CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	Claim for:
QRS 96 DSH MediKan Days Group	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: June 30, 1996 and September 30, 1996**
Provider	
vs.	
Wisconsin Physicians Services	**Review of: PRRB Dec. No. 2011-D24 Dated: April 6, 2011**
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) on remand of QRS 96 DSH MediKan Days Group v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Kansas, PRRB Case No. 2007-D24. The review is during the 60-day period in section 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Providers' requesting that the Administrator reverse the Board's decision. No other comments were submitted during this review period. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

On May 25, 2007, the Administrator issued a decision vacating and remanding to the Board for further record development and findings as to whether any aspect of the hold harmless provisions of Program Memorandum (PM) A-99-66 and A-01-13, applied to the Providers' in this case.[1] On review of the Board's decision, the Administrator had reversed

[1] See QRS 96 DSH MediKan Days Group v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Kansas, PRRB Case No. 2007-D24, December 7, 2005, Medicare and

the Board's decision that MediKan days were days for patients "eligible for medical assistance under a State plan approved under Title XIX of the Act." In addition, the Administrator noted that there was insufficient information in the record to determine whether there was Board jurisdiction over the appeal of University of Kansas Hospital (UKH), a member of the group, from a revised Notice of Program Reimbursement (NPR) and remanded the case to the Board to supplement the record and determined jurisdiction.

The Providers in this appeal are Via Christi Regional Medical Center (VCRMC), University of Kansas Hospital (UKH) and Stormont-Vail Regional Health Center (SVRHC) (hereafter "Providers"). The Providers are seeking to include MediKan or general assistance primary and secondary days in their disproportionate share computation. MediKan is a general assistance program operated by the Kansas Department of Social and Rehabilitation Services (SRS). MediKan is 100 percent funded by the State of Kansas and is the state health program for people who are getting general assistance from SRS. MediKan covers disabled individuals who do not qualify for Medicaid, but who are eligible for benefits under a general assistance program.[2]

For the fiscal periods in dispute (FYEs 6/30/96 and 9/30/96), the Providers furnished services to persons eligible for MediKan who were included in the State of Kansas paid days total on the Medicaid Provider Summary Report (PSR) because the MediKan program paid the Providers for furnishing services to such persons. Such days are referred to in this case as "primary" MediKan paid days. For the same fiscal periods in dispute, the Providers also provided services to persons eligible for MediKan who were not included in the State of Kansas paid days total on the Medicaid PSR because the MediKan program did not pay the Providers for furnishing services to such persons. Such days are referred to in this case as "secondary" MediKan eligible days.[3]

In computing the Providers' Medicare disproportionate share adjustment (DSH) for the fiscal periods in dispute the Intermediary erroneously allowed "primary" MediKan paid days to be included in the Medicaid patient percentage. This occurred because the Intermediary was not aware that "primary" MediKan paid days were included in the State of Kansas

---

Medicaid Guide (CCH) ¶ 81,698, vacated and remanded, CMS Administrator, May 25, 2007.

[2] Id. The MediKan program currently provides the following benefits to recipients: (1) twelve physician office visits per year, (2) diagnostic lab and radiology services, (3) prescription drugs, (4) durable medial equipment other than prosthetics and orthotics, (5) outpatient hospital diagnostic and lab services, (6) limited community health and hospitalization services.

[3] "Secondary" MediKan eligible days are days where a commercial insurance company paid as the primary payer and MediKan was the secondary insurer (i.e. MediKan "eligible"), but did not make a payment on the claim.See

Medicaid paid days total on the State's Medicaid Provider Statistical Report (PSR). The Intermediary did not, at any time, include "secondary" MediKan eligible days in the Medicare DSH adjustment because "secondary" MediKan eligible days were not included on the State of Kansas Medicaid paid days PSR that the Intermediary used as a basis for adjusting Medicaid days.

The point of contention between the parties is the fact that the Providers believe that the "secondary" MediKan eligible days should be included in the Medicaid patient percentage, as if the individual was eligible for Medicaid, in the calculation for the DSH payment.[4]

ISSUE AND BOARD'S DECISION

The issue is whether in light of the hold harmless provision of PM A-99-62 and A-01-13, the Intermediary should include all MediKan patient days, primary and secondary, in the Medicaid Proxy used to compute the Providers' disproportionate share hospital (DSH) adjustment.

On remand the Board held that the Intermediary properly excluded MediKan secondary patient days from the numerator of the Providers' Medicaid proxy. The Board found that the MediKan beneficiaries were not "eligible for medical assistance under a State plan approved under title XIX" and that the services provided under the MediKan program did not receive Federal matching funds except under the Medicaid DSH provisions.

In reviewing the Medicaid statute, the Board found that the term "medical assistance under a State plan approved under [Title] XIX" excluded days funded only by the state and charity care days even though those days may be counted for Medicaid DSH purposes. As the MediKan program was funded by "state and local governments" and included in the low income utilization rate, not the Medicaid inpatient utilization rate, the Board found that the MediKan patient days did not fall within the Medicaid statute definition of "eligible for medical assistance under a State plan" at § 1923 of the Act. The Board also referenced *Adena Regional Medical Center v. Leavitt,*[5] which concluded that the days related to beneficiaries eligible for the Ohio's Hospital Care Assurance Program (HCAP) should not

[4] While the scope of the Board's decision in this case included the issue of MediKan primary days, the initial case at PRRB Dec. No 2007-D24 was limited to whether the Intermediary's properly excluded secondary MediKan eligible days from the Provider's Medicare DSH calculation. As noted, this is because the Intermediary had already erroneously allowed the MediKan paid days, as described above, in the payments made pursuant to the appealed NPRs or in the case of the appeal from the revised NPR, the MediKan paid days had apparently been included in the earlier original NPR.

[5] 527 F. 3d 176 (D.C. Cir. 2008), *cert. denied*, 129 S. Ct. 1933 (2009).

be included in the Medicaid proxy of the Medicare DSH calculation.[6] The Court held that the phrase "eligible for medical assistance under a State plan approved under title XIX" referred to patients who are eligible for Medicaid. The Court rejected the argument that the days of patients who were counted toward a Medicaid DSH payment must be counted toward the Medicaid fraction of the Medicare DSH calculation.

Next, with respect to whether there was jurisdiction over the UKH's appeal from a revised NPR, the Board held that it had jurisdiction because there was a request that the Intermediary consider these days as part of a settlement agreement.[7] The Board noted that while these days were not included in the final DSH calculation, the settlement agreement gave the Provider the right to appeal the DSH days.[8]

Next, with respect to the hold harmless provision of the PM, the Board held that the Providers met the past payment prong for MediKan secondary days to be included in the Medicaid fraction of the Medicare DSH adjustment. The record showed that the Providers had erroneously received payment for their MediKan primary days during the relevant period because such days were erroneously included in the State of Kansas paid days total on the Medicaid Provider Summary Report (PS&R). The Board stated that the Intermediary has acknowledged that the Providers erroneously received payment for their MediKan primary days during the relevant period, and under the past payment prong, the Intermediary has held the Providers harmless for the additional payments resulting from the erroneous inclusion of these days. The Intermediary has included MediKan primary days with calculation for DSH payments and those days are, therefore, not in dispute.[9]

With respect to MediKan secondary days, the Board held that the Providers did not meet the past payment prong for MediKan primary days to be included in the Medicaid fraction of the

---

[66] Id.

[7] See Board's Jurisdictional Decision, dated June 18, 2009.

[8] On or about September 17, 2002, the Provider filed suit against the Secretary of Health and Human Services in the United States District Court for the District of Columbia. The Provider requested a writ of mandamus, under 28 U.S.C. § 1361, requesting the Secretary to order the Intermediary to reopen the Provider's FY 1995 and 1996 cost reports to apply HCFA Ruling 97-2. See University of Kansas Hospital Authority v. Tommy G. Thompson, Case No. 02-1925 (ESH). The Provider and the Secretary entered into a Stipulation of Settlement and Dismissal dated January 2, 2003. Under the Stipulation of Settlement and Dismissal, the Secretary agreed to require the Intermediary to conduct a reopening of the Provider's FY 1995 and 1996. In response, the Intermediary issued a notice of reopening and later issued a revised NPR which did not include MediKan secondary payor days in the DSH calculation. The Provider appealed.

[9] See QRS 1996 DSH MediKan Days v. Wisconsin Physicians Services, PRRB Case No. 2011-D24, April 6, 2011 at 15.

Medicare DSH adjustment. The Board noted that the parties had stipulated that these days were not included in the State of Kansas paid days total on the Medicaid PS&R. Therefore, the Board concluded that the past payment prong of the hold harmless provision was not applicable in this case.

Next with respect to the "Appeal Prong" the Board held that the appeal prong of the hold harmless provision was not applicable. In reaching this determination, the Board reviewed the Providers appeal request to the Board and found that their appeals failed to indicate, directly or indirectly, any dissatisfaction regarding secondary MediKan days in the DSH calculation. The Board noted that the issue of MediKan secondary days was not added until several years after the deadline. The Board stated that to allow the secondary days based solely on primary days having been included in the calculation without either party apparently even knowing they were among the State's listing, would exacerbate the error identified in the hold harmless provisions rather than fulfilling it purpose.[10] Therefore, the Board determined that the MediKan secondary days were properly excluded.

SUMMARY OF COMMENTS

The Provider submitted comments requesting that the Administrator reverse the Board's decision. The Provider incorporated by reference previous comments submitted in its position paper and post-hearing brief to the Board.

With regards to the substantive issue the Providers' argued that a plain reading of the Act requires that the "secondary" MediKan eligible days be included in the Providers' Medicare DSH calculation because MediKan is included within the Kansas State Plan under Title XIX. The Provider contended that MediKan days constitute "medical assistance" for purposes of the Medicare DSH statute and, therefore, must be counted. The Providers' asserted that Congressional intend is clear: patient days for medical assistance under a State Plan approved under Title XIX must be counted. Furthermore, reference to "a medical plan" in the singular is evidence that Kansas Medicaid and MediKan programs are part of the same Title XIX plan.[11]

The Providers' maintained that the "secondary" MediKan eligible days fall within the hold harmless requirements of PM A-99-62 and should therefore be included the DSH adjustment computation. Specifically, just as HCFA Ruling 97-2 provided that there was no distinction between Medicaid "paid" and "unpaid" days, there should be no distinction between "paid" and "unpaid" MediKan days. The Providers' contended that having included

---

[10] Id. at 18.

[11] See Kansas Administrative Regulations (K.A.R.) §§ 30-5-58 to 30-5-174. These provisions make frequent reference to "the Medicaid/MediKan program," demonstrating the existence of a program or plan with two parts rather than two distinct programs.

the paid MediKan days, the Intermediary should have included "unpaid" MediKan days. These days are subject to the protection of the hold harmless provisions set forth in the PM A-99-62.

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 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.[12] 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 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.[13] 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.[14]

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.[15] 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

---

[12] Section 1901 of the Social Security Act (Act) (Pub. Law 89-97.)
[13] Section 1902(a) (10) of the Act.
[14] Section 1902(a) (1) (C) (i) of the Act.
[15] Id. § 1902 *et. seq.* of the Act.

procedures.[16] 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, Section 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. As part of a State plan, section 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, Section 1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment maybe made.

Section 1923 of the Act implements the requirements that a State plan under Title XIX and provides 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 Section 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 criteria relies, *inter alia*, on the total amount of the hospital's charges for inpatient services which are attributable to charity care.[17]

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[18] 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

---

[16] Id.

[17] 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.

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

A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[19] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[20] At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries.[21] However, concerned with increasing costs, Congress enacted Title VI of the Social Security Amendments of 1983.[22] This provision added section 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.[23]

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 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…."[24] There are two methods to determine eligibility for a DSH adjustment: the "proxy method" and the "Pickle method."[25] 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:

---

[19] Section 1811-1821 of the Act.
[20] Section 1831-1848(j) of the Act.
[21] Under Medicare, Part A services are furnished by providers of services.
[22] Pub. Law No. 98-21.
[23] H.R. Rep. No. 25, 98 th Cong., 1 st Sess. 132 (1983).
[24] 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).
[25] The Pickle method is set forth at § 1886(d) (F) (i) (II) of the Act.

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

CMS implemented the statutory provisions at 42 CFR 412.106. The first computation, the "Medicare proxy" or "Clause I" is set forth at 42 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) 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.)

Relevant to 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 section 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:

> Consistent with the Courts of Appeals decisions on the issue of Medicaid days, the [CMS] Ruling 97-2 was meant to be inclusive, rather than exclusive. This means that, in 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). Any examples of days to be

counted given [CMS] Ruing or [CMS] instructions should not be construed as an all-inclusive list.

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….
The definition of Medicaid days for purposes of Medicare disproportionate share adjustment calculation includes all days that a beneficiary would have been eligible for Medicaid benefits, whether or not Medicaid paid for any services. This includes, but is not limited to, days that are determined to be medically necessary but for which payment is denied, days that are determined to be medically unnecessary and for which payment is denied, days that are utilized by a Medicaid beneficiary prior to an admission approval, days that are paid by a third party, and days that ah alien is considered a Medicaid beneficiary, whether or not it is an emergency service. However, 42 CFR 412.106(b) (4) precludes the counting of any patient days furnished to patients entitled to both Medicare Part A and Medicaid. Therefore, once the State has verified the eligibility of the hospital's patient data for Medicaid purposes, the intermediary must determine if any of these days are dual entitlement days and subtract them from the calculation.

While we do recognized days utilized by Medicaid beneficiaries through a Managed Care Organization (MCO) or Health Maintenance Organization (HMO), days that are utilized by State-only eligibility groups for which no Federal participation is available are not considered to be Medicaid beneficiaries under Title XIX. *Many States operate programs which include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to recipients of State-funded income support programs through the same administrative process as Medicaid. While providers may be unable to distinguish between State-only and Federal-State beneficiaries, States must be able to do so.* Similarly, some 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 hospital days for these non-Medicaid individuals would not be properly included in the calculation of Medicaid days.* State records should distinguish between individuals eligible under the State plan and individuals who are only eligible under a demonstration project or waiver. (Emphasis added.)

In addition, according to CMS's Memorandum dated June 12, 1997, if a cost report was settled prior to February 27, 1997, the hospital filed a jurisdictionally proper appeal on this issue; and the hospital submitted documentation to support a recalculation of Medicaid days, the Medicaid days was to be recalculated according to the principles contained in HCFA Ruling 97-2. However, this memorandum also stated that no action was required unless and until the hospital submitted the necessary data with evidence of it jurisdictionally proper appeal.

In order to clarify 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. The PM was in response to problems that occurred as a result hospitals and intermediaries relying on Medicaid State days data obtained from State Medicaid agencies to compute the DHS payment that commingle the types of otherwise ineligible days listed with the Medicaid days. 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, they 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 patient's 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).

Consistent with this explanation of days to be included in the Medicare DSH calculation, the PM 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.
>
> In addition, if a given patient day affects the level of *Medicaid* DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the *Medicare* DSH calculation.
>
> ****
>
> 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. [26]

The PM A-99-62 further instructed intermediaries to apply a hold harmless policy under certain limited circumstances. CMS stated:

> In accordance with the hold harmless position communicated by HCFA on October 15, 1999, for cost reporting periods beginning before January 1, 2000, you are not to disallow, within the parameters discussed below, the portion of Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days in the Medicaid days factor used in the Medicare DSH formula…. Although [CMS] has decided to allow the hospitals

---

[26] An attachment to the PM describes the type of days, description of the day and whether the day is a Title XIX day for purposes of the Medicare DSH calculation. In particular, the attachment describes "general assistance patient days" as "days for patients covered under a State-only (or county only) general assistance program (whether or not any payment is viable for health care services under the program). These patients are not Medicaid-eligible under the State plan." The general assistance patient days is not considered an "eligible Title XIX day." "Other State-only health program patient days" are described as "days for patients covered under a State-only health program. These patients are not Medicaid eligible under the State program." Likewise, State-only health program days are not eligible Title XIX days. Finally, charity care patient days are described as "days for patients not eligible for Medicaid or any other third-party payer and claimed as uncompensated care by a hospital. These patients are not Medicaid eligible under the State plan." Charity care patient days are not eligible Title XIX days.

> to be held harmless for receiving additional payments resulting from the erroneous inclusion of these types of otherwise ineligible days, this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DSH payments or any other Medicare payments.

Regarding hospitals that received payments reflecting the erroneous inclusion of days at issue, CMS stated that:

> In practical terms this means that you are not to reopen any cost reports for periods beginning before January 1, 2000 to disallow the portions of Medicare DSH payments attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days if the hospital received payments for those days based on those cost reports.... Furthermore, on or after October 15, 1999, you are not to accept reopening request for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.
>
> For cost reporting periods beginning before January 1, 2000, you are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999 (i.e., for open cost reports, you are to allow only those types of otherwise ineligible days that the hospital receive payment for in previous cost reporting periods settled before October 15, 1999). For example, if, for a given hospital, a portion of Medicare DSH payment was attributable to the erroneous inclusion of general assistance days for only the out-of State or HMO population in cost reports settled before October 15, 1999, you are to include the ineligible waiver days for only that population when settling open cost reports for cost reporting periods beginning before January 1, 2000. However, the actual number of general assistance and other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days, as well as Medicaid Title XIX days, that you allow for the open cost reports must be supported by auditable documentation provided by the hospital.

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… Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula on or after October 15, 1999, reopen the settled cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but only if the hospital appealed, before October 15, 2000, the denial of payment for the days in question in previous cost reporting periods. 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.)
>
> You are to continue paying the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, field a jurisdictionally proper appeal to the PRRB specifically for this issue on previously settled cost reports.
>
> Finally, you are reminded that, if a hospital has filed a jurisdictionally proper appeal with respect to HCFA 97-2 ruling and the hospital has otherwise received payment for the portion of Medicare DSH adjustment attributable to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days based on its paid Medicaid days, include these types of unpaid days in the Medicare DSH formula when revising the cost reports affected by the HCFA 97-2 appeal.

In the August 1, 2000 Federal Register, the Secretary reasserted his policy regarding general assistance days, State-only health program days and charity care days.

> General assistance days are days for patients covered under a State-only or county-only general assistance program, whether or not any payment is available for health care services under the program. Charity care days are those days that are utilized by patients who cannot afford to pay and whose care is not covered or paid by any health insurance program. While we

> recognize that these days may be included in the calculation of a State's Medicaid DSH payments, these patients are not Medicaid eligible under the State plan and are not considered Titled XIX beneficiaries.[27]

The Program Memorandum Transmittal A-01-13[28], dated January 25, 2001, restated the principles and instructions originally set out in PM A-99-62, and stated regarding Medicaid DSH days, that:

> Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid eligible. Sometime Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care of general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicaid formula.
>
> ….
>
> Days for patients covered under a State-only (or count-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan.

Finally, in a recently enacted statute Congress clarified the meaning of the phrase "eligible for medical assistance under a State plan approved under title XIX" by adding the following language:

> 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.[29]

---

[27] 65 Fed. Reg. 47054 at 47087 (Aug. 1, 2000).

[28] The PM, while restating certain longstanding interpretations in the background material, 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)

[29] Deficit Reduction Act of 2005, 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) ("DRA")

This amendment to § 1886(d) (5) (F) (vi) of the Act specifically addresses 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. In sum, CMS policy has consistently required the exclusion of days relating to general assistant or State only days and distinguishes between days for individuals that receive medical assistance under a Title XIX State plan and days for individuals that are not in fact eligible for medical assistance but may be a basis for Medicaid DSH payment under the State plan. These latter days are not counted for purposes of the Medicaid DSH payment.

Consistent with remand order rendered May 25, 2007 and herein incorporated by reference, the Administrator finds that section 1886(d)(5)(F)(vi)(II) of the Act requires for purposes of determining a Provider's "disproportionate patient percentage" that the Secretary count patient days attributable to patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act, but who were not also entitled to Medicare Part A. The Administrator finds that the Secretary has interpreted this statutory phrase "patients who (for such days) were eligible for medical assistance under a State Plan approved under title XIX," to mean "eligible for Medicaid."[30] The Administrator further finds that the term "Medicaid" refers to the joint State/Federal program of medical assistance authorized under Title XIX of the Act. If a patient is not eligible for Medicaid, than the patient is not eligible for medical assistance under a State plan approved under Title XIX.[31]

The Administrator finds that the language set forth in section 1886(d)(5)(F)(vi)(II) requires that the day be related to an individual eligible for "medical assistance under a state plan approved under Title XIX" also known as the Federal program Medicaid. The use of the term "medical assistance" at Sections 1901 and 1905 of the Social Security Act and the use of the term "medical assistance" at Section 1886(d)(5)(F)(vi)(II) of the Social Security Act is reasonably concluded to have the same meaning. As noted by the courts, "the interrelationship and close proximity of these provisions of the statute presents a classic case for the application of the normal rule of statutory construction that "identical words used in different parts of the same act are intended to have the same meaning."[32] Therefore, the Administrator finds the language at section 1886(d)(5)(F)(vi)(II) requires that for a day to be

---

[30] See Cabell Huntington Hosp. Inc., v. Shalala, 101 F.3d 984, 989 (4 th Cir. 1996) ("It is apparent that 'eligible for medical assistance under a State plan' refers to patients who meet the income, resource, and status qualifications specified by a particular state's Medicaid plan…").

[31] Stipulation of the Parties B (3) at p. 2.

[32] Sullivan v. Stroop, 496 U.S. 478, 484 (1990); Commissioner v. Lundy, 516 U.S. 235, 250 (1996).

counted, the individual must be eligible for medical assistance under Title XIX. That is, the individual must be eligible for the Federal government program also referred to as Medicaid.

Notably, the days involved in this case are related to individuals that are not eligible for medical assistance as that term is used under Title XIX and, thus, are not properly included in the Medicaid patient percentage of Medicare DSH calculation under §1886(d)(5)(F)(vi)(II) of the Act.[33] Rather, the Medicaid DSH formula includes Medi-Kan patients in its Medicaid DSH methodology.[34] The Administrator finds that reference to Medicaid/MediKan in the State Plan approved under Title XIX is limited to the criteria for determining if hospitals are eligible for the Kansas Medicaid DSH adjustment and the amount of such Medicaid DSH payment. Notably, all State plans are required to provide for DSH payments and the Kansas Medicaid DSH program includes the MediKan days in its Medicaid DSH methodology. Thus, the Medicaid DSH methodology, may involve some expenditure of Federal financial participation (FFP) based on the care provided to MediKan individuals by these hospitals. Regardless of the methodology used by this State to calculate its Medicaid DSH payments (whether it is by the Medicaid inpatient utilization rate, the low income utilization rate or under the special rule) these patient days cannot be included under section 1886(d)(5)(F) as a Medicaid patient day as the MediKan program is by definition for individuals not eligible for Medicaid.[35] The approval of the Kansas Medicaid DSH provision under the State plan and the expenditure of Medicaid DSH FPP does not constitute "medical assistance" for the individuals at issue in this case as that term is used under Title XIX and Title XVIII.[36] Therefore, the Administrator finds that the days relating to patients

---

[33] The Providers found the application of this rule of statutory construction made the word "approved" superfluous and that another rule of statutory construction requires that all words in a statute be given effect. The excerpt of Kansas State Statute section 39-708c(a) indicates approved and unapproved plans. The Providers noted that the MediKan program is derived from the State Secretary's "power to develop a State plan in regard to assistance and services in which the Federal government not participate" (i.e., a plan that is not approved under Medicaid).

[34] See, e.g., Provider Post-Hearing Brief Exhibit 1 (State assurances letter explaining that Attachment 4.19A describes the methodology under 42 CFR 447.253(b)(1)(ii)(A) to be used to determine disproportionate share hospitals and payments); Exhibit 2 (Medicaid State Plan Attachment 4.19-A describing method of determining Medicaid DSH payment which includes references to MediKan).

[35] See e.g. Section 2600 of the The Kansas Economic and Employment Support Manual ("MediKan is a totally state regulated and funded program and covers disabled individuals who do not qualify for Medicaid but are eligible for cash benefits under the general assistance program.")

[36] Furthermore, even if the expenditure of FFP was relevant, it was not demonstrated that these days were in fact included in the calculation of the State Medicaid DSH. The Provider argued that these days should be included under the Medicare DSH calculation because the

eligible for the MediKan program do not fall within the legal meaning of patient days attributable to *patients who were eligible for medical assistance under a State plan approved under Title XIX of the Act*. Consequently, these days are not properly included in the numerator of the Medicaid patient percentage fraction in calculating the Medicare DSH adjustment.

However, the Administrator finds that on December 1, 1999, CMS issued PM A-99-62 to Fiscal Intermediaries (FI) advising them to hold harmless (i.e., not recoup overpayment) 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, 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). PM A-99-62 advised intermediaries to include "these types of unpaid days" (i.e., "secondary" MediKan eligible days) in the Medicare DSH formula when revising cost reports affected by HCFA Ruling 97-2, if the Provider had filed a jurisdictionally proper appeal, with respect to HCFA Ruling 97-2 and the Provider otherwise had received payment for the portion of Medicare DSH adjustment attributed to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days" based on its paid Medicaid days. (Emphasis added).

In this case, the record show that the Intermediary erroneously allowed "primary" MediKan paid days to be included in the Medicaid proxy and those days were not at issue in this case. This occurred because such days were included in the State of Kansas Medicaid paid days total on the Medicaid PSR. However, the record shows that "secondary" MediKan eligible days were not erroneously included in the Medicaid proxy because (among other things) such days were not included in the State of Kansas Medicaid paid day total on the Medicaid PSR because the MediKan program did not pay the Providers for furnishing services to such

---

MediKan days are included under the Medicaid DSH program and, therefore, they are included under the State plan. However, the unpaid days were not included on the State's PSR and it is indicated these are days in which the patient was not uninsured (as they were covered by commercial insurances as primary) and, therefore, MediKan was the secondary payer. Thus, not only are the Medi-Kan patients not Medicaid eligible, but it is not clear that these unpaid secondary MediKan days are even included under the State plan DSH program and, therefore, are in fact different in that respect from the paid Medi-Kan days.

persons. Therefore, the Providers did not receive payment reflecting the erroneous inclusion of these days in the cost reports at issue and prior to October 15, 1999.[37]

The Providers contend that the "secondary" MediKan eligible days also satisfied the "hold harmless" provision of PM A-99-62. First, the Providers contend that they filed a jurisdictionally proper appeal to the Board on the issue of the exclusion of "secondary" MediKan eligible days from the Medicare DSH formula before October 15, 1999. Next, the Providers argue that just as HCFA Ruling 97-2 provided that there was no distinction between Medicaid "paid" and "unpaid" days, there should be no distinction between "paid" and "unpaid" MediKan days. The Providers contended that having included the paid MediKan days, the Intermediary should have included "unpaid" MediKan days. Therefore, the provider claims these days ("secondary" MediKan eligible days) are subject to the protection of the hold harmless provisions set forth in the PM A-99-62.

Relevant to these facts, the PM A-99-62 instructs intermediaries not to accept reopening request for previously settled cost reports or amendments to previously submitted cost report pertaining to the inclusion of these types of days in the Medicare DSH formula after October 15, 1999. The PM A-99-62 also instructs intermediaries to include these *types of days* (in this case, "secondary" MediKan eligible days) only if these days had been erroneous included in the provider's Medicare DSH calculation in the past. The record shows that these Providers' never received payment for "secondary" MediKan eligible days because such days were not included in the State of Kansas Medicaid day total on the Medicaid PSR. Furthermore, the record does not demonstrate that the Providers requested that "secondary" MediKan eligible days be added to the list of issues pending before the Board prior to October 15, 1999. Applicable to these facts, the PM A-99-62, clearly instructed intermediaries "not to reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days ("secondary" MediKan eligible 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 under unrelated issues." Consequently, the Board correctly found that with respect to the secondary the Intermediary did not include these days under the hold harmless methodology set forth in the PM and Transmittal.

Regarding the jurisdictional issue in this case for UKH, section 1878(a) of the Act and the regulations at 42 C.F.R.405.1835 set forth the requirements for Board jurisdiction. A provider may obtain a hearing before the Board with respect to its fiscal intermediary's determination of its cost report, inter alia, only if: the provider is dissatisfied with a final determination of its fiscal

[37] The Board extensively reviewed the record and made special note of the apparent erroneously inclusion of secondary MediKan days in an intermediary's settlement, while this case was on remand, and accepted the unrebutted explanation offered by the Intermediary for that error as not relevant to this case.

intermediary as to the amount of reimbursement due the provider for the period covered by such report; there is $10,000 or more in controversy; and the provider filed a request for a hearing within 180 days after the notice of the intermediary's final determination.[38]

Moreover, the regulation at 42 CFR 405.1885(a) also allows for a reopening of an intermediary determination. When a cost report is reopened, the regulation at 42 CFR 405.1889 provides that:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875, 405.1877 are applicable.

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

Relevant to the matter, on or about September 17, 2002, the UKH filed suit against the Secretary of Health and Human Services in the United States District Court for the District of Columbia. The Provider requested a writ of mandamus, under 28 U.S.C. §1361, requesting the Secretary to order the Intermediary to reopen the Provider's FY 1995 and 1996 cost reports to apply HCFA Ruling 97-2. *See* University of Kansas Hospital Authority v. Tommy G. Thompson, Case No. 02-1925 (ESH). The Provider and the Secretary entered into a Stipulation of Settlement and Dismissal dated January 2, 2003. Under the Stipulation of Settlement and Dismissal, the Secretary agreed to require the Intermediary to conduct a reopening of the Provider's FY 1995 and 1996. In response, the Intermediary issued a notice of reopening and later issued a revised NPR to effectuate HCFAR 97-2. The Intermediary did not include MediKan secondary payor days in the DSH calculation.

The record shows that prior to the lawsuit, the Provider had requested a reopening dated September 14, 2001, requesting inclusion of 1,301 Medicaid eligible days, 301 Medikan days, 127 Medicaid spenddown days and 15 Medicaid days paid after the cut-off that were not included in the Medicaid day count at the time of the cost report settlement. (Provider Exhibit 3) As a result, the Provider UKH now argues that the "Intermediary clearly was on notice at the time of the reopening following the Stipulation of settlement and dismissal that the provider sought inclusion of the 301 Medikan days." However, the Administrator finds that the revised NPR was a result of a lawsuit. The lawsuit was brought to require the

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

Secretary to reopen the Provider's cost report to implement HCFA Ruling 97-2. The instructions to HCFA Ruling 97-2, dated June 17, 1997 (*infra*), a date well before the settlement and dismissal, had explicitly restated CMS policy that State only days did not qualify for inclusion under the Ruling.

Notably, the Provider did not challenge the scope of days to be included under the Ruling in its lawsuit, but rather was specifically requesting the Secretary be required to reopen in order to have days included pursuant to the Ruling. The Provider subsequently specifically agreed to a settlement pursuant to an implementation of the Ruling. The Intermediary's reopening notice, dated February 3, 2003, stated that the reason for the reopening was: "HHS Secretary Determination. Effectuation of Settlement in the Case of University of Kansas Hospital Authority v. Thompson …. Application of HCFAR 97-2 to Medicaid DSH adjustment." (Provider Exhibit 7) The Provider itself apparently understood the scope of the settlement agreement. In particular, by letter dated March 21, 2003, the Provider submitted documentation relating to the effectuation of the settlement. The attached documentation included an explanation that "Patients with MediKan coverage were identified in the match by a 'K' under coverage type….. The patients are displayed in a separate schedule to facilitate the intermediary disallowance." (Provider Exhibit 12)

After a review of the facts of the case pertaining to UKH's appeal of the April 17, 2003 revised NPR, the Administrator finds that the cost report was reopened to implement HCFAR 97-2. AS previously emphasized by CMS in June 1997, State only days specifically did not qualify for inclusion under HCFAR 97-2. Consequently, the Administrator finds that the issue of the unpaid MediKan days was outside the scope of the revised NPR and that the Board does not have jurisdiction over this issue pursuant to this revised NPR.

In addition, the provisions in the settlement agreement that the provider "shall have a right to challenge the Intermediary's final determination of the Hospital's FY 1995 and FY 1996 DSH payment under HCFAR 97-2" cannot be read broader than the rights assigned by the regulation or the scope of the agreement. The Provider's lawsuit was not challenging the scope of the days specifically excluded under HCFAR 97-2 but rather sought to have HCFAR 97-2 implemented. Thus, any appeal provision would be limited to the issue, for example, involving the adequacy of the additional information that the Hospital believed was necessary for the intermediary to apply the payment provisions of HCFAR 97-2 to the Hospital's FY 1995 and FY 1996 Medicare DSH payments and not as to the legal issue as to the type of days to be included under HCFAR 97-2.

Finally, the Hospitals cannot use the PM A-99-62 and Transmittal A-01-13 to "bootstrap" jurisdiction of this issue to the revised NPR that was appealed. The Administrator recognizes that the PM states:"Finally you are reminded that, *if a hospital has filed a jurisdictionally proper appeal with respect to the HCFA 97-2 ruling* and the hospital has otherwise received

payment for the portion of the Medicare DHS adjustment attributable to the inclusion of general assistance or other State-only days health programs, charity care Medicaid DSH and or ineligible waiver or demonstration population days based on its paid Medicaid days include these types of unpaid days in the Medicare DSH formula when revising the cost reports affected by the HCFA 97-2 appeal."

Plainly, to receive the benefit of this aspect of the January 15, 2001 hold harmless provision as part of the effectuation of a HCFAR 97-2 payment, a provider must have had a "jurisdictionally proper appeal with respect to HCFAR 97-2." In this instance, the lawsuit brought by the UKH was pursuant to mandamus court jurisdiction and occurred because the Provider did not have a jurisdictionally proper appeal with respect to HCFA 97-2. Moreover, the September 14, 2001 reopening request that precipitated the lawsuit under HCFAR 97-2 (and also requested the inclusion of other days such as unpaid MediKan days) occurred almost two years after the October 15, 1999 cut-off date for accepting reopening under the hold harmless provision. Notably, the "hold harmless" PM stated that: "on or after October 15, 1999, you are not to accept reopening requests for previously settled cost reports …pertaining to the inclusion of these types of days in the Medicare DSH formula." These facts further support that the settlement, which was the basis for the revised NPR, was limited to implementation of the HCFAR 97-2 and that the language of the PM and Transmittal A-01-13, did not extend the scope of HCFAR 97-2 to include the MediKan unpaid days issue as part of the revised NPR.

DECISION

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

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

Date: 5/27/11

/s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Office
Centers for Medicare & Medicaid Services