CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
St. Joseph's Hospital **Provider** **vs.** **Blue Cross /Blue Shield Association** **Noridian Administrative Services** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 08/31/95** **Review of:** **PRRB Dec. No. 2004-D32** **Dated: August 12, 2004**

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 Intermediary submitted comments, 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. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's adjustment to the Provider's disproportionate share hospital (DSH) payment was proper. The Board found that the Provider was covered under the "hold harmless" provision of Program Memorandum (PM) A-99-62 because it claimed general assistance (GA) days in its initial and subsequent submissions, on or before October 15, 1999. Therefore, the Board reversed the Intermediary's determination and remanded the matter to the Intermediary to recalculate the Provider's DSH payment.

In reaching this determination, the Board held that the need for any specific language in the appeal was unknown at the time the Provider filed its appeal and should not be used to deny the Provider's otherwise valid appeal. The Board further held that it was undisputed that the Provider did include GA days in the days it submitted to the Intermediary in its DSH calculations, and that the Intermediary's denial of all the Provider's DSH data, therefore denied the GA days that the Provider claimed. The Board stated that the Intermediary audit work-papers clearly identified all of the reasons for denying the Provider's DSH data, and that the Provider specifically addressed the Intermediary's audit adjustment in its appeal and made reference to the Intermediary's work-papers. The Board also found that the Intermediary intended to disallow GA days and the Provider intended to appeal their disallowance based on the audit adjustments and the underlying work-papers.

In addition, the Board found that other circumstances supported the Provider's claim that it intended to appeal GA days. The Board found that the Provider appealed the audit adjustment before the issuance of the PM A-99-62 and therefore could not have been aware that CMS would require any special phrases to be used in order to appeal the GA days at issue in this case. The Board further found that the Provider transferred other issues out of its DSH appeal, but retained the failure to include non-Medicaid days in its instant appeal. The Board stated that it did not believe that the initial position paper was intended to substantially address any specific DSH issue and that the Provider's alternate arguments are moot since it found that the Provider's appeal included the GA days at issue.

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Administrator reverse the Board's decision because it reflected an incorrect interpretation of the regulations and program instructions. Specifically, the Intermediary argued that the Provider did not meet the "hold-harmless" provision of PM A-99-62 because the Provider's appeal request was general, and the position paper never specifically addressed the issue with respect to GA days. The Intermediary points out that the Provider filed its preliminary position paper in December 1999, and made no specific reference to the GA days issue, and therefore, the Provider made no focused complaint about rejection of GA days in its DSH claim. Only after the issuance of PM A-99-62, did the Provider acknowledge the GA days in its argument. The Provider's final position paper was filed on March 31, 2000.

The Provider commented requesting that the Administrator affirm the Board's decision. Specifically, the Provider argued that it had a jurisdictionally proper

appeal on the issue of the excluded GA days because they filed a request for a hearing on March 18, 1998, appealing DSH adjustment number 46, which included "non-Medicaid" days, before October 15, 1999. The Provider disagreed with the Intermediary's contention that it had to specifically addressed the issue of GA days in its request for a hearing since the Intermediary's adjustment clearly indicated that it was the Provider's inclusion of non-Medicaid days, in the data that cause the Intermediary to deny the entire DSH payment.

The Provider also argued that the Board, as the best arbitrator, is in the best position to determine what constitutes a jurisdictionally proper appeal on a certain issue because the "hold harmless" policy in the PM A-99-62, uses Board jurisdiction as a mechanism for determining whether a provider had perfected its appeal rights on the issue of GA Days prior to CMS's announcement of the Policy.

The Provider further contended that it's appeal presented a stronger case under the "hold-harmless" policy than the *Castle Medical Center*[1] appeal because unlike the fortuitous timing of the provider in *Castle*, the GA days issue was part of the Provider's appeal from the very beginning, over a year and a half before the issuance of the PM A-99-62. At that time, the Provider contended there was no other required manner of displaying a belief of its entitlement to DSH based on the days used in preparing its as-filed DSH adjustment (which included GA days) than filing an appeal before the Board. By continuing to pursue its GA days appeal after transferring other aspects of its DSH appeal to group appeals, the Provider argued that it was steadfastly in pursuit of the adjustment in the manner prescribed by the applicable statutes, regulation, and manual instructions. The Provider contends that the Administrator should preserve the Board's decision, and find that the Provider met its criteria, as it did in *Castle*, in order to evidence a reasoned application of the Hold Harmless policy.

In another case, *United Hospital v. Thompson*[2], the Provider argued that the Board found that the Provider there did not fit within the requirements of the PM A-99-62 based on its failure to add the GA Days issue after the October 15, 1999 deadline. The Provider distinguished itself from *United Hospital* in that the Provider in United added the GA days on a date after the October 15, 1999, deadline. Therefore, it argued that the Board should not reverse its decision because the Provider in the instant case filed its appeal well before the deadline.

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[1] PRRB Decision No. 2003-D6 (Admin. Dec. dated Sept. 12, 2003).

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

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Relevant to the issues 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.[3] 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 (Act), establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[4] 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.[5]

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.[6] If the State plan is approved by CMS, 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.[7] In particular, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who

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[3] Section 1901 of the Act(Pub. Law 89-97).
[4] Section 1902(a)(10) of the Act.
[5] Section 1902(a)(1)(C)(i) of the Act.
[6] Id. Section 1902, et. seq., of the Act.
[7] Id.

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.

However, Congress recognized that the requirements of Title XIX under which a State may participate in the Medicaid program created certain obstacles to experimental State heath-care initiatives. Congress amended Title XI of the Act to provide flexibility for States to pursue such experimental programs.[8] Under § 1115 of the Act, a State that wants to conduct such an experimental program must submit an application to the Secretary for approval. The Secretary may approve the application, if, it is determined that the demonstration project is likely to assist in promoting the objectives of certain programs established under the Act, including Medicaid.[9] To facilitate the operation of an approved demonstration project, the Secretary 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.[10] In addition, the Secretary may direct that costs of the demonstration project that otherwise would not qualify as Medicaid expenditures, "be regarded as expenditures under the State Title XIX plan (i.e., receive Federal Financial Participation (FFP)). Thus, individuals who are not eligible for medical assistance under the State plan approved under Title XIX of the Act might be eligible for medical assistance under a §1115 demonstration project.

In addition to the medical assistance provided under Title XIX and Title XI, the Social Security Amendments of 1965[11] established title XVIII of the Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to entitled beneficiaries. The Medicare program primarily provides medical services to aged and disabled persons and consists of two Parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[12] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[13] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[14] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[15] This provision added § 1886(d) of the Act and established the prospective payment system

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[8] Section 1115 of the Act.

[9] Id.

[10] Id.

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

[12] Section 1811-1821 of the Act.

[13] Section 1831-1848(j) of the Act.

[14] Under Medicare, Part A services are furnished by providers of services.

[15] Pub. Law No. 98.21.

(PPS) 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 PPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding cost effective hospital practices.[16]

These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under PPS, 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 PPS 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…."[17]

There are two methods to determine eligibility for a DSH adjustment: the "proxy method" and the "Pickle method."[18] To be eligible for the DSH payment under the proxy method, a PPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Relevant to this case, with respect to the proxy method, §1886(d)(5)(F)(vi) of the Act states that the terms "disproportionate patient percentage" means the sum of two fractions which is expressed as a percentage for a hospital's cost reporting period. The fractions are often referred to as the "Medicare low-income proxy" and the Medicaid low-income proxy", respectively, and are defined as follows:

> (I) the fraction (expressed as a percentage) the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under Part A of this title and were entitled to supplemental security income benefits (excluding any State supplementation) under title XVI of this Act and the denominator of which is the number of such hospital's patients day

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[16] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

[17] 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).

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

> 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 patients 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 athe denominator of which is the total number of the hospital patients days for such period. (Emphasis added.)

CMS implemented the provisions of the Act at 42 C.F.R. 412.106. The regulation explains the proxy method. Relevant to this case, the first computation, the "Medicare proxy" or "Clause I" set fort at 42 C.F.R. 412.106(b)(2)(1995) states:

> (2) *First computation*: *Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, [CMS]—
>
> (i) Determines the number of covered patient days that—
> (A) Are associated with discharges occurring during each month; and
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementations:
> (ii) Adds the results for the whole period; and
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of patient days that—
> (A) Are associated with discharges that occur during that period: and
> (B) Are furnished to patients entitled to Medicare Part A.
> (Emphasis added.)

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

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

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. Revised 412.106(b)(4) applies to cost reporting periods beginning on or after October 1, 1998. However, relevant to this case, 42 CFR 412.106(b)(4)(iii)(1998) states that:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that patient as eligible for Medicaid during each claimed patient day.

Similarly, the Secretary noted in revising paragraph (b)(4) that:

> Since the proposed revisions were intended simply to conform the regulations to HCFA Ruling 97-2 (and hence to the four adverse court decisions) revised 412.106(b)(4) would reiterate the Ruling's change of interpretation that the Medicaid fraction under section 1886(d)(5)(F)(vi)(II) of the Act includes such hospital patient day for a patient eligible for Medicaid on such day, regardless of whether particular items or services were covered or paid under the State Medicaid Plan. Our proposed revisions, in 412.106(b)(4), like the Ruling, would continue to place on the hospital the burdens of production, proof and verification as to each claimed Medicaid patient day.[19]

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[19] 63 Fed. Reg. 40954, 400985 (1998). As noted in the HCFA Ruling 97-2, Medicare intermediaries would determine the amounts due and make appropriate payments through normal procedures for the applicable periods. However, the Ruling stressed that:

> Claims must, of course, meet <u>all other applicable requirements</u>. This includes the requirement for data that are adequate to document the claimed days. The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patients inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted. (Emphasis added.)

Thus, while the documentation language was added to the regulations in 1998, it was simply restating longstanding Medicare rules, that in order for a provider to receive payment it must be able to document its claim with verifiable data.[20]

In conjunction with the regulatory 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)….
>
> We note that individuals who are eligible for payments under a demonstration project, but would not be eligible under the provisions of the underlying State plan, are not included in this definition. Demonstration projects often involve waivers of State plan provisions; individuals eligible only by virtue of those waivers are not eligible under the State plan itself. Thus, they would not meet the statutory definition of Medicaid days….

In particular, concerning individuals eligible for payment under a demonstration project, CMS explained that:

> [S]ome States have a demonstration project which includes expanded eligibility populations who would not be eligible under a State plan under title XIX, or a State waiver which includes people who are not and would not have been Medicaid Title XIX beneficiaries. Inpatient

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[20] See, e.g., Section 1815(a) of the Act ("[N]o such payment shall be made to any provider unless it has furnished such information, as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid…."); 42 CFR 413.20 and 413.24.

> hospital days for these non-Medicaid individuals would not be properly included in the calculation of Medicaid days. State record should distinguish between individuals eligible under the State plan and individuals who are only eligible under a demonstration project or waiver.

However, while CMS assumed that State record would distinguish between individuals eligible under the State plan and those individuals who were eligible under a demonstration project or waiver, problems arose. In 1999, CMS observed certain practices and policies regarding Medicare DSH payment reflecting confusion regarding the counting of those State-only and waiver days for purposes of the DSH calculation. CMS determined that certain hospitals and intermediaries relied on Medicaid days data obtained from State Medicaid agencies to compute Medicare DSH payments and that some of those agencies commingled the types of otherwise ineligible days listed above with Medicaid Title XIX days in the data transmitted to hospitals and/or intermediaries.

In order to again state the definition of eligible Medicaid days and to communicate a hold harmless position for cost reporting periods beginning before January 1, 2000, for certain providers, CMS issued Program Memorandum (PM) A-99-62, Dated December 1999. This program memorandum again explained that State-only and waiver days were not to be counted in the Medicaid proxy. With respect to included days, 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. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under and approved Title XIX State plan.

Consistent with this definition of days to be included, the PM-A-99-62 stated regarding the exclusion of days, that:

> Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program…. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

> ….
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> Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate document to substantiate the number of Medicaid days claimed.

In addition, for those providers that were genuinely confused or held a genuine belief that, for example, certain "State-only" days and/or "waiver days were to be included in the DSH calculation, CMS announced a hold harmless policy for cost reporting periods beginning before January 1, 2000. Pertinent to this case, CMS instructed intermediaries, pursuant to the PM A-99-62, to apply the old harmless policy under certain limited circumstances. Regarding hospitals that did not receive payments reflecting the erroneous inclusion of days at issue, CMS stated that:

> If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days. The actual number of these types of days that you use in this revision must be properly supported by adequate documentation provided by the hospital. 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. (Emphasis added.)

Subsequent to PM A-99-62, a series of questions and answers was published by CMS.[21] Questions 12 through 15 deals with various aspects of the "hold harmless" provision. Of particular relevance is Q15:

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[21] Intermediary Exhibit 2. CMS Memorandum dated March 13, 2000 with attachment "Questions and Answers Related to Program Memorandum Intermediaries A-99-62."

> Q15. How are intermediaries to handle a situation where the hospital filed a jurisdictionally proper general DSH appeal without specifically addressing the ineligible days (i.e., general assistance or other State-only health programs, charity care, Medicaid DSH, and / or ineligible waiver or demonstration population days)?
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> A. PM A-99-62 specifies on page 3 and page 4 that the hold harmless provision applies only to jurisdictionally proper appeals on the issue of the exclusion of these types of days from the Medicare DSH formula. This reinforces the statement in the last sentence of the first paragraph on page 3 of the PM which states "… this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DSH payments…" Therefore, the intermediaries should not apply the hold harmless provisions in situations of general Medicare DSH appeals unless the hospital furnishes proof that the appeal includes the issue of these types of ineligible days. Even if the appeal is somewhat more specific and address Medicaid days, the intermediary should make every effort to determine whether the general assistance of other Stat-only health program, charity care, Medicaid DSH, and/ or ineligible waiver or demonstration days are at issue….

The record shows that during the Intermediary's audit of the Provider fiscal year 1995 cost report, the Intermediary conducted a sample review of the patient days used to determine the Medicaid Proxy. The Intermediary rejected the entire report because the sample review resulted in a larger than acceptable error rate (5 out of 25) based, among other things, the inclusion of non-Medicaid patient days (general assistance, alternative care and Medicare patients were noted) in the patient day report. The record showed that the Provider regenerated the report but because the report included non-Medicaid patients again (i.e. general assistance, alternative care and Medicare patients) and other errors, the Intermediary rejected the report.

The Provider then generated a third report. The third report had an error rate of 22 percent. Problems identified by the Intermediary for the sampled days included the Provider's failure to supply remittance advices, claims paid by either Consolidated Chemical Dependency or UCARE MN[22] which required a further breakdown to determine what fund paid the claim, a claim paid by BCBS and, finally, patients that were general assistance. The Provider did not respond with documentation of its DSH claim which quantified how many days sought were medical assistance

[22] Consolidated Chemical Dependency and UCARE MN appear to be commercial managed care plans.

days and which days were in the problem category. Accordingly, since the Provider did not supply an acceptable report to support the number of Medical Assistance days for the DSH calculation, the Intermediary disallowed the Provider's entire DSH payment. This was consistent with the Intermediary's treatment of the Provider's cost report for the prior cost reporting period where the Provider failed to submit medical assistance remittance advices for the majority of the items selected for sampling.[23]

On March 18, 1998, the Provider appealed the Intermediary's DSH adjustment as well as other matters to the Board. By letters dated July 12, 1999, the Provider requested that the SSI ratio and Title XIX eligible Medicaid days be transferred to respective group appeals. A preliminary position paper was filed by the Provider, dated December 27, 1999. In the preliminary position paper, the Provider's DSH argument was brief and did not state a position that GA days should affirmatively be a part of its DSH calculation. The Intermediary submitted a final position paper, dated March 20, 2000 and did not address the substance of Issue No. 10 regarding the DSH adjustment noting that the issue had two parts both of which had been transferred to group appeals. On March 31, 2000, when the Provider filed its final Position paper, the Provider argued for the inclusion of GA days with specific reference to PM A-99-26. Finally, by letter dated April 29, 2002, the Provider wrote to the Board stating that: "We may have inadvertently transferred the GA days issue from the case number 98-2100 to case number 95-1407G but it is our intent for the GA days issue to remain with this case."

The Provider contends that it is entitled to the benefit of the "hold harmless" provision found in PM A-99-62 because they filed a request for a hearing that included the DSH adjustment issue on March 18, 1998. The Provider disagrees with the Intermediary's position that the "hold harmless" provision did not apply because the Provider's did not specifically appeal "these types of days" (i.e., GA days) prior to October 15, 1999.

The Administrator does not agree with the Provider's contentions. The Administrator finds that the Provider does not meet the requirements of the "hold harmless" provision of PM A-99-62. The PM A-99-62 advised Intermediaries' to hold harmless (i.e., not recoup overpayment) from those providers that had been improperly allowed to included "general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" in their calculation of the Medicaid fraction. (Emphasis added). In addition, PM A-99-62 also advised Intermediaries to hold harmless those providers that had filed a jurisdictionally proper appeal before October 15, 1999,

[23] Provider Exhibit 10-2.

on the precise issue of "general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" even if the provider had not been erroneously reimbursed for the inclusion of otherwise ineligible days in their cost report. (Emphasis added).

In this case the record shows that the Provider, by letter dated March 18, 1998, appealed the Intermediary's DSH adjustment number 46.[24] The Provider's appeal request subsequently stated:

> We believe the DSH reimbursement is significantly understated. The Intermediary did not properly recognize all appropriate DSH related days of service. Effect is $10,000.

The record also shows that on December 27, 1999, when the Provider filed its preliminary position paper, there was no mention of "these types of days" (i.e., GA days) in the Provider DSH argument. Only after the issuance of PM A-99-62, did the Provider acknowledge GA days in its final position paper filed on March 31, 2000. Thus, the Administrator finds no clear statement by the Provider before October 15, 1999, that it was appealing GA days.

Reflective of the ambiguity of the Provider's appeal, the Intermediary's position paper shows that it considered all the DSH issues, represented by the SSI ratio issue and the Title XIX eligible Medicaid days, had been transferred to group appeals. Later still, by letter dated April 29, 2002, the Provider suggested that it may have "inadvertently transferred the GA days issue," which involves the Medicaid proxy, to the SSI ratio group appeal, but that it should be kept as part of the individual case.[25]

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[24] The Provider also argues that the Intermediary's DSH adjustment proves its point as it states that it was made: "To disallow DSH since the Provider is including non-Medicaid days in the DSH calculation." However, the term "non-Medicaid days" as reflected in the Intermediary's work papers is broad and includes various categories of days for which the Provider was unable to demonstrate Medicaid eligibility.

[25] This allegation was made despite the fact that the only document filed regarding the addition of this Provider to that group appeal was the July 12, 1999 letter that only stated that: "this aspect of Issue No. 10 is being transferred from Case No. 98-2100." No supporting documentation was supplied suggesting the GA day issue was recognized at that time. Also adding to the confusion of this allegation is the fact that the basis for the SSI ratio group appeal is to challenge the efficacy of the SSI ratio component of the calculation, because of privacy right disputes allegedly preventing access to patients' names who have qualified as SSI recipients. Thus,

The Administrator finds that PM A-99-62, instructed Intermediaries "not to 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 the Board on other Medicare DSH issues or other unrelated issues."(Emphasis added.) The Administrator agrees with the District Court in *United Hospital*,[26] which stated:

> The Program Memo does not extend to all hospitals that had filed a jurisdictionally proper appeal before October 15, 1999, and that raised the issue of the exclusion of general assistance days. Rather, on it face, the Program Memo extends only to hospitals that had filed a jurisdictionally proper appeal on the issue of the exclusion of general assistance days before October 15, 1999. In other words, on it face, the Program Memo requires that, in order to be eligible for relief, a hospital must have raised the precise issue of exclusion of general assistance days before October 15, 1999.

In this case, the Administrator finds that, while the Provider filed an appeal before October 15, 1999, the appeal did not raise the precise issue of the exclusion of GA days. The point of PM A-99-62 was not to give providers ideas on how to increase their DSH payment and the Provider's appeal history does not present anything resembling a clear case that it believed GA days were in fact countable in the DSH calculation prior to October 15, 1999. The PM provides a bright line test for eligibility for the hold harmless provisions, which the Provider fails to meet in this case.

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the group appeal involves the "Medicare" proxy, not the Medicaid proxy, involved in this case.

[26] Supra n.3.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: 10/13/04

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services