PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D40

PROVIDERS –
Adventist DSH Waiver Days Group

Provider Nos.: Various

vs.

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

DATE OF HEARING -
March 5, 2009

Cost Reporting Periods Ended -
Various

CASE NO.: 01-1346G

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ISSUE:

Whether the Intermediary's calculation of the Providers' Medicare disproportionate share hospital ("DSH") payments improperly excluded "expansion waiver" days attributable to patients who received medical assistance through Tennessee's Medicaid demonstration project waiver program approved by the Secretary under section 1115 of the Social Security Act ("section 1115").

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the 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's payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the 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. §§405.1835-405.1837.

Medicare DSH Payment

Since 1983, Medicare has paid most hospitals for the operating costs of inpatient hospital services under a prospective payment system ("PPS"). 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412. Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments. 42 U.S.C. § 1395ww(d); 42 C.F.R. Part 412. One of those adjustments is the DSH payment. See 42 U.S.C. § 1395ww(d)(5)(F); 42 C.F.R. § 412.106.

A hospital that serves a disproportionate share of low-income patients - a DSH - is entitled to an upward percentage adjustment to the standard PPS rates. See 42 U.S.C. § 1395ww(d)(5)(F). A hospital's qualification for a DSH adjustment, and the amount of the DSH payment made to a qualifying hospital, are based on the hospital's "disproportionate patient percentage." Id.; 42 C.F.R. § 412.106(b).

The statute defines "disproportionate patient percentage" as the sum of two fractions, the Medicare and Medicaid fractions. 42 U.S.C. § 1395ww(d)(5)(F)(vi). See 42 C.F.R.

§ 412.106(b). The Medicaid fraction is at issue in this case. The statute defines the numerator of the Medicaid fraction, at issue here, as:

> the number of the hospital's patient days for [a cost reporting] 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) (emphasis added).

CMS's Prior Construction of "Eligible for Medical Assistance Under a State Plan" in the Medicaid Fraction

From 1986 through 1997, CMS narrowly construed the Medicare DSH statute to exclude Medicaid patient days that were not actually paid by a State Medicaid program from the number of "eligible" days used for determining the DSH payment. See 51 Fed. Reg. 16,772, 16,777 (May 6, 1986) (interim final rule); 51 Fed. Reg. 31,454, 31,460-61 (Sept. 3, 1986) (final rule). Pursuant to a series of court determinations, CMS rescinded its prior policy and amended the DSH regulation to provide that the calculation must include all days for which a patient was "eligible for Medicaid . . . regardless of whether particular items or services were covered or paid under the State Medicaid plan." 63 Fed. Reg. 40,954, 40,985 (July 31, 1998). See 42 C.F.R. §412.106(b)(4) (1998).

The new rule confirmed that "eligible for medical assistance" does not mean "paid by Medicaid," but raised controversy about the proper interpretation of the term. On December 1, 1999, the Secretary issued Program Memorandum A-99-62 ("PM A-99-62")[1], Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation (Dec. 1, 1999). PM A-99-62 addressed the agency's policy as to the meaning of Medicaid "eligibility" effective January 1, 2000 and established a "hold harmless" rule under which hospitals meeting two different criteria would be permitted to receive DSH payments based on "ineligible days."[2] Id.

CMS took the position in federal court that "eligible for medical assistance" should have the same meaning for Medicare DSH as for Medicaid DSH and the D.C. Circuit accepted that view. Appellant's Corrected Opening Brief at 25-27, Adena Reg'l Med. Ctr. v. Leavitt, No. 07-5273 (D.C. Cir. 2008); Adena Reg'l Med. Ctr. v. Leavitt, 527 F.3d 176 (D.C. Cir. 2008), cert. denied, 2009 WL 901536 (2009).

The Medicaid Program

[1] Exhibit P-9.

[2] Two groups were entitled to these payments under the hold harmless rule of PM A-99-62. The first group, consisting of hospitals that had received DSH payments based on otherwise "ineligible days" for cost reporting periods settled before October 15, 1999, could continue to receive DSH payments based on those days for cost reporting periods beginning prior to January 1, 2000. The second group, consisting of hospitals that had not received DSH payments based on "ineligible days" but had appealed the exclusion of the otherwise "ineligible days" prior to October 15, 1999, could also receive payment for those days for the cost years under appeal.

Medicaid is a jointly-funded federal and state program established in Title XIX of the Act to provide "medical assistance" to indigent persons who meet certain eligibility criteria. 42 U.S.C. § 1396; 42 C.F.R. § 430.0. The term "medical assistance" means "payment of part or all of the cost" of 25 different types of health care services listed in the statute, including inpatient hospital services. 42 U.S.C. § 1396d(a); 42 C.F.R. §§ 430.0, 440.1, 440.2, and 440.10. To participate in the Medicaid program and receive Federal funding, a State must submit a "State plan" that meets federal requirements for approval by the Secretary of Health and Human Services ("the Secretary"). 42 U.S.C. §§ 1396, 1396a; 42 C.F.R. Part 430.

The Federal Medicaid statute authorizes payment of Federal matching funds according to a "Federal medical assistance percentage," or "FMAP," for State expenditures on "medical assistance under the State plan." 42 U.S.C. § 1396b(a)(1); 42 C.F.R. § 433.10; See 42 U.S.C. § 1396d(b) (defining the FMAP). These Federal matching funds are also called "Federal Financial Participation" or "FFP." There is no authority in the Federal Medicaid statute for a State to make payments under an approved Medicaid State plan for items or services furnished to individuals who are not considered to be eligible for some Medicaid benefit. See 42 C.F.R. Part 433, Subpart A.

Section 1115 Waivers

Section 1115 of the Act, 42 U.S.C. § 1315, permits the Secretary to waive certain statutory Medicaid requirements to permit "experimental, pilot, or demonstration project[s]" that are "likely to assist in promoting the objectives" of Title XIX. 42 U.S.C. § 1315(a). Section 1115, in relevant part, reads as follows:

> (a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title . . . XIX, . . . in a State or States—
>
> (1) the Secretary may waive compliance with any of the requirements of section . . . 1902 [of the Act; 42 U.S.C. §1396a] as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and
>
> (2)(A) costs of such project which would not otherwise be included as expenditures under section . . . 1903 [of the Act; 42 U.S.C. §1396b] . . . shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate. . . .

Id.

Section 1115(a)(l) allows the Secretary to waive the requirements of section 1902 (42 U.S.C.

§1396a) "to the extent and for the period determined necessary" by the Secretary. 42 U.S.C. §1315(a)(l). Section 1902 of the Act contains Medicaid State plan requirements, including requirements as to eligible populations. Section 1115(a)(2)(A) allows a State to receive Medicaid federal matching for medical assistance under section 1903 (42 U.S.C. § 1396b),

including medical assistance provided to expanded eligibility populations, for which the State would not ordinarily be entitled to receive Federal matching. 42 U.S.C. §1315(a)(2). Section 1903 of the Act governs the payment of Federal matching funds under Title XIX.

Under some section 1115 waivers, the State furnishes medical assistance to a population that otherwise could have been made eligible for Medicaid; under others, the State furnishes medical assistance to expanded eligibility populations that could not otherwise have been made eligible for Medicaid. 65 Fed. Reg. 3136 (Jan. 20, 2000) (interim final rule). As stated by CMS, the waiver statute "allows for the expansion populations to be treated as Medicaid beneficiaries." Id. at 3137.

CMS Policy on Section 1115 Waiver Days for Medicare DSH

Until early 2000, the Medicare regulations did not explicitly address the treatment of section 1115 waiver days for purposes of the DSH calculation other than the requirement that intermediaries include all days attributable to patients who were eligible for medical assistance under an approved State plan. See 42 C.F.R. § 412.106 (1999). Some hospitals were allowed to include days attributable to section 1115 expansion populations, while others were not. See 65 Fed. Reg. at 3137. As stated by CMS, "because [CMS's] prior guidance on certain aspects of [the] Medicare DSH policy was insufficiently clear, many hospitals in States with approved Section 1115 expansion waivers [had] been receiving Medicare DSH payments reflecting the inclusion of expansion population patient days" prior to January 2000. Id. at 3137.

Through PM A-99-62, CMS instructed fiscal intermediaries to allow the inclusion of "ineligible waiver or demonstration population days" for cost reporting periods beginning before January 1, 2000, to the extent that they had allowed their inclusion for cost reporting periods settled prior to October 15, 1999. PM A-99-62 does not define what are or are not eligible waiver population days, or state CMS's policy on the treatment of such days. PM A-99-62 includes a chart that summarizes the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation. The listing makes no reference to any type of Section 1115 waiver days.

On January 20, 2000, CMS issued an "interim final rule with comment period" to address the treatment under Medicare DSH of inpatient days attributable to patients who were eligible for medical assistance in a State with a Section 1115 Medicaid waiver. 65 Fed. Reg. 3136. This interim final rule amended CMS' regulation to provide that, effective with discharges occurring on or after January 20, 2000, hospitals may include the patient days of all populations eligible for Title XIX matching payments through a State's section 1115 waiver. 65 Fed. Reg. at 3136-37; 65 Fed. Reg. 47,026, 47,086 (Aug. 1, 2000); see 42 C.F.R. § 412.106(b)(4)(ii).[3]

In the same interim final rule, CMS asserted that its policy was to exclude waiver "expansion days" from the Medicare DSH calculation prior to January 20, 2000. See 65 Fed. Reg. at 3136. CMS explained:

[3] The implementing regulations read as follows: "Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act." 42 C.F.R. § 412.106(b)(4)(ii).

> While [CMS] initially determined that States under a Medicaid expansion waiver could not include those expansion waiver days as part of the Medicare DSH adjustment calculation, we have since consulted extensively with Medicaid staff and have determined that section 1115 expansion waiver days are utilized by patients whose care is considered to be an approved expenditure under Title XIX . . . [T]hese days are considered to be Title XIX days by Medicaid standards.

65 Fed. Reg. at 47,087.

Challenges to Exclusion of Waiver Days and the Deficit Reduction Act of 2005

Hospitals that were not permitted by their Medicare fiscal intermediaries to include expansion waiver days for periods prior to January 20, 2000 appealed the issue. The Ninth Circuit held that the plain language of Section 1115 requires that the Medicare DSH calculation include inpatient days of individuals who received assistance as "expansion populations" pursuant to a Section 1115 waiver. See Portland Adventist Med. Ctr. v. Thompson, 399 F.3d 1091 (9th Cir. 2005).

Congress then passed Section 5002 of the Deficit Reduction Act of 2005 ("DRA"). Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5002, 120 Stat. 4, 31 (Feb. 8, 2006). Section 5002(a) amends the Medicare DSH statute to address Section 1115 waiver days. Under the amendment, " . . . 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 XIX."

Section 5002(b) of the DRA amended CMS' regulation to provide that, effective with discharges occurring on or after January 20, 2000, hospitals may include the patient days of all populations eligible for Title XIX matching payments through a State's section 1115 waiver in calculating the Provider's Medicare DSH adjustment. Id.

Following the passage of the DRA, the United States Court of Appeals for the District of Columbia Circuit ultimately considered whether expansion waiver days could be excluded from the Medicare DSH calculation for periods prior to January 20, 2000 in light of the DRA. Exhibit P-1, Cookville Reg'l Med. Ctr. v. Leavitt, 531 F.3d 844 (D.C. Cir. 2008), cert. denied, 129 S. Ct. 1524 (2009).

The D.C. Circuit upheld the exclusion of these days, concluding "that it was unclear, prior to the Deficit Reduction Act, whether the Secretary had discretion to exclude the expansion waiver population from the disproportionate share hospital adjustment." Id. at 849. In the court's view, the DRA "ratified the Secretary's earlier policies, 'including the policy . . . regarding discharges occurring prior to January 20, 2000' to emphasize that the Secretary always had this discretionary authority." Id. In making this finding, the D.C. Circuit disagreed with the Ninth Circuit's conclusion that the plain language of Section 1115, prior to the enactment of the DRA, required the inclusion of the expansion waiver days. Id. at 848-9. The Cookville Court, however was not asked to consider, and therefore did not address, whether the plain language of the Medicare DSH statute itself required the Secretary to include those days.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Providers are Takoma Adventist Hospital, provider number 44-0050, and Tennessee Christian Medical Center, provider number 44-0135. Both of the Providers are general acute care hospitals located in Tennessee that operated under the common ownership or control of Adventist Health System during the periods at issue.

The Medicare fiscal intermediary for the Providers was Riverbend Government Benefits Administrators until May 1999, after which Blue Cross/Blue Shield of Florida and then First Coast Service Options served the facilities. Those organizations and the BlueCross BlueShield Association are referred to collectively and individually herein as the "Intermediary." The Providers have designated First Coast Service Options as the lead intermediary in this group appeal.

The Intermediary audited each of the cost reports at issue and made final determinations as to the Providers' Medicare DSH payments. The Providers appealed to the Board the exclusion of the section 1115 expansion waiver days at issue from the Providers' Medicare DSH calculations and met the jurisdictional requirements of 42 U.S.C. § 1395oo and 42 C.F.R. §§ 405.1835 - 405.1840 (2008).

The Providers were represented at the hearing by Stephanie A. Webster, Esq., of King & Spalding, L.L.P. The Intermediary was represented by Bernard Talbert, Esq., of BlueCross Blue Shield Association.

STIPULATIONS OF THE PARTIES:

The Providers and the Intermediary further stipulated as follows:

1. On November 18, 1993, the Centers for Medicare and Medicaid Services ("CMS") approved Tennessee's Medicaid demonstration project called "TennCare" under section 1115. Tennessee implemented TennCare on January 1, 1994.[4]

2. In addition to persons who would otherwise be eligible for medical assistance under a State plan even without a waiver, TennCare furnished medical assistance to uninsured and uninsurable individuals who would not otherwise have been eligible for medical assistance under the Tennessee State plan as it existed prior to the section 1115 waiver. These latter individuals are known as "expansion populations.[5]

3. The patient days at issue in this group appeal are attributable to expansion populations who received medical assistance under the TennCare program approved under section 1115.[6]

4. In the November 18, 1993 letter approving the TennCare waiver program, CMS informed Tennessee of its determination that expenditures made by the State to furnish assistance to

[4] Stipulations ¶ 3.
[5] Id. ¶ 4.
[6] Id. ¶ 5.

the expansion populations covered by the waiver would be "regarded as expenditures under the State's Title XIX plan."[7]

5. Pursuant to CMS's approval of the TennCare waiver under section 1115, Tennessee received Federal matching funds under Title XIX of the Social Security Act for expenditures made by the State during the periods at issue to furnish medical assistance to the expansion populations covered under TennCare.[8]

The Parties also agreed to the number of inpatient days at issue attributable to TennCare expansion waiver populations[9] and agreed that if the Providers prevail in this appeal, the Intermediary would revise the numerator of the Medicaid fraction for each of the cost reporting periods at issue to include those expansion waiver days.[10]

PROVIDERS' CONTENTIONS:

The Providers contend that the Tennessee "waiver expansion" days are days attributable to individuals who were eligible for medical assistance under the Tennessee State plan approved by CMS under Title XIX, and should therefore be counted in the numerator of the Medicaid fraction of the Medicare DSH calculation. First, in approving the TennCare waiver, CMS exercised its section 1115 discretion to determine that the expansion waiver populations "shall be regarded" as eligible for medical assistance under Title XIX. While the D.C. Circuit concluded in Cookeville that section 1115 did not clearly foreclose CMS's discretion in determining whether and the extent to which expansion waiver populations shall be regarded as eligible for medical assistance, CMS exercised any discretion it had to regard the TennCare expansion waiver patients as eligible for medical assistance, and the agency is bound by this prior determination for purposes of the Providers' Medicare DSH calculations even after Cookeville.

Second, the Providers contend that, as found by the Ninth Circuit in Portland Adventist, and consistent with Adena, the exclusion of expansion waiver days from the Medicare DSH calculation is inconsistent with the plain meaning of the Act. Specifically, even if Section 1115 itself is ambiguous the plain language of the DSH statute, as construed by the Secretary and affirmed by the D.C. Circuit in Adena, requires that these expansion waiver days be counted. As a result, in the Providers' view, the DRA is impermissibly retroactive, and cannot be read to require the exclusion of the waiver days at issue here.

Finally, the Providers assert that CMS and its Medicare fiscal intermediaries inconsistently treated expansion waiver days, and their exclusion for some providers and not others is arbitrary and capricious. For all of these reasons, the Providers' Medicare DSH calculations should therefore be corrected to include those days.

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[7] Id. ¶ 6
[8] Id ¶7.
[9] Id. ¶8
[10] Id. ¶ 9.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that TennCare "waiver expansion" days for the periods at issue in this appeal may not be included in the DSH calculation. The Intermediary argues that it was not until August 1, 2000 that CMS issued a Final Rule allowing hospitals to include the patient days of all populations that receive benefits under a section 1115 demonstration project in calculating the DSH adjustment.[11] The Intermediary contends further that CMS subsequently clarified the issue in the Federal Register dated August 1, 2003, which stated that, for discharges after January 20, 2000, hospitals may include section 1115 patient days in the Medicaid fraction. For discharges prior to January 20, 2000, hospitals may include only those days for populations that were or could have been made eligible under a state plan.[12]

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 and concludes that the Intermediary's exclusion of the section 1115 expansion waiver days was proper.

The Board finds that CMS properly exercised its discretion in determining that the expansion populations at issue were not regarded as eligible for medical assistance under Tennessee's Medicaid State plan prior to January 20, 2000. In the recent Cookeville decision, the D.C. Circuit upheld the exclusion of these days, concluding "that it was unclear, prior to the Deficit Reduction Act (DRA), whether the Secretary had discretion to exclude the expansion waiver population from the disproportionate share hospital adjustment." In the court's view, the DRA "ratified the Secretary's earlier policies, 'including the policy . . . regarding discharges occurring prior to January 20, 2000' to emphasize that the Secretary always had this discretionary authority."[13]

The Board concurs with the rationale adopted by the court. Under sections 1115(a) and 1115(a)(1), "any experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of . . . [Title] XIX," the Secretary may waive compliance with any of the requirements of section 1902 "to the extent and for the period he finds necessary to enable such State or States to carry out such project." Section 1115(a)(2)(A), in turn, provides that the costs of a waiver project "shall . . . be regarded as expenditures under the State plan" "to the extent and for the period prescribed by the Secretary" under section 1115(a)(1) (emphasis added). CMS exercised its discretion to disallow the Section 1115 days and the Intermediary consistently enforced that disallowance. Tennessee hospitals received instructions from this Intermediary indicating that expansion waiver days would not be included in their Medicare DSH calculations.[14]

The Board finds that CMS' treatment of Section 1115 days was based on an evolving policy and recognizes that prior to 2000 some hospitals were allowed to include days attributable to section 1115 expansion populations in the Medicare DSH calculation, while others were not. Indeed, the

[11] 65 F.R.47086 to 47087, Aug. 1, 2000.
[12] 65 F.R. 45420-45421, Aug. 1, 2003.
[13] Cookeville, 531 F.3d at 849.
[14] See Exhibit P-8 at 81.

interim final rule dated January 20, 2000 stated, "because [CMS's] prior guidance on certain aspects of [the] Medicare DSH policy was insufficiently clear, many hospitals in States with approved section 1115 expansion waivers [had] been receiving Medicare DSH payments reflecting the inclusion of expansion population patient days".[15] The statute permits the Secretary to adopt the policy stated in the preamble. The State plan's inclusion of the days does not override the policy stated in the preamble. In this case, the Secretary exercised the discretion granted by the statute to disallow section 1115 days. The Board accordingly concludes that the Secretary's disallowance was proper.

DECISION AND ORDER:

The Intermediary properly excluded section 1115 expansion waiver days from the number of Medicaid eligible days used for purposes of calculating the Medicaid fractions of the Providers' Medicare DSH payments for the periods at issue.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq.
Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Suzanne Cochran
Chairperson

DATE: July 02, 2010

[15] See 65 Fed. Reg. at 3137

Revised Schedule of Providers in Group (Schedule A)

Group Name: Adventist DSH Waiver Days

Representative: Christopher L. Keough

Case No.: 01-1346G Issue: Whether the Intermediary Improperly Excluded Tennessee Expansion Waiver Days from the Medicaid Fraction for DSH

					A	B	C	D
	Provider No.	**Provider Name**	**FYE**	**FI**	**NPR Date**	**Date of Req for Hearing**	**No. of Days**	**Audit Adj.**
1	44-0135	Tennessee Christian Medical Center, Davidson Co., TN	06/30/95	Riverbend	09/30/97	03/27/98	178	31
2	44-0135	Tennessee Christian Medical Center, Davidson Co., TN	06/30/96	Riverbend	09/30/98	03/26/99	177	61
3	44-0135	Tennessee Christian Medical Center, Davidson Co., TN	06/30/97	Riverbend	09/28/99	03/24/00	178	26
4	44-0050	Takoma Greenville, Greene Co., TN	12/31/97	Riverbend	08/22/00	12/18/00	118	N/A[1]
5	44-0135	Tennessee Christian Medical Center, Davidson Co., TN	06/30/98	Riverbend	09/28/00	02/02/01	127	36
6	44-0050	Takoma Greenville, Greene Co., TN	12/31/98	Riverbend	06/05/01	07/26/01	57	N/A[1]
7	44-0135	Tennessee Christian Medical Center, Davidson Co., TN	06/30/99	FCSO	09/30/02	01/16/03	108	9[1]
8	44-0050	Takoma Greenville, Greene Co., TN	12/31/99	FCSO	09/28/02 7/13/04	01/16/03 12/16/04	111	7 18
9	44-0135	Tennessee Christian Medical Center, Davidson Co., TN	06/30/00	FCSO	09/30/02	01/16/03	108	N/A[1]
10	44-0050	Takoma Greenville, Greene Co., TN	12/31/00	FCSO	09/26/03	11/4/03	39	N/A[1]
11	40-0110	Southern Christian Medical Center, Yauco Co., Puerto Rico	12/31/00	Cooperativa de Seguros de Vida de Puerto Rico	9/26/03	1/12/04	108	6, 27

1.By memorandum dated October 1, 1996, the Intermediary instructed the Providers not to claim TennCare expansion days (for uninsured and uninsurable patients) as Medicaid days. (Copy of memorandum included in exhibits 6D, 7D, 9D, and 10D). Accordingly, the Providers did not make a claim for a DSH adjustment based on these days for periods prior to January 20, 2000.