CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Baptist Memorial Hospital	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 09/30/94**
Provider	
vs.	
Blue Cross /Blue Shield Association Riverbend Government Benefits Administrators	**Review of: PRRB Dec. No. 2007-D43 Dated: June 29, 2007**
Intermediary	

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 Center for Medicare Management (CMM) submitted comments, requesting reversal of the Board's decision. The Intermediary commented requesting reversal of the Board's decision. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Provider requesting that the Administrator affirm the Board's decision. Supplemental comments were submitted by CMM. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Provider is entitled under CMS Program Memorandum (PM) A-99-62, to include Social Security Act, § 1115 waiver days for expanded Medicaid populations (aka TennCare) in the Medicaid component of its disproportionate share hospital (DSH) calculation.

The Board held that the Provider was entitled to include the § 1115 waiver days in the Medicaid component of the Medicare DSH calculation. In reaching this conclusion, 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. The Board disagreed with the Intermediary's contention that the Provider did not meet the filing requirement of PM A-99-62 and, therefore, was not entitled to the "hold harmless" provisions of PM-A-99-62. The Board relying on St. Joseph Hospital v. Leavitt,[1] concluded that there was no need for the Provider to use specific language (i.e., TennCare days) in it's appeal request, dated March 19, 1998. Furthermore, relying on United Hospital v. Thompson,[2] the Board held that § 1115 waiver days could be added to the DSH calculation if claimed in an existing appeal before the PM A-99-62 was issued.

The Board agreed with the Intermediary that the Provider appeal began as a general DSH case. However, the issue was expanded and clarified in its November 29, 2999 preliminary position paper filed before the issuance of the PM. Therefore, the Provider filed a jurisdictionally proper appeal to the Board before the October 15, 1999 deadline established by PM A-99-62. The Provider incurred and claimed TennCare days eligible for payment under the hold harmless provisions of PM A-99-62. Thus, the Provider was entitled to include the §1115 wavier (TennCare) days in the Medicaid component of the DHS calculation.

SUMMARY OF COMMENTS

CMM submitted initial and supplemental comments requesting that the Administrator reverse the Board's decision. CMM stated that the issue is not whether the Provider had prior knowledge of the provisions of PM A-99-62 when it filed its preliminary position paper, but whether the Provider filed a jurisdictionally proper appeal on the precise issue of §1115 waiver days on, or before, October 15, 1999. Therefore, since the Provider did not add the § 1115 waiver days to its appeal until November 29, 1999 they did not have a jurisdictionally proper appeal pending on this issue on October 15, 1999. Furthermore, 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 approximately $75,000. Therefore, it was apparent that the Provider intended to appeal days other than § 1115 waiver days when it submitted it initial appeal.

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[1] 425 F. Supp. 2d 94 (D.D.C., 2006).

[2] 2003 U.S. Dist. LEXIS 9942 (D. Minn. June 9, 2003), aff'd 2004 U.S. App. 8th Cir. LEXIS 1882.

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary argued that the Board incorrectly applied the terms of PM-A-99-62. The Intermediary noted that the Board found that the Provider's appeal began as a general DSH case, however, the Board incorrectly also determined that the Provider's filing was a jurisdictionally proper appeal before the October 15, 1999 deadline

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider contended that it satisfied the requirements of PM A-99-62 and therefore is entitled to have the stipulated 2,020 TennCare expanded waiver days included in the Medicare component of its fiscal year ending (FYE) 1994 cost report DSH calculation. The Provider argued that its March 19, 1998 appeal satisfied the requirements of PM A-99-62. The Provider argued that, at the time it appealed the NPR concerning its 1994 cost report, there was no requirement that providers reference each and every reason why they challenged a particular audit adjustment. Rather, the Provider maintained that the Board rules required that they identify in writing each audit adjustment in dispute, with a short explanation of the issue. Accordingly, the Provider maintains that the filing of its preliminary position paper filed with the Board on November 29, 1999 complied with the Board's rules (see Provider Reimbursement Manual (PRM) § 2921.5) by elaborating on the reasons for its appeal of audit adjustment no. 49. Furthermore, relying on St. Joseph's Hospital, supra, the Provider argued that "magic words" or particular phrasing are not necessary for relief.[3]

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 are included in the record and those received timely have been considered.

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.[4] 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

[3] The Provider's August 17, 2007 supplemental comments were not filed within the 15-days allowed under the regulation and were not considered, but these comments have been included in the administrative record.

[4] Section 1901 of the Social Security Act (Pub. Law 89-97).

States are required to provide Medicaid coverage to the categorically needy.[5] 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.[6]

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.[7] 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.[8] 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.

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.[9] 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

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[5] Section 1902(a) (10) of the Act.
[6] Section 1902(a) (1) (C) (i) of the Act.
[7] Id. §1902 et. seq. of the Act.
[8] Id.
[9] 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."

part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment maybe made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX provide for an adjustment in payment for inpatient hospital services furnished by a disproportionate share hospital. A hospital maybe 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.[10]

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.[11] Under §1115 of subchapter XI of the Act, a State that wishes to conduct such an innovative program must 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.[12] 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.[13] In addition, CMS may direct that costs of the demonstration project that otherwise would not "otherwise" qualify as section 1903 Medicaid expenditures, "be regarded as expenditures under the State plan approved under [Title XIX]."[14]

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[15] established

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[10] 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 Medicare assistance under the state plan or have no health insurance (or other source of third part coverage for services provide 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.

[11] Section 1115 of the Act.

[12] Id.

[13] Id.

[14] Id.

[15] Pub. Law No. 89-97.

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,[16] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[17] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[18] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[19] 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.[20]

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 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…."[21] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[22] 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

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[16] Section 1811-1821 of the Act.
[17] Section 1831-1848(j) of the Act.
[18] Under Medicare, Part A services are furnished by providers of services.
[19] Pub. Law No. 98.21.
[20] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[21] 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).
[22] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

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 C.F.R. § 412.106. The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 C.F.R. § 412.106(b) (2). Relevant to this case, the second computation, the "Medicaid-low income proxy", or "Clause II", is set forth at 42 C.F.R. § 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 C.F.R. § 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).[23]

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

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

> 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.[24] The intent of the hold harmless policy was to "hold 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

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[24] See PM-A-99-62 ("In accordance with the hold harmless position communicated by HCFA on October 15, 1999. ...) See also, Provider Exhibit 24 (HCFA letter to State Medicaid Directors enclosing October 15 letter from Deputy Administrator to Senator Roth.) See also St. Joseph Hospital v Leavitt, 425 F. Supp. 94, 96 (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.")

the Medicare DSH calculation.[25] 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 §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.[26]

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.[27]

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[25] 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.")

[26] 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)

[27] 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).

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 particular case centers 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. The record shows that the pertinent portion of the Provider's appeal stated:

> 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.[28]

The Provider argued that it is entitled to relief under the hold harmless provisions of PM A-99-62 because they filed 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 (TennCare) days. The record shows that the claim for § 1115 waiver (TennCare) days was added pursuant to the Provider's November 29, 1999 preliminary position paper after the relevant October 15, 1999 date.[29] The Administrator finds that a general DSH appeal that does not specifically address the §1115 waiver (TennCare) 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

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[28] See also Provider's Joint statement of Issues, dated April 23, 1998.

[29] In addition, as CMM noted, the amount in controversy cited by the Provider would also not indicate that the Provider intended to raise the issue of the TennCare 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. In this case, the parties stipulated to the issue being raised in the preliminary position paper. See Provider Exhibit 1.

Intermediary properly did not allow payment for the § 1115 waiver (TennCare) days under those provisions.[30]

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 (TennCare) 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 (TennCare) waiver days had been transferred from this case (PRRB Case No. 98-1942) to the group appeal and involved the same Provider, the same issue (payment of TennCare days) and the same cost year.[31]

In the case now before the Administrator, the Intermediary filed objections stating that it believed it was inappropriate to proceed with a hearing in this case.[32] The Intermediary claimed that the same issue covering the same cost reporting year "cannot be included in a group appeal and an individual appeal at the same time." In response, the Board, by letter dated April 20, 2006, concluded that these cases "present two different *arguments* for achieving the same end: inclusion of §1115 waiver days in the DSH fraction. The *argument* in the current case is not common to that in the group appeal and the Board will hear the case." (Emphasis added.) Hence, the Board acknowledged that the cases involve the same issue, but only represented different arguments to support payment of the same disputed 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 regulation, nor the general principles of res judicata allow for the

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[30] The Administrator also finds that the court cases cited by the Board do not support its position and also are not binding.

[31] See Provider's letter, dated July 28, 2000 stating that the "Provider formally requests that the undermentioned issue be added to each of the existing appeals ... Are patient days associated with general assistance and TennCare, other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days to be included in the Medicaid days factor ..." and requesting transfer of such "undermentioned issue" to the group appeal.

[32] See Intermediary's April 17, 2006 letter to the Board.

Provider to bifurcate its arguments into various cases for the same claim for reimbursement for the §1115 TennCare waiver days. This would also prohibit 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:

> 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.[33]

Accordingly, 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.[34]

Consequently, as the Board improperly heard the case, the Administrator finds that the Board's decision should be vacated and the case dismissed.

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[33] 48 Fed. Reg. 22920 (May 23, 1983).

[34] Particularly problematic is the fact that even after the issue had been "bifurcated and included in a group appeal, the Provider continued to argue both that the statute allowed for these days, as well as the "hold harmless" provisions of the PM in its supplemental position paper, dated August 23, 2004.

DECISION

In accordance with the foregoing, the Board's decision is vacated and the case is dismissed.

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

Date: 8/29/07

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