days of that revised NPR, by letter dated May 6, 2002, the Provider applied for an RCL exception request.[13] The Intermediary requested clarification from CMS. The Intermediary, by letter dated May 14, 2002, denied the Provider's exception request made pursuant to the revised NPR. In setting forth CMS rationale, the Intermediary explained that:

> If the cost report was finalized with the total routine service costs for comparison to the cost limit ... less than the inpatient routine service cost limitation....then the provider did not qualify for an exception since the provider's cost was less than the limit. If the same cost report was reopened

[9] 42 C.F.R. § 413.30(f) (1995).
[10] Provider's Exhibit P-1.
[11] Provider's Exhibit P-2.
[12] Provider's Exhibit P-4.
[13] Provider's Exhibit P-5.

> and the total routine service costs for comparison to the costs limit ... ended up, as a result of the reopening adjustments greater than the inpatient routine service cost limitation then the provider would now qualify [to apply] for a routine cost limit exception and the 180 day clock would begin on the date of the intermediary's corrected notice of program reimbursement.

The Board held that CMS' disallowance of the Provider's request for an exception pursuant to the revised NPR was improper. The Board found no basis in the regulation or the PRM for CMS' limiting the filing of an RCL exception request to an initial NPR.

Applying the statute, regulations, PRM and CMS policy to the facts of this case, the Administrator finds that the Provider is not entitled to an exception to its RCL for FYE 1995 pursuant to the revised NPR. The Administrator finds that the Medicare regulations limit the scope of administrative review of revised NPRs to matters the fiscal intermediary reconsidered in revising the NPR. As the regulation shows, an exception request is intricately related to the NPR. Likewise, an exception request made pursuant to a revised NPR is intricately related to those items and costs adjusted in the revised NPR. A revised NPR does not give a provider new appeal rights for costs that could have been appealed under the original NPR. Likewise, a provider's request for an exception made pursuant to a revised NPR is limited to those items and costs at issue in the revised NPR. Finally, the Board's review of any appeal of a determination on that exception request is also limited to those items and costs adjusted on the revised NPR as it is the revised NPR that forms the basis for Board jurisdiction.

In this case, the record shows that the Provider did not exercise its right to request an exception within the required 180-days of the original NPR as set forth at 42 C.f.R. § 413.30(c) for costs that exceeded the limits, but rather requested an exception from the revised NPR. The record shows that the revised NPR reduced the allocation of home office costs to the Provider's acute care, PPS exempt units, and the SNF.[14] In this instance, the revised NPR resulted in a negative adjustment of which $27,488 which was applied to the SNF resulting in a lowering of the amount of the difference between the total costs and the RCL. Therefore, since the revised NPR did nothing more than lower the difference between total costs and the RCL, the Provider is not entitled to an exception to its RCL for FYE 1995 made pursuant to the revised NPR. The Administrator finds that CMS' policy is consistent with the regulations at 42 C.F.R. §§413.30(c) and 405.1889 in prohibiting a SNF from receiving relief from costs that exceeded the RCL which were not affected by the revision of the NPR.

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[14] Intermediary's Supplemental Position Paper on RCL Exception Issue at 2.

Issue No. 2: Section 1115 Waiver Days

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[15] The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Social Security Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[16] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 et seq.] and Supplemental Security Income or SSI [42 USC 1381, et seq.] Participating States may elect to provide for payments of medical services to those aged blind or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as an SSI recipient) are insufficient to pay for necessary medical care.[17]

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, inter alia, the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered.[18] If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[19] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan.

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[15] Section 1901 of the Social Security Act (Pub. Law 89-97).
[16] Section 1902(a) (10) of the Act.
[17] Section 1902(a) (1) (C) (i) of the Act.
[18] Id. §1902 et seq., of the Act.
[19] Id.

In particular, §1901 of the Social Security Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services ...." Section 1902 sets forth the criteria for State plan approval.[20] As part of a State plan, §1902(a) (13) (A) (iv) requires that a State plan provide for a public process for determination of payment under the plan for, inter alia, hospital services which in the case of hospitals, take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs. Notably, § 1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment may be made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX provides for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital may be deemed to be a Medicaid disproportionate share hospital pursuant to §1923(b) (1) (A), which addresses a hospital's Medicaid inpatient utilization rate, or under paragraph (B), which addresses a hospital's low-income utilization rate. The latter criterion relies, inter alia, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[21]

Congress recognized that the various conditions and requirements of Title XIX of the Act, under which a State may participate in the Medicaid program created certain obstacles to potentially innovative and productive State health-care initiatives. Consequently, Title XI of the Act was amended to allow States to pursue such innovative programs.[22] Under §1115 of subchapter XI of the Act, a State that wishes to conduct such an innovative program must

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[20] 42 CFR 200.203 defining a State plan as "a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement."

[21] Congress has revisited the Medicaid DSH provision several times since its establishment. In 1993, Congress enacted further limits on DSH payments pursuant to section 13621 of Pub. Law 103-66 that took into consideration costs incurred for furnishing hospital services by the hospital to individuals who are either eligible for medical assistance under the State plan or have no health insurance (or other source of third part coverage for services provided during the year). The Medicaid DSH payments may not exceed the hospital's Medicaid shortfall; that is, the amount by which the costs of treating Medicaid patients exceeds hospital Medicaid payments plus the cost of treating the uninsured.

[22] Section 1115 of the Act.

submit an application to CMS for approval. CMS may approve the application, if, in their judgment the demonstration project is likely to assist in promoting the objectives of certain programs established under the Act, including Medicaid.[23] To facilitate the operation of an approved demonstration projects, CMS may waive compliance with specified requirements of Title XIX, to the extent necessary and for the period necessary to enable the State to carry out the demonstration project.[24] In addition, CMS may direct that costs of the demonstration project that would not "otherwise" qualify as section 1903 Medicaid expenditures, "be regarded as expenditures under the State plan approved under [Title XIX]."[25]

While Title XIX implemented medical assistance pursuant to a cooperative program with the States for certain low-income individuals, the Social Security Amendments of 1965[26] established Title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[27] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[28] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[29] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[30] This provision added §1886(d) of the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries, other than physician's services, associated with each discharge. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[31]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care, providers are reimburse their inpatient operating costs on the basis of prospectively determined national and regional rates

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[23] Id.
[24] Id.
[25] Id.
[26] Pub. Law No. 89-97.
[27] Section 1811-1821 of the Act.
[28] Section 1831-1848(j) of the Act.
[29] Under Medicare, Part A services are furnished by providers of services.
[30] Pub. Law No. 98-21.
[31] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

for each discharge rather than reasonable operating costs. Thus, hospitals are paid based on a predetermined amount depending on the patient's diagnosis at the time of discharge. Hospitals are paid a fixed amount for each patient based on one of almost 500 diagnosis related groups (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to §1886(d) (5) (F) (i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients...."[32] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[33] To be eligible for the DSH payment under the proxy method, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, §1886 (d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the Medicaid low-income proxy", respectively, and are defined as follows:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day for such fiscal year which were made up of patients who (for such days) were entitled to benefits under Part A of this title.
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> (II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consists of patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX, but who were not entitled to benefits under Part A of this title, and the denominator of which is the total number of the hospital patient days for such period. (Emphasis added.)

CMS implemented the statutory provisions at 42 CFR §412.106. The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 CFR §412.106(b) (2). Relevant to this

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[32] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See also 51 Fed. Reg. 16772, 16773-16776 (1986).

[33] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

case, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 CFR §412.106(b) (4) (1995) and provides that:

> Second computation. The fiscal intermediary determines, for the hospital's cost reporting period, the number of patient days furnished to patients entitled to Medicaid but not to Medicare Part A, and divides that number by the total number of patient days in the same period. (Emphasis added.)

Although not at issue in this case, CMS revised 42 CFR § 412.106(b)(4) to conform to HCFA Ruling 97-2, which was issued in light of Federal Circuit Court decisions disagreeing with CMS' interpretation of a certain portion of §1886(d)(5)(vi)(II) of the Act. In conjunction with this revision, CMS issued a Memorandum dated June 12, 1997, which explained the counting of patient days under the Medicaid fraction, stating that:

> [I]n calculating the number of Medicaid days, fiscal intermediaries should ask themselves, "Was this person a Medicaid (Title XIX beneficiary on that day of service?' If the answer is "yes," the day counts in the Medicare disproportionate share adjustment calculation. This does not mean that title XIX had to be responsible for payment for any particular services. It means that the person had to have been determined by a State agency to be eligible for Federally-funded medical assistance for any one of the services covered under the State Medicaid Title XIX plan (even if no Medicaid payment is made for inpatient hospital services or any other covered service)....

Problems were identified by CMS regarding the payment of the DSH adjustment to providers based on Medicaid data that commingled the days for ineligible Medicaid patients with the eligible Medicaid patients. Intense concerns regarding the recoupment of these improper payments were publicized and also shared with CMS by providers and their political representatives. In response to these concerns, CMS announced in a letter to the Chairman of the Senate Finance Committee, dated October 15, 1999, a "hold harmless" policy.

In order to clarify the definition of eligible Medicaid days and to further communicate the hold harmless position for cost reporting periods beginning before January 1, 2000, CMS issued Program Memorandum (PM) A-99-62, dated December 1999. In clarifying the type of days that were proper to include in the Medicaid proxy, the PM A-99-62 stated that the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. The PM explained that:

> In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for Medicaid days reflects several key concepts. First, the focus is on the patients' eligibility for Medicaid benefits as determined by the State, not the hospital's eligibility for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX state plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan).[34]

Regarding hospitals that did not receive payments in the cost year reflecting the erroneous inclusion of days at issue, CMS stated that:

> If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days.... Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues.

The October 15, 1999 deadline date was established in light of CMS' announcement of its hold harmless policy on that date.[35] The intent of the hold harmless policy was to "hold

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[34] An attachment to the PM describes the type of day, description of the day and whether the day is a Title XIX day for purposes of the Medicare DSH calculation.

[35] See PM-A-99-62 ("In accordance with the hold harmless position communicated by HCFA on October 15, 1999....) See also, St. Joseph Hospital v Leavitt, 425 F. Supp. 94, 96

harmless providers that had evidenced an expectation of being reimbursed for those types of days prior to the date the policy was first announced by CMS. Accordingly, the October 15, 1999 date is a finite date (i.e., bright line test) by which a provider must have identified these types of days in its appeal.

As the Secretary restated in 2000, for the relevant fiscal period in dispute, the Secretary's policy was to include in the Medicare DSH calculation only those days for populations under the Title XI §1115 waiver who were or could have been made eligible under a State plan. The patient days of the "expanded" eligibility groups, however, were not to be included in the Medicare DSH calculation.[36] This policy did not affect the longstanding policy of not counting general assistance or State-only days in the Medicare DSH calculation. The policy of excluding § 1115 waiver expansion populations from the DSH calculation was revisited by CMS and, effective with discharges occurring on, or after, January 20, 2000, certain

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(D.D.C. 2006); United Hospital v. Thompson, Civil Action No. 02-3479, 2003 U.S Dist LEXUS 9942 (June 9, 2003) at 5 acknowledging the basis for the October 15, 1999 date as due to CMS' announcement of the policy. *See also,* e.g., various PRRB decisions such as *Good Samaritan*, PRRB Dec. No. 2007-D35 ("HCFA agreed to abandon its effort to recoup these funds. HCFA's decision was communicated in a letter dated October 15, 1999."); Joint Signature Memorandum concerning PM-A-92-66, Questions Related to PM-A-99-62 ("Q12 What is the significance of the October 15, 1999 date as it relates to appeals? A. October 15, 1999 is the date that HCFA first communicated the hold harmless position. Therefore in order to have an appeal resolved by the intermediary under the hold harmless rules described in PM-A0-99-62 a hospital must have filed an appeal on the issue for at least one of its cost reports for a cost reporting period beginning before January 1, 2000 before the October 15, 1999 date that HCFA first announced the hold harmless position.")

[36] 65 Fed. Reg. 3136 (Jan. 20, 2000). ("In some section 1115 waivers, a given population that otherwise could have been made eligible for Medicaid under section 1902(r)(2) or 1931(b) in a State plan amendment was made eligible under the section 1115 waiver. This population was referred to as hypothetical eligible, and is a specific, finite population identifiable in the budget neutrality agreements found in the Special Terms and Conditions for the demonstrations. The patient days utilized by that population are to be recognized for purposes of calculating the Medicare DSH adjustment. In addition, the section 1115 waiver may provide for medical assistance to expanded eligibility populations that could not otherwise be made eligible for Medicaid. Under current policy, hospitals were to include in the Medicare DSH calculation only those days for populations under the §1115 waiver who were or could have been made eligible under a state plan. Patient days of the expected eligibility groups however, were not to be included in the Medicare DSH calculation.")

§1115 waiver expansion were to be included in the Medicare DSH calculation in accordance with the instructions as specified in more detail in the January 20, 2000 Federal Register.[37]

Finally, in a recently enacted legislation, Congress clarified the meaning of the phrase "eligible for medical assistance under a State plan approved under title XIX" with respect to patients not Medicaid eligible, but who are regarded as such, because they receive benefits under a demonstration project approved under title XI. Congress added language to §1886(d)(5)(F)(vi)(II) of the Act which stated that:

> In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.[38]

This amendment to §1886(d)(5)(F)(vi) of the Act specifically addressed the scope of the Secretary's authority to include (or exclude), in determining the numerator of the Medicaid fraction of the Medicare DSH calculation, patient days of patients not eligible for medical assistance under a State plan but who receive benefits under a demonstration project approved under Title XI of the Act. This enactment clearly distinguishes those patients eligible to receive benefits under Medicaid from those patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

This case is presents facts similar to those presented in Baptist I. The Board's decision focusesd in that case on whether the Provider's March 19, 1998 appeal of its fiscal year ending (FYE) 1994 notice of program reimbursement (NPR) satisfied the requirements of PM-A-99-62. In that case, the record showed that the pertinent portion of the Provider's appeal stated:

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[37] Id. Finally, in 2001, CMS issued a Program Memorandum (PM) Transmittal A-01-13 which restated certain longstanding interpretations in the background material and clarified certain other points for cost reporting periods beginning on or after January 1, 2000, with respect to the hold harmless policy. See Transmittal A-01-13; Change Request 1052 (January 25, 2001).

[38] Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, §5002, 120 Stat. 4, 31 (February 8, 2006) (codified in part at 42 U.S.C. §1395ww (d)(5)(F)(vi)(II).

> The Intermediary incorrectly calculated the Disproportionate Share Adjustment. The audit adjustment in question is#49 attached hereto. The reimbursement impact of this adjustment is approximately $75,000.[39]

The Provider argued that it is entitled to relief under the hold harmless provisions of PM A-99-62 because it filed a jurisdictionally proper appeal before the Board on, or before, October 15, 1999. However, the record shows that the Provider's March 19, 1998 request for a hearing did not specifically address §1115 waiver days. The record shows that the claim for § 1115 waiver days was added pursuant to the Provider's November 29, 1999 preliminary position paper after the relevant October 15, 1999 date.[40] The Administrator finds that a general DSH appeal that does not specifically address the §1115 waiver days claim does not fall within the parameters of the hold harmless provisions of PM A-99-62. Consequently, based on the facts of this case, the Intermediary properly did not allow payment for the §1115 waiver days under those provisions.[41]

However, the Administrator finds that to reach the foregoing determination on the merits of the Provider's argument, with respect to the "hold harmless" provision, is not necessary in light of the controlling Medicare law and the general principles of res judicata. The Administrator takes notice of a June 27, 2007 judgment by the United States District Court for the District of Columbia in Baptist Memorial Hospital, et al., v. Leavitt, CA No. 1:06-cv-00437-JR (June 27, 2007). A decision was entered in favor of the Secretary and against the Provider in the issue involving the §1115 waiver days for the same cost year. That case was the result of the Board's grant of expedited judicial review of a group appeal dated January 4, 2006 for PRRB Case No. 00-3588G. The issue of §1115 waiver days had been

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[39] See e.g. Joint statement of Issues, dated October 20, 2006.

[40] In addition, as CMM noted in this case and *Baptist I*, the amount in controversy cited by the Provider would also not indicate that the Provider intended to raise the issue of the waiver days in this appeal prior to October 15, 1999. Furthermore, the preliminary position paper is a document that is created to exchange between parties to assist in moving the case forward and it is the evidence of the exchange (not the preliminary position paper, itself) that must be supplied to the Board. As a general matter, the preliminary position is not made a part of the record. Therefore, the preliminary position paper is not an appropriate vehicle for adding an issue in a case.

[41] The Administrator also finds that the court cases cited by the Board in *Baptist I* do not support its position and also are not binding. The Administrator also incorporates by reference his decision in *Baptist I.*

transferred from this case (PRRB Case No.03-0132) to the group appeal and involved the same Provider, the same issue (payment of waiver days) and the same cost year.[42]

The case of *Baptist I* represented the same issue to the Administrator. With respect to *Baptist I*, the Administrator vacated the Board's decision on grounds of res judicata. The Provider similarly in this case has brought a separate appeal to the Board under a different theory for the same FYE 09/30/95 as presented in Baptist Memorial Hospital, et al., v. Leavitt, CA No. 1:06-cv-00437-JR (June 27, 2007) in which the District Court entered a judgment in favor of the Secretary and against the Provider regarding §1115 wavier (TennCare) days. Thus, the record shows that the Provider has presented alternative arguments claiming reimbursement for the same issue and cost year in separate appeals, one still pending administratively and the other now decided by the court.

Accordingly, the Administrator finds that the Board improperly heard this case. Neither the specific Medicare law and regulations, nor the general principles of res judicata allow for the Provider to bifurcate its arguments into various cases for the same claim for reimbursement for the §1115 waiver days. These principles are not over ridden by the transfer of an argument on an issue to a group appeal or certification for expedited judicial review.

In particular, the regulation, at 42 CFR 405.1837(a) explains that a group of providers may bring an appeal before the Board but only if: "the matters at issue involve a common question of fact or of interpretation of law, regulations or CMS Rulings." Further, with respect to expedited judicial review, the Secretary specifically addressed this situation. In particular, in response to commenters, the Secretary stated in the final rule establishing expedited judicial review that:

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[42] See Provider's letter, dated September 9, 2005, stating that the "Provider hereby requests to transfer the following issue to the PRRB group appeal Baptist Memorial 94-96 patient Days Group Appeal, PRRB Case No. 00-3588G: Disproportionate Share Section 1115 Waiver Days-Invalid CMS Limiting Policy-Whether the Intermediary erred in excluding expansion population Section 1115 Waiver days from the DSH Medicaid Day Count ...." The Provider had appealed the Section 1115 Waiver days pursuant to a revised NPR dated Feb 2, 2005, by letter dated August 19, 2005. The Board merged the appeal of the revised NPR with the Provider's original appeal Case No. 03-0132. `However, the reopening relating to the 02/02/95 revised NPR does not demonstrated that the scope of that revised NPR extended to include section 1115 waiver days and, thus, under 42 CFR 405.1885, the issue was properly added as an appeal of the revised NPR. The basis for the reopening, while resulting in a DSH adjustment, is not in the record. Documents that are reflective of a 2003 appeal filing, as the case no. would indicate, were not merged into the record.

> In our view, the law authorizes the bypassing of the required Board hearing only with respect to those matters in dispute for which the sole issue to be resolved is the validity of the law, regulations or HCFA Rulings which the Board cannot decide. Clearly, the law does not provide for a Board hearing and an expedited administrative review determination *on separate facets of the same matter in dispute*, nor does it provide for the Board hearing to be bypassed on disputed matters that are within the authority of the Board to decide.[43] (Emphasis added.)

The Medicare law requires that all aspects of an issue remain intact as one case for a final administrative determination. The Medicare principles are also consistent with the general principles of res judiciata. For example, *Black's Law Dictionary* defines res judicata as: "an affirmative defense barring the same parties from litigating a second lawsuit on the same claim, or other claims arising from the same transaction or series of transactions and that could have been —but was not —raised in the same suit." Similar to the foregoing Medicare principles, the principle of res judicata is meant to protect the values of repose and efficiency. In this case, the bifurcation of the same claim into two cases based on the two arguments has erroneously resulted in two administrative proceedings, where only one administrative proceeding was required.[44]

Consequently, as the Board improperly heard this issue, the Administrator finds that the Board's decision should be vacated and dismissed as to Issue No. 2.[45]

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[43] 48 Fed. Reg. 22920 (May 23, 1983).

[44] The CIRP appeal provisions do not necessitate that the principles of *res judicata* be ignored. Instead, either the Provider was not properly a part of the CIRP as the issue/facts were not the same for all of the providers or the CIRP "issue" should not have been "EJRed" as it presented a mixed question of law and fact. Not being able to EJR a case is not a foregoing of its appeal rights.

[45] As the case is moot with respect to section 1115 waiver days for the FYE 9/30/95, the Administrator does not address whether the issue was properly added pursuant to the revised NPR, especially in light of the sparse record concerning the revised NPR dated 2/25/2005 and the lack of documentation on the appeal prior to 2005.

DECISION

Issue No 1.

The Board's decision is reversed as to Issue No. 1. CMS' denial of the Provider's request for an exception to the RCL pursuant to the Provider's revised NPR, dated 11/06/2001 for FYE 9/30/1995 is affirmed.

Issue No. 2

The Board's decision is vacated and the case is dismissed as to Issue No. 2.

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

Date: 10/29/07 /s/

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