PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D24

PROVIDER -
The Queen's Medical Center
Honolulu, Hawaii

Provider No.: 12-0001

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
First Coast Service Options, Inc.-CA

DATE OF HEARING -
February 12, 2009

Cost Reporting Period Ended –
June 27, 1998

CASE NO.: 01-2257

INDEX

ISSUE:

Whether First Coast Service Options, Inc. (Intermediary) improperly excluded patient days associated with patients who were dually eligible for both the Medicare and Medicaid programs but for such days there was no Medicare Part A payment or coverage available (dual eligible days) from the numerators of both the Medicaid and Supplemental Security Income (SSI) percentages of the Medicare disproportionate share hospital (DSH) computation for purposes of The Queen's Medical Center's (Provider) fiscal year ended June 27, 1998 (FYE 6/27/98) Medicare cost report.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 providers under Medicare law and interpretive guidelines published by CMS. See 42 U.S.C. §1395h; 42 C.F.R. §§413.20 and 413.24.

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. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the receipt of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). 42 U.S.C. §1395ww(d). The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. 42 U.S.C. §1395ww(d)(5). This case involves one of the hospital-specific adjustments, specifically the "disproportionate share hospital," or "DSH" adjustment. The Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. §1395ww(d)(5)(F)(i)(I).

Whether a hospital qualifies for the DSH adjustment, and how large an adjustment it receives, depends on the hospital's "disproportionate patient percentage." 42 U.S.C. §1395ww(d)(5)(F)(v). The "disproportionate patient percentage" is the sum of two fractions, the "Medicare and Medicaid fractions," expressed as a percentage for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). A provider whose DSH percentage meets certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital services. 42 U.S.C. §1395ww(d)(5)(F)(ii). The Medicare fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income (SSI), excluding patients receiving state supplementation only, and the denominator is the number of hospital patient days for patients entitled to Medicare Part A. Id. See also, 42 C.F.R. §412.106(b)(2). The Medicare fraction is also referred to as the Medicare proxy or the SSI fraction. The Medicaid fraction's numerator is the number of hospital patient days for patients who were "eligible for medical assistance under a State plan approved under . . . [Title] XIX" for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period. Id; See also, 42 C.F.R. §412.106(b)(4). The Medicaid fraction is also referred to as the Medicaid proxy.

The Medicaid fraction is the only fraction under the Title XVIII Medicare DSH statute at issue in this case.

Part A of the Medicare Act covers "inpatient hospital services." 42 U.S.C. §1395d(a)(1). This benefit includes the right to have Medicare payment made on the beneficiary's behalf for 90 days of inpatient hospital service, per spell of illness, plus 60 additional "lifetime reserve" days. Id. 42 C.F.R. §409.61. No payment may be made under Part A for inpatient hospital services furnished to a beneficiary after exhaustion of this benefit. 42 U.S.C. §1395d(b)(1).

The regulation provides that the fiscal intermediary determines . . . "[t]he 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." 42 C.F.R. §412.106(b)(4).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider is a 526[1] bed general service acute care hospital located in Honolulu, Hawaii. During FYE 6/27/98, the Provider treated patients who were eligible for both Medicare and Medicaid but for whom Medicare Part A benefits were not available for one of three reasons. First, some of these dual eligible patients had exhausted their Part A benefits (dual eligible exhausted days). Second, some of these dual eligible patients were no longer in need of acute care and were instead waiting for transfer to an intermediate care facility (ICF) and thus receiving a level of care not recognized, covered or paid by Medicare (ICF wait list days). Third some patients had a primary insurer other than Medicare who paid for and covered the entire inpatient hospital stay even though these patients also had Medicare coverage ("Medicare as secondary payor days" or "MSP" days"). For each of these three categories of days, the patients were eligible for both Medicare and Medicaid but there was no payment made under Medicare Part A.

Prior to hearing, the parties executed the following joint stipulation:[2]

1. During FYE 6/27/98, the Provider offered inpatient hospital patient care to individuals eligible for both Medicare and Medicaid (dual eligible patients) who during their stay either exhausted their Medicare Part A benefits (exhausted days), were in an inpatient bed but waiting for transfer to an intermediate care facility (ICF waitlist days) or were not covered by Medicare because a secondary (sic) payor paid for the entire stay (MSP days).

2. None of the days in these categories, i.e., exhausted days, ICF waitlist days and MSP days, were covered or paid by Medicare and thus were not in the Medicare/supplemental security income (SSI) percent of the latest audited cost report. The Contractor has performed audit work that confirms that the dual eligible days at issue in this case are not already included in the Medicare DSH SSI percent. Further, none of these days (i.e., exhausted days, ICF waitlist days, or MSP days) were included in the Medicaid percentage of the Medicare DSH computation on the latest audited cost report.

3. All the dual eligible exhausted, dual eligible ICF wait list and dual eligible MSP days at issue in this case were for patients who were eligible for Medicaid on such days.

4. For FYE 6/27/98, upon the Contractor's audit and review, the Contractor and Provider agree that the Provider had 737 dual eligible exhausted days, 647 dual eligible ICF waitlist days, and 747

[1] The Intermediary position paper lists 565 licensed hospital beds.
[2] Provider's Supplemental Exhibit PS-1.

dual eligible MSP days, for a total of 2,131 dual eligible days at issue in this case. See Exhibit 1 to the Joint stipulation (Contractor audit workpaper); and

5. The parties agree that, should the Provider prevail at the PRRB or in court, there is no need to remand for a determination or audit of the number of dual eligible days at issue. Instead, the parties agree that, should the Provider prevail, the Provider's recalculated DSH payments shall be based on the addition of any PRRB or court-approved dual eligible days into the numerator of either the DSH SSI percent or the DSH Medicaid percent (depending on the outcome of the litigation at the PRRB or in court).

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary erred in not including patient days associated with dually eligible Medicare Part A exhausted, ICF wait list, and MSP patients in the Medicaid percentage of the Provider's DSH calculation. The Provider contends that when an inpatient day of care is not payable or covered under the patient's Part A benefit, the patient is no longer entitled to Medicare Part A benefits. Thus, based on the language of the DSH statute, it follows that such days of the dual eligible patient's stay, when not covered or paid by Medicare Part A, should be included (if all other requirements are met) in the Medicaid percentage of the DSH adjustment. In the alternative, the Provider contends that, if the Board is not inclined to incorporate the dual eligible exhausted, ICF wait list and MSP days in the Provider's Medicaid percentage, then the days should be included in the Provider's SSI percentage rather than completely excluded from the DSH calculation. Recent policy statements from CMS support the Provider's contention that the patient days in question must be included in one of the components of the DSH calculation.

The statute establishes that the Medicaid proxy must include:

> 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 subchapter XIX of this chapter, but who were not entitled to benefits under part A of this subchapter. . . .

42 U.S.C. §1395ww(d)(5)(F)(vi)(II). Accordingly, under the statute, the inclusion of patient days in the Medicaid proxy depends on whether the patients were "eligible" for Medicaid, but not "entitled" to Medicare benefits for the days in question.

A number of federal courts, including the ninth Circuit, have construed the terms "eligible" and "entitled" as used in the DSH statute. The courts have consistently found that these terms are not synonymous or interchangeable. The term "eligibility" refers to the qualification for benefits or the capability of receiving those benefits. Whereas "[t]o be entitled to some benefit means that one possesses the right or title to that benefit" or "the absolute . . . right . . . to . . . payment." Jewish Hospital, Inc. v. Secretary of Health & Human Services, 19 F .3d 270, 274-275 (6th Cir. 1994). See also Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996); Cabell Huntington Hospital v. Shalala, 101 F.3d 984, 987 (4th Cir. 1996); Deaconess Health Services Corporation v. Shalala, 83 F.3d 1041 (8th Cir. 1996) affirming 912 F. Supp. 438 (E.D. Mo. 1995). In other words, eligibility is not tied to payment for services, while entitlement is tied to payment.

In the Provider's case, there is no dispute that, for the patient days in question, the patients were qualified (or "eligible") for Medicare and Medicaid benefits. However, by virtue of having exhausted their Medicare Part A benefits or receiving the noncovered ICF wait list level of care or having their entire stay paid by an insurer primary to Medicare (MSP), the patients no longer had any right or entitlement to

Medicare coverage or of payment for the inpatient services/days at issue. That is, the dually eligible patients were not "entitled" to Medicare Part A benefits for the days at issue. Further, based upon the audit work mentioned in the parties' joint stipulation,[3] there is no dispute over the number of dual eligible days at issue in this case.

Thus, the days at issue are precisely the type of days that Congress mandated for inclusion in the Medicaid proxy of the DSH statute, i.e., the days are associated with patients who were eligible for Medicaid, but not entitled to Medicare Part A benefits for such days. See, 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). The Intermediary, therefore, improperly excluded these patient days from the Provider's DSH calculation.

Consistent with the foregoing, this Board has opined on multiple occasions that days associated with otherwise dually eligible patients who have exhausted their Medicare Part A benefits should be counted in the Medicaid proxy of the DSH calculation.

Finally, the Provider contends CMS policy statements show that the noncovered Part A exhausted, ICF waitlist and MSP days should be included in the DSH calculation. As early as August 2004, CMS publicly issued a policy statement on its website that supports including days associated with Medicare/Medicaid dually eligible patients who have exhausted their Medicare Part A benefits in the Medicaid Proxy of the DSH calculation. See Centers for Medicare & Medicaid Services, "Disproportionate Share Hospital Adjustment – Dual Eligible Patient Days" [hereinafter "Internet Statement"].

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly calculated DSH according to 42 C.F.R. §412.106, and that CMS has addressed the question of Medicaid days for those who are enrolled in the Medicare Part A program, but not paid by Medicare Part A. An April 19, 2001 letter addressed to the Blue Cross and Blue Shield Association (BCBSA)[4] states in part:

> When calculating the DSH percentage, a patient who has exhausted Medicare Part A coverage is still eligible for Medicare. Therefore, even if the remainder of the hospital stay is paid by Medicaid, that patient is considered to be dual-eligible, and the days would not count in the calculation for Medicaid.

The Intermediary also relies in the following statement at pages 49098 and 49099 of Federal Register, Vol. 69, No. 154, dated August 11, 2004:

> Our current policy is, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual-eligible and the patient days are included in the Medicare fraction of the DSH patient percentage but not the Medicaid fraction. This is consistent with the language of section 1886(d)(5)(F)(vi)(II) of the Act, which specifies that patients entitled to benefits under Medicare Part A are excluded from the Medicaid fraction.

The Intermediary's also offers as support the CMS Administrator's reversal of the Board's decision Alhambra Hospital v. Blue Cross Blue Shield Association/United Government Services, LLC-CA, PRRB Dec. No. 2005-D47, July 29, 2005 Medicare & Medicaid Guide

[3] See Exhibits PS-1.
[4] See Exhibit I-3

(CCH) ¶81,371, rev'd. by CMS Admin. Dec. September 30, 2005, Medicare & Medicaid Guide (CCH) ¶81,441. It states:

> The Administrator finds that the statutory phrase in the Medicaid proxy "but who were not entitled to benefits under Medicare part A of this title" can reasonably be interpreted to prevent the inclusion of the days at issue in the numerator of the Medicaid proxy. The Medicaid low-income proxy specifically excludes from its calculations patients entitled to Medicare Part A and limits its proxy to Medicaid only eligible patients. The relevant language of the Medicaid proxy indicates that it is the status of the Medicare patient, as opposed to the coverage of the days under Medicare, which determines whether a patient day is included in the numerator of the Medicaid proxy. The phrase "but who were not entitled to benefits under Part A" does not indicate that days for which Medicare has not paid should be included in the numerator of the Medicaid proxy. Consequently, it is reasonable to conclude that the phrase "entitled to benefits under Part A," as used in this Clause II phrase, refers to the status of the patient, as a Medicare beneficiary, rather than whether the patient was entitled to coverage by Medicare for the days at issue.

Regarding the Provider's alternative argument that the disputed DSH days should be included in the SSI numerator of the Medicare DSH calculation, the Intermediary argues that based on the "go forward" policy as stated in the *Federal Register*, the type of days disputed in this appeal can only be counted from October 1, 2004 onward.[5] No retroactive application is allowed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds that Medicare Part A exhausted benefits days, ICF waitlist days, and MSP days should be included in the Medicaid percentage that is used to calculate the DSH adjustment payment.

The Board concludes that the Intermediary's exclusion of Medicaid-eligible days for patients who had exhausted Medicare Part A benefits (dual eligible exhausted days) violates the plain language of the Medicare statute. The Medicare DSH statute defines the numerator of the Medicaid fraction as the number of days for patients who were eligible for Medicaid but "not entitled to benefits under Part A" of Medicare. 42 U.S.C. §1395ww(d)(5)(F)(vi)(II). 42 C.F.R. §412.106(b)(4).

The statutory definition of entitlement to benefits under Medicare Part A means the right to have payment made on the patient's behalf for covered services. See 42 U.S.C. §1395d(a); 42 U.S.C. §426(c)(1). With respect to Part A exhausted benefit days, the Medicare statute provides that the Part A benefit for inpatient hospital services covers 90 days per spell of illness with a lifetime reserve of 60 days. 42 U.S.C. §1395d(a)(1) see also 42 C.F.R. §409.61(a). Therefore, an individual is entitled "to have payment made on his behalf" only for those days. 42 U.S.C. §1395d(a)(1). Payment "may not be made" for inpatient days in excess of those limits. 42 U.S.C. §1395d(b)(1). As articulated by CMS in the preamble to a 1990 Federal register notice, "[e]ntitlement to payment under Part A ceases after the beneficiary has used 90 days in a benefit period and has either exhausted the lifetime reserve days or elected not to use available lifetime reserve days." 55 Fed. Reg. 35990, 35996 (Sept. 4, 1990) (emphasis added). The dual eligible days at issue here were not attributable to patients who were entitled to have payment made on their

[5] Transcript (TR) at 11 and 12.

behalf for those days. Thus, the Medicaid eligible patients were not "entitled" to Medicare part A for those days at issue, and the days should be included in the numerator of the Medicaid fraction.

By excluding the dual eligible exhausted days from the Medicaid fraction, the Intermediary is effectively equating the terms "eligible" and "entitled" in the DSH statute. Four circuit courts rejected CMS' prior attempts to equate these two terms. See Jewish, supra; Cabell, supra; Legacy, supra; and Deaconess, supra. Moreover, in HCFA Ruling 97-2, the agency acquiesced in these court decisions. See HCFA Ruling 97-2 (Feb. 27, 1997); see also 63 Fed. Reg. at 40984, 40985 (July 31, 1998). As the Sixth Circuit concluded in Jewish.

> The Secretary would have this Court conflate eligibility with entitlement. Adjacent provisions utilizing different terms, however, must connote different meanings. To be *entitled* to some benefit means that one possesses the *right* or *title* to that benefit. Thus, the Medicare proxy *fixes* the calculation upon the absolute right to receive an independent and readily defined payment.
>
> By way of contrast, the Medicaid proxy speaks solely of *eligibility*. While Congress intended to refer to the qualification for Medicaid benefits in the calculation of this proxy, Congress could not have intended to fix its calculation on the actual payment of benefits in the state administered program. Had Congress intended that result, it would have also defined the Medicaid proxy in terms of entitlement to state Medicaid payments. Rather, Congress defined the Medicaid proxy with respect to eligibility for and not actual payment of benefits.

Jewish at 275.

Under these authorities, the patients at issue here were not "entitled to benefits" under Medicare Part A because they did not have the right to have payment made on their behalf for the days at issue. The days at issue occurred after these patients had exhausted Part A benefits for inpatient hospital services. Accordingly, consistent with the plain meaning of the statute, the exhausted days for which the patients were not entitled to receive payment should be included in the numerator of the Medicaid fraction to the extent that the patients were eligible for Medicaid.

The Board also finds that the Intermediary's exclusion of these days from the Medicaid fraction for the period at issue is inconsistent with CMS' interpretation. Prior to the change in the regulations in 2004, CMS considered Part A exhausted patient days to not be entitled to benefits under Medicare Part A.

For example, in 1996, the Secretary affirmed the Board's decision that days billed to, and paid by Medicaid, after patients had exhausted Medicare Part A benefits, may properly be included in the Medicaid fraction. See Presbyterian Medical Center of Philadelphia v. Aetna Life Insurance Company, CMS Administrator, November 29, 1996, Medicare & Medicaid Guide (CCH) ¶45,032. In 1998, the Board held that dual-eligible patient days should be included in the numerator of the Medicaid fraction after the patient has exhausted Medicare Part A benefits. See, Jersey Shore Med. Ctr v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Dec. No. 99-D4, Medicare & Medicaid Guide (CCH) ¶ 80,083 (Aug. 26, 1998). The Administrator vacated the Board's decision and remanded the case for a different reason, without commenting on the Board's decision regarding Part A exhausted days. Jersey Shore Med. Ctr., CMS Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 80,153 (Jan. 4, 1999).

In the May 19, 2003 notice of the proposed inpatient PPS rule for Federal fiscal year 2004, CMS stated that all dual-eligible patient days "are counted" in the *SSI fraction* as Part A "entitled" days even after a

Medicare beneficiary exhausts Part A benefits. 68 Fed. Reg. 27154, 27207 (May 19, 2003). The following year, in the preamble to the final inpatient PPS rule for fiscal year 2005, CMS admitted that this statement in the May 19, 2003 proposed rule was incorrect. In the final PPS rule for fiscal year 2005, CMS stated:

> It has come to our attention that we inadvertently misstated our current policy with regard to the treatment of certain inpatient days for dual-eligible in the proposed rule of May 19, 2003 (68 FR 27207). In that proposed rule, we indicated that a dual eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. Our policy has been that only covered patient days are included in the Medicare fraction.

69 Fed. Reg. at 49098 (Aug. 11, 2004). This clarification contradicts the rationale given by the Administrator in other rulings where he has said that the Medicaid fraction should not include dual eligible exhausted days because those days were included in the SSI fraction. *See, e.g.*, Edgewater Medical Center v. Blue Cross Blue Shield of Illinois,CMS Administrator Decision 2000-D44 and 2000-D45, June 16, 2000, Medicare & Medicaid Guide (CCH) ¶80,525 and Castle Medical Center CMS Administrator Decision 2003-D6, Sep. 12, 2003, Medicare & Medicaid Guide (CCH) ¶81,085.

In the final rule, adopted in August 2004, CMS stated that it was "revising" the DSH regulation in order to begin counting all dual eligible days in the SSI fraction beginning with discharges on or after October 1, 2004. 69 Fed. Reg. 49099. CMS made clear that this revision to the regulation implemented the policy to be applied prospectively:

> *[W]e are adopting a policy* to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage . . . . This policy *will be effective for discharges occurring on or after October 1, 2004*. (emphasis added)[6]

Id.

For periods prior to the October 1, 2004 effective date of the new rule, CMS's policy and practice was that dual eligible days were not considered to be "entitled" to benefits under Medicare Part A, and thus were excluded from the SSI fraction. Id. at 49098-99.

The change in the regulation in 2004 to count dual eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Part A hospital coverage, was effective for discharges occurring on or after October 1, 2004. Since the days at issue in this case are not affected by the new regulation, the Board has based its decision in this case on its interpretation of the law and regulations that existed prior to the change in the regulation and has not addressed the Provider's arguments that CMS' changes in the regulation are otherwise invalid.

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[6] Likewise, in its final rule implementing section 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173 (2003), CMS explained that the "policy change" with respect to dual eligible MSP days applies to "FY 2005 and subsequent years." 670 Fed. Reg. 47278, 47441 (Aug. 12, 2005).

The Board also finds that the Intermediary's exclusion of the days at issue from the Medicaid fraction is also inconsistent with the position of the Secretary of Health and Human Services (Secretary) in Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.C.C. 2008).[7] The Secretary conceded that exhausted days are not Medicare "covered" days for which patients are "entitled to benefits under Part A" for purposes of the Medicare/SSI fraction of DSH calculation.[8] The Board agrees with the Provider's position that if the days are not "entitled" under Part A for purposes of the Medicare/SSI fraction, then they cannot be entitled for purposes of the Medicaid fraction. See, e.g., Adena Reg'l Med. Ctr. v. Leavitt, 527 F.3d 176, 180 (D.C. Cir. 2008) ("as the Supreme Court has instructed on countless occasions, we are to presume that identical words used in . . . the same act are intended to have the same meaning.")

Similar to exhausted days, there is no entitlement to payment under Medicare Part A for wait list days and MSP days. The same rationale therefore applies to these days and requires that the dual eligible days be counted in the Medicaid fraction of the DSH calculation.

The Intermediary has conceded that the days in issue were not included in the denominator of the SSI fraction described in 42 U.S.C. §1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. §412.106(b), that includes days for which CMS has determined that the patients were entitled to benefits under Medicare Part A.[9] Since the days at issue in this case were not included in the DSH Medicare/SSI fraction no adjustment to that fraction is needed.

DECISION AND ORDER:

The Providers' Part A exhausted benefit days, ICF waitlist, and MSP day are properly included in the Medicaid fraction of the DSH calculation. The Intermediary's adjustments are modified to agree with the stipulated days.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: April 2, 2010

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[7] In that case, the hospital challenged the Secretary's calculation of its Medicare/SSI fractions for its fiscal years ending 1993, 1994, 1995, and 1996.

[8] See Defendants' Memorandum of Points and Authorities in Support of Defendant Leavitt's Motion for Summary Judgment and in Opposition to Plaintiff's Motion for Summary Judgment at 21, 24; see also Plaintiff's Reply Memorandum in Support of Its Motion for Summary Judgment and Memorandum in Opposition to Defendant Leavitt's Motion for Summary Judgment at 35, Baystate, 545 F. Supp. 2d 20 (D.D.C. 2008).

[9] See Stipulation 4.