CENTERS FOR MEDICARE AND MEDICAID SERVICES

Order of the Administrator

In the case of:	**Claim for:**
Maine Type 6 Medicaid Dual Eligible Days DSH Groups	**Provider Cost Reimbursement Determination for Cost Years Ending: Various**
Provider	
vs.	
BlueCross BlueShield Association/ National Government Services	**Review of:**
Intermediary	**PRRB Dec. No. 2013-D9 Dated: March 29, 2013**

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 mandated in § 1878(f)(l) of the Social Security Act (Act), as amended (42 U.S.C. § 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Providers, the Intermediary, CMS' Office of Financial Management (OFM) respectively commented requesting that the Board's decision be modified. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

This case is composed of a consolidation of six group appeals involving 10 hospitals, which are all located in the State of Maine. The respective groups are composed of cost reporting periods for fiscal years ending (FYE) 1993[1], 1995[2], 1997[3], 1998[4], 1999[5] and

[1] PRRB Case No. 09-0480G. This group included Maine General Hospital, FYE 1994.
[2] PRRB Case No. 09-0383G.This group included Brighton Medical Center, FYE 1991.
[3] PRRB Case No. 09-0416G.
[4] PRRB Case No. 09-0487G
[5] PRRB Case No. 07-2217G

2000[6]. The Providers included in the Medicaid Fraction portion of the disproportionate hospital share (DSH) adjustment payment, the days for Medicaid/Medicare dually eligible patients that were not entitled to Supplemental Security Income (SSI) (referred to non-SSI "Type 6" days). The Providers argued that, since such days are not counted in the numerator of the Medicare fraction of the DSH calculation, they should be included in the numerator of the Medicaid fraction. The Intermediary initially included non-SSI Type 6 days in the numerator of the Medicaid fraction when calculating the Providers' DSH adjustment payments for purposes of revised Notices of Program reimbursement issued to effectuate an administrative resolution for certain of the Providers and in the initial NPRs for other providers in these groups. The Intermediary subsequently determined that it was incorrect to include the non-SSI Type 6 days in the DSH adjustment. The Intermediary issued reopening notices for the revised NPRs to reconsider the DSH payment under section 1886(d)(5) and, *inter alia*, recalculate the DSH payments by excluding the non-SSI Type 6 days. Other Providers' cost reports were still open and thus did not require reopening and were settled reflecting this same exclusion. The Intermediary subsequently issued revised NPRs or initial NPRs that excluded the non-SSI Type 6 days from the DSH calculation and included additional appropriate Medicaid days where such days were updated and identified by providers for inclusion.

ISSUE AND BOARD'S DECISION

The issue before the Board was whether the Intermediary's reopening adjustment to exclude Type 6 Medicaid dual eligible days from the Providers' Medicaid fraction used in the calculation of the disproportionate share hospital (DSH) adjustment was proper.[7]

The Board affirmed the Intermediary's adjustments for certain Providers' cost years and reversed the Intermediary's adjustments for other Providers' cost years. Generally, with respect to the propriety of excluding the days at issue, the Board found that excluding the non-SSI Type 6 Medicaid dual eligible days from the DSH payment calculations is proper. Despite the Providers' argument to the contrary, the Board determined that a plain reading of the DSH statute and regulations provides that the non-SSI Type 6, referred to as "dual

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[6] PRRB Case No. 07-2291G

[7] However, some of the groups identified the issue as "whether the Intermediary's adjustment to exclude Type 6 Medicaid dual eligible days from the Providers' Medicaid fraction used in the calculation of the disproportionate share hospital (DSH) adjustment was proper." *See* Maine 1999 Type 6 Medicaid Dual Eligible Days DSH Group Appeal, PRRB Case No. 07-2217G, Provider Exhibit 7, Schedule of Providers in Group, Issue; Maine 1999 Type 6 Medicaid Dual Eligible Days DSH Group Appeal, PRRB Case No. 07-2217G, Provider Exhibit 7, Schedule of Providers in Group, Issue; Maine 2000 Type 6 Medicaid Dual Eligible Days DSH Group Appeal, PRRB Case No. 07-2291G, Provider Exhibit 7, Schedule of Providers in Group, Issue.

eligible" days by the parties, represented days for patients eligible for Medicaid and entitled to Medicare Part A. The Board found that under §1886(d)(5)(F)(vi)(II) of the Act and 42 C.F .R. §412.1 06(b)(4) and consistent with prior Board decisions, dual eligible days are not included in the numerator of either the Medicare or Medicaid fraction for the DSH calculation.

Moreover, the Board found that, contrary to the Providers' argument, CMS Program Memorandum (PM) A-99-62 does not apply to the non-SSI Type 6 dual eligible days at issue because the "hold harmless" provision only applies to: general assistance, State only health program, charity care, Medicaid DSH and/or waiver or demonstration population days. The Board noted that PM A-99-62 was issued to clarify the definition of eligible Medicaid days in the Medicare DSH calculation. In addition, the PM memorialized a "hold harmless" policy, previously communicated on October 15, 1999, for cost reporting periods beginning before January 1, 2000. The Board also referred to a letter dated May 6, 2005 from the CMS Administrator to Senator Olympia Snowe, which stated that PM A- 99-62 does not address dual eligible days. Thus, the Board concluded that it is beyond its authority to expand the hold-harmless provisions of PM A-99-62 to include the non-SSI Type 6 dual eligible days at issue.

Regarding the Provider's argument that they should be held "without fault" under section 1870 of the Social Security Act for the overpayment, the Board found that the overpayments at issue did not involve individual claims, and instead pertained to aggregate payments related to DSH adjustments. The Board found that the "without fault" waiver provisions in the statute did not apply in this case.

Regarding the reopening, the Board found the Intermediary properly excluded the non-SSI Type 6 Medicaid dual eligible days from the DSH calculation for certain Providers and cost reporting periods.[8] The Board determined that the Intermediary's notices for certain

[8] The Board concluded that the Intermediary properly denied the non-SSI Type 6 Medicaid dual eligible days for the DSH payment calculations for the following Providers and Cost Reporting Periods, because either the reopening was timely or a reopening was not necessary as the cost report was still open;

Provider/Provider No.	Cost Reporting Period Ending	Date of Previous NPR	Date of Notice of Reopening	Years from NPR to Reopening
Eastern Maine Medical Center 20-0033	09/30/1995	12/05/2002	6/20/2005	2 ½
Mercy Hospital 20-0008	12/31/1998	12/30/2002	6/20/2005	2 ½
MaineGeneral Medical Center 20-0039	06/30/2000	9/30/2002	6/20/2005	2 ¾

Providers issued following the Administrator letter of May 6, 2005,[9] satisfied the regulation and program instructions for notices of reopening because the notices included complete explanations for the reopening and afforded the Providers the opportunity to comment or submit additional evidence in the form of a rebuttal. Thus, the Board concluded that, unlike the purported notices of reopening issued from June 3, 2003 through September 27, 2004, the post-May 6, 2005 notices '"perfected" the notices of reopening. The Board also noted that, for two Providers and their corresponding specified cost reporting periods, a notice of reopening was unnecessary because the adjustment was made in the original NPR.[10]

With respect to the other Providers in the group, the Board found that the Intermediary's reopening adjustments excluding the non-SSI Type 6 Medicaid dual eligible days from the DSH payment calculations were improper because the notices were issued more than three years from the date of the NPR.[11]

Maine Medical Center 20-0009 * (Notice of reopening unnecessary because the adjustment was made in the original NPR).	9/30/2000	NA	NA	NA
MaineGeneral Medical Center 20-0039 * (Notice of reopening unnecessary because the adjustment was made in the original NPR).	6/30/1999	NA	NA	NA

[9] *See* Provider's Exhibit P-16 (Letter from the CMS Administrator to Senator Olympia Snow).

[10] *See* n. 1.

[11] The Board concluded that the Intermediary should not have denied the non-SSI Type 6 Medicaid dual eligible days for the DSH payment calculations for the following Providers and Cost Reporting Periods as the reopenings were not timely:

Provider/Provider No.	**Cost Reporting Period Ending**	**Date of Previous NPR**	**Date of Notice of Reopening**	**Years from NPR to Reopening**
Maine Medical Center 20-0009	09/30/1993 09/30/1993 09/30/1997* 09/30/1998* 09/30/1999	12/17/2001 1/23/2001 9/20/2002	6/20/2005 10/19/2005 3/5/2007	3 ½ 3 ¾ 4 ½
Central Maine Medical Center 20-0024	6/30/1993 6/30/1995 6/30/1996 6/30/1997 6/30/1998 6/30/1999	1/28/2002 6/28/2002 9/29/2000 10/16/2003 10/13/2003 8/16/2002	6/20/2005 2/23/2006 6/13/2006 11/13/2006 2/12/2007 8/2/2007	3 ½ 3 2/3 6 5 ¾ 3 1/3 5

The Board first found that the facts demonstrated that the mandatory reopening provision under 42 C.F.R. §405.1885(b) apply to these cases as: the notices were issued in order to correct the DSH payment consistent with the law; the CMS Administrator letter dated May 6, 2005 stated that the "cost reports must be reopened and a DSH payment adjustment made in order to reflect consistent application of the DSH dual eligible day calculations." However, the Board found that the mandatory reopening provisions in 42 C.F.R. §405.1885(b) were not satisfied. There was no evidence that CMS sent an instruction stating that the determinations were incorrect and were to be reopened and thus the regulatory provision of 42 CFR 405.1885(b) were not met.[12] The Board noted that the CMS Administrator's letter dated May 6, 2005 was addressed to Senator Olympia Snowe rather than to the Intermediary. The Board found that absent CMS instructions explicitly directing the Intermediary to reopen the determinations, the regulatory provisions of 42 C.F.R. § 405.1885(b) were not satisfied.

The Board determined that 42 C.F.R. §405.1887 is the controlling regulation and, under that regulation, the Board found that notices of reopening issued by the Intermediary between June 3, 2003 and September 27, 2004 were not proper. In reviewing these notices issued for these Providers, the Board found that written notices lacked a complete explanation as to the circumstances surrounding the reopening, i.e., the exclusion of Type

Mid-Coast Hospital 20-0021	9/30/1993 9/30/1997	10/25/2000 9/26/2000	6/20/2005 10/19/2005	4 ¾ 4
Eastern Maine Medical Center 20-0033	9/27/1997 9/26/1998 9/26/1999	11/30/2001 6/14/2002 9/30/2002	10/20/2005 2/23/2006 6/13/2006	4 3 ¾ 3 ¾
Brighton Medical Center 20/0017	8/31/1991 9/30/1995	12/07/2000 5/17/2002	6/20/2005 10/19/2005	4 ½ 3 ½
Mercy Hospital 20-0008	12/31/1997	9/28/2000	10/19/2005	5
Northern Maine Medical Center 20-0052	9/30/1997	9/19/2000	6/20/2005	4 ¾
Southern Maine Medical Center 20-0019	4/30/1998 4/30/1999	7/30/2001 8/31/2001	6/20/2005 10/20/2005	4 ¾ 3 5/6
Kennebec Valley Medical Center 20-0015	6/30/1993 6/30/1997	10/25/2000 9/26/2000	6/20/2005 10/19/2005	4 2/3 5

*With respect to Maine Medical Center for the cost reporting periods ending September 30, 1997 and September 30, 1998 (FYs 1997 and 1998), the Board found that the Intermediary acknowledged that the "perfected" notices were not issued to this Provider because it had previously submitted the necessary documentation for FY s 1997 and 1998. The only notices of reopening for these FYs were issued on June 9, 2003. The Board found these notices of reopening lacked the requisite information and the Board found the Intermediary did not satisfy its burden in showing that a proper and timely notice of reopening was issued to Maine Medical Center for FY s 1997 and 1998.

[12] Intermediary's Final Position Paper at 8; Transcript of Oral Hearing (Tr.) at 30-31.

6 eligible days from the DSH calculation. Moreover, the Board found that the written notices did not afford the Providers the opportunity to comment, object or submit evidence in rebuttal of the Intermediary's reopening and the DSH calculation consistent with 42 C.F.R. §405.1887(b). The Board noted the Intermediary's argument that the Providers were given the requisite notice before and after issuance of the notices. However, the Intermediary's May 29, 2003, letter memorializing this action, the Board found referenced only cost reports which were currently being process for settlement, as well as those currently being prepared. The Board stated there was no mention that the Intermediary intended to reopen any closed cost reports to adjust the DSH payment calculation.

The Board found that the meetings held by the Intermediary with the Providers subsequent to the notices of reopening did not satisfy the requirements of 42 C.F.R. §405.1887 or the program instructions at the Provider Reimbursement Manual (CMS Pub. 15-1) §2932(A). The Board noted that the regulations and program instructions specifically state that a written notice of reopening shall include a complete explanation of the basis for the revision and afford the party a reasonable period of time in which to present any additional evidence or arguments in support of its position. Thus, the Board concluded that the purported written notices of reopening issued by the Intermediary between June 3, 2003 and September 27, 2004 lacked the required information as required by the regulations and did not constitute proper notices of reopening.

SUMMARY OF COMMENTS

The CMS Office of Financial Management (OFM) commented requesting reversal, in part, of the Board's decision. OFM stated that under 42 C.F.R. §405.1835(a)(2), a criteria for the right to a Board hearing as part of a group appeal is that the matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations or CMS rulings that is common to each provider in the group. However, in this instance, the only issue before the Board on Providers' Group Appeal involved the Providers' challenges to the Intermediary's exclusion of Maine Type 6 dual eligible days from the Medicaid fraction used in the DSH adjustment.

OFM contended that the Providers expanded this issue in their position paper to include a second issue regarding the adequacy of the reopening notification. OFM argued that the inclusion of this issue must be barred and that the Providers' claim that some, or all, of the Intermediary's reopening notices, were improper should never have been addressed by the Board. OFM stated that the individual Provider appeals did not raise the issue of the reopening notification, or the adequacy of the reopening procedures. Thus, OFM argued that questioning the propriety of the reopening raises a second issue in violation of the

regulatory limitations of a group appeals under 42 C.F.R. §405.1835(a)(2). OFM also cited to several cases in support of its position.[13]

With respect to the adequacy of notices, OFM asserted that the Providers' Position Paper showed that the Providers were given an opportunity to comment and that there was substantial proof in the record that the reopening notices met the required standard. OFM stated that, contrary to the Providers' assertion, the Intermediary's notices of reopening issued in 2003 and 2004 clearly stated that the Intermediary was reopening "to review and correct DSH payment calculation in accordance with Section 1886(d)(5)(F) of the Social Security Act and under 42 C.F.R. §412.106."

In addition, OFM pointed out that, when the Intermediary announced its position regarding non-SSI Type 6 days had changed after May 2003, a number of discussions took place between the Providers and the Intermediary. OFM also stated that Maine hospitals met with a CMS official and that subsequently, additional discussions with CMS ensued with the assistance of Maine's U.S. Senate delegation. Further, since the Intermediary did not issue the first revised Notice of Program Reimbursement (RNPR) incorporating the disallowance of Type 6 days until 2004, the Providers, the Intermediary and CMS were actively engaged in extensive dialogue over a protracted period between May 2003 and May 2005. OFM contended that these facts demonstrated that Providers were provided ample opportunity to comment, object, and provide evidence in rebuttal. Thus, OFM contended that the Providers' arguments that questioned whether there were proper reopening, lacked substance.

With respect to the specific language in the notices, at issue, OFM argued that the language used by the Intermediary in the reopening notices complied with the manual. The reopening notice stated that the cost report was being reopened to review the DSH payment calculation to ensure it was in compliance with Section 1886(d)(5)(F) of the Social Security Act and 42 C.F.R. §412.106 and to correct the payment calculation if it was not. OFM pointed out that the language in the RNPR was appropriate in that it allowed the removal of Medicaid days from the DSH calculation that were not in compliance, and allowed the inclusion of patient days that may not have been included in the original NPR.

OFM stressed that the Intermediary's review of the DSH payment calculation resulted in the removal of the Maine Type 6 dual-eligible days. However, in conjunction with the revised NPR, the Providers were afforded the opportunity to add additional Medicaid eligible days that were not previously reported. OFM argued that allowing additional Medicaid eligible days would result in additional Medicare reimbursement to help offset

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[13] *See, Harrison House of Georgetown v. Blue Cross BlueShield Assn.,* PRRB Dec. 2009-D14; *Harbor Healthcare & Rehabilitation Center v. BlueCross BlueShield Assn.,* PRRB Dec. 2007-D64; and, *Canon v. BlueCross BlueShieldAssn.,* PRRB Dec. 2010-D34.

the effect of the removal of the dual-eligible Type 6 days. OFM noted that the language used in the reopening needed to be sufficiently broad in order to accomplish the goal to include and exclude various categories of Medicaid days. When reopening a cost report, the Intermediary is required to send a written reopening notice detailing the issues revisited in the reopening and that the PRM 15-1 §2932 required that the correction notice explain the basis of correction with as much of the detail as is required. In this case, OFM argued that the language used in the Intermediary's revised NPR met this standard.

The Providers commented, requesting that the Board's decision be affirmed. The Providers argued that they were "without fault" and must be held harmless pursuant to the statute. The Providers claimed that CMS has used the "without fault" provision when it held harmless a number of hospitals in New York and Pennsylvania that improperly included State-only days in their (non-Medicaid eligible) DSH calculation.[14] The Providers noted that the basis for terminating recoupment of improperly included State only days was that "guidance on how to claim these funds was not sufficiently clear."[15]

Further, the Providers argued that the Intermediary's notices were inadequate, noting that the Intermediary admitted that the reopening notices issued in 2003 and 2004 did not fully comply with each and every aspect of the notice requirements in the PRM. The Providers asserted that the Board recognized that Medicare rules are technical in nature and have consequences and that the CMS Administrator routinely disallows a provider's claim based upon a technical violation of the Medicare regulations and program instructions. Therefore, the Providers argued that the Intermediary cannot toll the three-year reopening requirement with defective reopening notices.

In disagreeing with the Intermediary's assertion that the Board's collection of reopening notices from the Provider and the Intermediary was a procedural error, the Providers argued that the Intermediary is required, pursuant to 42 C.F.R. §405.1843(a)(3), to ensure that evidence used in making determinations is included in the record. The Providers argued that the Intermediary did not object to the Board's request for the evidence, and the Intermediary failed to enter a timely objection. The Providers also objected to the Intermediary attaching a spreadsheet to its comments with different dates than those supported by the record.

The Intermediary commented, requesting that the Board's decision be reversed for certain of the Providers and affirmed for other Providers. The Intermediary argued that the "without fault" statutory provision does not apply to aggregate overpayment issues including cost report errors, but only to individual claims. The Intermediary argued that it recognized the error of including Maine's Type 6 non-SSI eligible days in the Medicaid

[14] Provider's Exhibit 10.

[15] Provider's Exhibit 17 (Letter from Michael Hash, CMS Deputy Administrator to Senator William V. Roth, Chairman Senate Finance Committee (Oct. 15, 1999)).

fraction and, as such, a mandatory notice of reopening was not necessary in order to rectify the mistake. Thus, under these facts the mandatory reopening provisions would never be applicable.

Further, the Intermediary pointed out that CMS never instructed the Intermediary, in writing, to re-open the challenged cost reports and there was no written directive, as may be expected in the case of a mandatory reopening. The Intermediary argued that an oral directive from an unidentified CMS official is not a directive or instruction within the meaning of the regulation. The Intermediary noted that the Intermediary "self-reported" the error, met with officials of the Maine Hospital Association to discuss the need for adjustments, and coordinated the issue with relevant officials of CMS in the ordinary course of business. Therefore, the Intermediary argued, there was no "mandatory" directive from CMS, but merely coordination. In addition, the Intermediary asserted that the Board's reliance on the May 6, 2005 letter from the CMS Administrator to former Senator Olympia Snowe of Maine is erroneous because it is not a mandatory directive to the Intermediary or any Provider. In fact, the Intermediary noted that the Administrator's letter to Senator Snowe was sent two years after the Intermediary sent the initial reopening letters beginning in June 2003.

With respect to the adequacy of the notices at issue, the Intermediary argued that the notices sent in 2004 and earlier provided full and adequate notice to Providers that their cost reports were to be reopened to "review and correct the disproportionate share Hospital (DSH) payment calculation .... " The Intermediary stated that the general notice was clearly given that a review will be conducted of the DSH calculation and corrections may be made which satisfied due process. Each letter was followed up with a more explicit letter which the Board acknowledged met any applicable requirements of the regulations and PRM provisions.

In further support, the Intermediary noted that the Administrator has found that the absence of the specific language or requirements in the PRM does not necessarily render a reopening invalid. The Intermediary argued that there were countless meetings and activities undertaken by the Intermediary to discuss with the Providers the exclusion of Maine Type 6 days from the Medicaid fraction. The Intermediary asserted that they sent notices of reopening as an exercise of discretion pursuant to 42 C.F.R. § 405.1885(a), to correct the error of including Maine's non-SSI Type 6 days in the Medicaid fraction for calendar years 1993, 1995 and 1997 through 2000.[16]

Moreover, the Intermediary asserted that its notices of reopening were timely pursuant to their discretion and, for all the years and all the Providers, there was a reopening letter sent commencing on June 9, 2003 that met the three year reopening. The Intermediary noted that the reopening letters invited the Providers to submit any additional days they might be

[16] Tr. at 57-58, 60.

able to document for the affected fiscal years for inclusion in the DSH calculation to lessen the financial impact of the removal of the Type 6 days from the DSH calculation.

Finally, the Intermediary stated that the Board's request for additional documents after the hearing concluded constituted procedural error. The Intermediary noted that the Board requested copies of reopening letters that the Provider had not made part of the record, or addressed through oral testimony at the hearing, and that the record reflects that on November 3, 2011 the Provider responded "with some of the missing notices."[17] The Intermediary claimed that it sent a number of reopening letters to the Board on March 15, 2012.[18] However, there is no indication that these requested reopening letters were ever marked as exhibits and made a formal part of the record. The Intermediary argued that the Providers never made these reopening letters a part of the records, nor present testimony regarding them, because they were never made part of the Providers' case. The Intermediary argued, that the absence of any opportunity to present any testimony regarding this evidence, or brief it, constituted a gross abuse of discretion and reversible error. The Intermediary requested that the Administrator should consider whether a remand to the Board to fully develop the record is warranted.

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

I. Disproportionate Share Hospital Adjustment Payment

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. The program is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Social Security Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[19] The "categorically needy" are persons

[17] *See* Board Letters, dated October 13, 2011 and February 15,2012.

[18] The Intermediary stated that the Transcript of the Oral Hearing does not reflect that the missing notices were requested at the hearing. The date of request for the reopening notices is reflected in the February 15, 2012letter from Mr. Braganza to Mr. Grimes.

[19] Section 1902(a)(l 0) of the Act.

eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income or SSI. 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.[20]

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.[21] If the State plan is approved by CMS, under §1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan. In particular, §1901 of the Social Security Act sets forth that appropriations under that title are "[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services ..."

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[22] 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 payment reimbursement for inpatient hospital and related post-hospital, home health, and hospice care,[23] and Part B, which is supplemental voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.[24]

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[20] Section 1902(a)(l)(C)(i) of the Act.
[21] §1902 of the Act.
[22] Pub. Law No. 89-97.
[23] Section 1811-1821 of the Act.
[24] Section 1831-18480) of the Act.

At its inception in 1965, Medicare paid for the reasonable cost of furnishing covered services to beneficiaries. Concerned with increasing costs, Congress amended the Social Security Act in 1983[25] and added § 1886(d) of the Act, establishing 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.[26]

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 reimbursed 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 diagnosis related groups (DRG) subject to certain payment adjustments.

Concerned with possible payment inequities for IPPS hospitals that treat a disproportionate share of low-income patients, pursuant to § 1886(d)(5)(F)(i) of the Act, Congress directed the Secretary to provide, for discharges occurring after May 1, 1986, "for hospitals serving a significantly disproportionate number of low-income patients…"[27] There are two methods to determine eligibility for a Medicare DSH adjustment: the "proxy method" and the "Pickle method."[28] To be eligible for the DSH payment, an IPPS hospital must meet certain criteria concerning, inter alia, its disproportionate patient percentage. Relevant to this case, §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" or "Medicaid!SSI fraction," and the "Medicaid low-income proxy" or "Medicaid fraction," and are defined as follows:

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

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[25] Pub. Law No. 98-21.
[26] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).
[27] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). *See also* 51 Fed. Reg. 16,772, 16,773-16,776 (1986).
[28] The Pickle method is set forth at section 1886(d) (F) (i) (II) of the Act.

> 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.)

The regulation at 42 C.F.R. §412.106 explains the proxy method. The first computation, the Medicare/SSI fraction set forth at 42 C.F.R. §412.106(b)(2)[29] (1994) 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.

In addition, the second computation, the Medicaid fraction, 1s set forth at 42 C.F .R. §412.106(b)(4) (1994) 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.[30] (Emphasis added.)

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[29] This is the language used in the regulation in effect for the cost periods at issue.

[30] The relevant parts of the regulation has remained unchanged for the various cost reporting periods at issue. Effective for discharges occurring on or after January 20, 2000 certain changes were made: "Second computation. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply: (i) A patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical

II. Hold Harmless and Without fault provisions

The Providers argued that the days at issue should be allowed based upon the "hold harmless" principles advanced in Program Memorandum A-99-62[31] which provided, inter alia, that:

> "Hold Harmless for cost reporting periods beginning before January 1, 2000"
> 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. This is consistent with HCFA's determination that hospitals and intermediaries relied, for the most part, 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. Although HCFA has decided to allow the hospitals 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.

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assistance under an approved State Medicaid plan on such day, regardless of whether particular items or services were covered or paid under the State plan. (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act. (iii) 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 a patient was eligible for Medicaid during each claimed patient hospital day."(2000)

[31] Change Request 1052, dated December 1999. This language was reissued pursuant to Program Memorandum A-01-13 (Change request 1052 dated January 25, 2001).

> Hospitals That Received Payments Reflecting the Erroneous Inclusion of Days at Issue
> In practical terms this means that you are not to reopen any cost reports for cost reporting 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. If, prior to the issuance of this Program Memorandum, you reopened a settled cost report to disallow the portion of Medicare DSH payment attributable to the inclusion of these types of days, reopen that cost report again and refund the amounts (including interest) collected. Do not, however, pay the hospitals interest on the amounts previously recouped as result of the disallowance. Furthermore, on or after October 15, 1999, you are not to accept reopening requests 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 received 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

In addition, the Providers stated that relief from the exclusion of the days from the DSH calculation should be found under section 1870 of the Social Security Act. The Medicare statute provides the “without fault” provision in the case of an overpayment “on behalf of Individuals and settlement of claims for benefits on behalf of deceased individuals”, at section 1870 which states that:

> (a) Any payment under this title to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Where-

(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines (A) that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or (B) that such provider of services or other person was without fault with respect to the payment of such excess over the correct amount, or

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For purposes of clause (B) of paragraph (1), such provider of services or such other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the Secretary's determination that more than such correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.

(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814(e)) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4), if such adjustment (or recovery) would defeat the purposes of title II or title XVIII or would be against equity and good conscience. Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this title) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this title by reason of the provisions of paragraph (1) or (9) of section 1862(a) and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title.

III Reopening Issue

Medicare providers are required to file cost reports annually.[32] After receipt of the cost report, the Intermediary issues a Notice of Program Reimbursement or "NPR," which reflects a determination by the intermediary of the total amount due the Provider. Both the statute and regulation provide a mechanism for providers to appeal such a determination if certain criteria are met.[33]

In addition, a final determination may be reopened. The regulation at 42 C.F.R. §405.1885 explains regarding the reopening of a determination that:

> (a) A determination of an intermediary…may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary…, either on motion of such intermediary..., or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 years of the date of the notice of the intermediary... No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

The regulation at 42 C.F.R. §405.1885(b) provides for the CMS directed "mandatory reopening," which explains that:

> (b)(1) An intermediary determination or an intermediary hearing decision must be reopened and revised by the intermediary if, within the 3-year period specified in paragraph (a) of this section, CMS-
> (i) Provides notice to the intermediary that the intermediary determination or the intermediary hearing decision is inconsistent with the applicable law, regulations, CMS ruling, or CMS general instructions in effect, and as CMS understood those legal provisions, at the time the determination or decision was rendered by the intermediary; and
> (ii) Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision.
> (2) A change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.
>
> ****

[32] 42 C.F.R. §413.24.
[33] Section 1878(a) of the Social Security Act.

> (e) Notwithstanding an intermediary's discretion to reopen or not reopen an intermediary determination or an intermediary hearing decision under paragraphs (a) and (c) of this section, CMS may direct an intermediary to reopen, or not to reopen, an intermediary determination or an intermediary hearing decision in accordance with paragraphs (a) and (c) of this section.

CMS discussed the longstanding policy regarding "mandatory reopening" in the final IPPS FFY 2003 rate rule stating that:

> We have never considered a notice or other document from CMS that only states or implies that an intermediary determination or an intermediary hearing decision is inconsistent with law, regulations, CMS ruling, or CMS general instructions, sufficient to require intermediary reopening under §405.1885(b).
> ***
> Therefore, we are proposing to revise §405.1885(b) to make clear that, in order to trigger the intermediary's obligation to reopen, the notice from CMS to the intermediary must explicitly direct the intermediary to reopen based on a finding that an intermediary determination or an intermediary hearing decision is inconsistent with the law, regulations, CMS ruling, or CMS general instructions in effect, and as we understood those legal provisions, at the time the determination or decision was rendered. We are also proposing to clarify §405.1885 to reflect our longstanding interpretation (discussed above) that a change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to judicial precedent or otherwise, is not a basis for reopening an intermediary determination or an intermediary hearing decision under this section.[34]

Further in the final rule clarifying the regulation consistent with longstanding policy, CMS stated that:

> Under §405 .1885(b), an intermediary determination or an intermediary hearing decision "must be reopened and revised by the intermediary if, within the aforementioned 3-year period, the Centers for Medicare & Medicaid Services notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the Centers for Medicare & Medicaid Services." We

[34] 67 Fed. Reg. 31404 "Centers for Medicare & Medicaid Services 42 CFR Parts 405, 412, 413, 482, 485, and 489 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates" (Proposed rule) (May 9, 2002)

> have always considered our notice, which is a precondition of mandatory intermediary reopening under §405.1885(b), to be one in which we explicitly direct the intermediary to reopen. We have never considered a notice or other document from us that only states or implies that an intermediary determination or an intermediary hearing decision is inconsistent with law, regulations, CMS ruling, or CMS general instructions, sufficient to require intermediary reopening under §405.1885(b).[35]

With respect to the reopening process, the regulation provides at 42 CFR §405.1887 the criteria for the "Notice of reopening" and states that:

> (a) All parties to any reopening described above shall be given written notice of the reopening. When such reopening results in any revision in the prior decision notice of said revision or revisions will be mailed to the parties with a complete explanation of the basis for the revision or revisions....
> (b) In any such reopening, the parties to the prior decision shall be allowed a reasonable period of time in which to present any additional evidence or argument in support of their position.

In addition the Provider Reimbursement Manual provides that:

2932. Notices (Including Notices of refusal) Related to reopening and correction.

> A. Requirements of the Notice.--When any determination or decision is reopened as provided in §2931 or it is decided not to reopen, notice of such reopening (or refusal to reopen--see §2931.1 below) will be mailed to the provider..... The notice of reopening will be issued by the intermediary .... as required by §2931.1. The provider or other party will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it was necessary to take such action, and the opportunity to comment, object, or submit evidence in rebuttal.

[35] 67 Fed. Reg. 49982 "Centers for Medicare & Medicaid Services 42 CFR Parts 405, 412, 413, and 485 Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2003 Rates" (Final rule)(August 1, 2002).

Findings and Conclusions

The initial dispute in this case was whether the days for the non-SSI Type 6 Medicaid/Medicare dual eligible patients are to be included in the Medicaid fraction component of the Medicare DSH payment calculation. The Providers are six groups of ten hospitals appealing various cost reporting periods. In the final position papers, the Providers argued on the merits that the days were to be included as Congress intended to count all Medicaid eligible days, the case law supported the inclusion of these days as they were for Medicaid eligible patients, and CMS' subsequent clarification of the type of days to be included in the DSH calculation, supports the inclusion. The Providers argued that they are entitled to relief from the overpayment determinations as they are similarly not at fault like those providers held harmless under the provisions of the PM A-99-62. In addition, the Providers should be granted relief under the waiver of liability under Section 1870 of the Act.

The Providers in the final position paper also argued that the Intermediary was not authorized to reopen an administrative resolution without a specific instruction from CMS which did not occur. The revised NPR that was reopened was the result of an administrative resolution (AR) to preclude further litigation on specific issues subjecting this reopening to issue or claim preclusion (referencing a sample settlement agreement at Provider Exhibit P-20). The Providers also argued that a proper reopening did not occur until May 6, 2005. The initial reopening notices issued for some of the Providers, from 2003-2004, were too broad and did not specify the reason for the reopening, nor give the Providers the opportunity to submit comments, etc. Because the Intermediary allowed the Providers to originally include the non-SSI type 6 days, the only type of reopening possible was a mandatory reopening pursuant to CMS instructions. As the only letter that fits the mandatory reopening provision is the May 6, 2005 Administrator letter to Senator Snowe, the AR issued NPRs dated prior to May 6, 2003, are beyond the three year reopening window.

The Exclusion of non-SSI Type 6 days from the Numerator of the Medicaid fraction

In the adjustment at issue, the days were excluded from the numerator of the "Medicaid fraction" as the Medicaid patients were also eligible for Medicare Part A. Under the Medicaid program (Maine Care) patients with cross-over Medicare/Medicaid benefits that are not eligible for SSI are processed and identified on the remittance advice as "Type 6" days. The Intermediary maintained that such days should not be included in the Medicaid fraction as these are days do not meet the criteria of days for "a patient 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."

With respect to the merits of the dispute as to whether the non-SSI Type 6 days should be included in the numerator of the Medicaid fraction, the Administrator finds that the Intermediary's application of the law was correct. Section 1886(d)(5)(F)(vi)(II) of the Act requires for purposes of determining the Providers' "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. Thus applying the plain language of the regulation, the days at issue cannot be included in the numerator of the Medicaid fraction.

Hold Harmless/Without Fault

The Administrator finds that, neither the "hold harmless" provision of PM A-99-62, nor the "without fault" provision of section 1870 of the Act, can grant the relief requested by the Providers. The PMA -99-62 inter alia, addressed the agency's policy as to the meaning of days that are to be properly included in the Medicare DSH calculation effective January 1, 2000 and established a "hold harmless" rule under which hospitals meeting certain specified criteria would be permitted to receive DSH payments based on "ineligible days." As the Board properly found, PM A-99-62 does not apply to the non-SSI Type 6 dual eligible days at issue because the hold harmless provision only applies to: general assistance, State only health program, charity care, Medicaid DSH and/or waiver or demonstration population days. In addition, two groups were entitled to these payments under the hold harmless rule of PM A-99-62 for these specified days. The first group, consisting of hospitals that had received DSH payments based on those certain specified types of days for cost reporting periods settled before October 15, 1999, that were determined to be ineligible for inclusion, could continue to receive DSH payments based on those days for cost reporting periods beginning prior to January 1, 2000. The second group, consisting of hospitals that had not received DSH payments based on these specified "ineligible days" but had appealed the exclusion of the these specific types of "ineligible days" prior to October 15, 1999, could also receive payment for those days for the cost years under appeal. The Providers in these cases are not attempting to receive payments for the types of days involved in PM A-99-62.[36] Therefore, as the Board correctly determined, the Providers cannot be granted relief under a "hold harmless" theory.

[36] Further, the courts have upheld challenges to the Secretary's limiting application of the PM, where providers claimed that the PM policy "arbitrarily" allowed only certain situated providers to receive payment. The courts determination that the decision to hold certain providers to be harmless for the prior erroneous inclusion of State-only programs was a reasonable and rationale exercise of the Program's authority. *See* e.g. *United Hospital v. Thompson*, 383 F.3d 728 (8th Cir. 2004) (where the Court found that the PM A-99-62 was rational and a proper exercise of the Secretary's authority and rejected a hospital's claim that PM A-99-62 was arbitrary.).

In addition, the Providers stated that relief from the exclusion of the days from the DSH calculation should be found under Section 1870 of the Social Security Act. The Medicare statute provides the "without fault" provision in the case of an overpayment "on behalf of Individuals and settlement of claims for benefits on behalf of deceased individuals", at section 1870. However, the Provider's argument, that the Intermediary cannot recover overpayments from the Provider as it is "without fault" under section 1870 of the Act, is not proper. In a proposed rule, CMS explained the statutory basis for its policy of not applying the "without fault" provision to aggregate overpayment issues, stating that:

> Under section 1870 of the Act, if the provider is found to be without fault for an overpayment, the individual who received the service for which payment was made is liable for the overpayment. Therefore application of the without fault provision in section 1870 of the Act is limited to overpayments for individual claims for which liability can ultimately be shifted to a specific individual.
>
> Consequently, the without fault provisions under section 1870 do not extend to aggregate overpayment issues, such as Medicare cost report errors, because liability for an individual claim cannot be shifted to a specific individual. For certain providers, aggregate overpayments resulted from payment under a reasonable cost payment methodology in which payment is made on an interim basis throughout the year, with appropriate adjustments made upon settlement of the annual cost reports. Because Medicare cost report errors are not directly associated with specific services, liability cannot be shifted from a specific provider to a specific individual.
>
> Thus, the without fault provisions of this proposed rule would not apply to overpayments resulting from aggregate payment issues, such as cost report errors. These overpayments are addressed in section 1878 of the Act, which contains provisions relating to the Provider Reimbursement Review Board and the circumstances under which a provider may obtain a hearing with the Board.[37]

This case involves an aggregate overpayment resulting from an incorrect DSH payment. Thus, as a matter of law, the facts of this case fall outside the application of the "without fault" provisions. Consequently, evaluation of the overpayment determination under the without fault provision is incorrect. The Board was correct in finding that the overpayments at issue did not involve individual claims, and instead pertained to aggregate payments related to DSH adjustments and in finding that the waiver provisions at section 1870 did not apply in this case.

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[37] 63 Fed. Reg. 14,506 at 14,510 (March 25, 1998).

Group Appeals

The regulation at 42 C.P.R. 405.1837 explains the criteria *fqr* group appeals and provides at paragraph that: "The matters at issue involve a common question of fact or of interpretation of law, regulations or HCFA Rulings." Assuming *arguendo,* there were findings that any of the reopenings were untimely, the problem of allowing a second factually based issue in the group appeals is apparent. The group appeal procedures require that there be a singular legal issue and or fact. Hence no variation in facts that might vary the outcome for each individual provider/cost year is the purpose of the group appeal provisions. In this case, the reopening issue had different underlying facts for each provider/cost year that might result in different rulings as evident among other thing with the different phrasing of the issue between groups. Further, for those Providers that raised the reopening issue timely, the Providers' reopening challenge is fundamental to each Provider's respective individual request for a hearing and any substantive issues appealed therein from the revised NPR and not exclusive to the Type6 days purported to be the issue in these cases.

Moreover, related to the inclusion of this issue in the Group appeals, the reopening generally was only mentioned in the original requests for hearing in a limited number of requests for hearings for the respective provider(s) listing of issues. For example, Maine Medical Center's Individual Request for Hearing, dated July 21, 2006 (FYE 1993) lists the following issues: (1.) Disproportionate Share Adjustment (DSH) a. Medicaid eligible days, b. dual eligible days, c. Medicare Part A Exhausted Days, d. SSI percentage and (2) "Issues subject to reopened administrative resolution" For the latter, the Provider stated that: "The provider contends that the Intermediary cannot reopen an issue subject to an executed AR. Furthermore, even assuming an AR can be reopened the provider contends that the Intermediary cannot selectively reopen an administrative resolution" and, thus, all issues must be reinstated if the Board allows the reopening. *(See e.g.* Provider Exhibit P-3-1.B) While the reopening is challenged within the context of the AR, the reopening issue raised does not include a challenge on the sufficiency and hence timeliness of the notices.

Further, other Providers did not raise reopening at all in their individual request for a hearing. For example, Central Maine Medical Center's Individual Request for a Hearing, dated December 8, 2006, only challenged (1.) Disproportionate Share Adjustment (DSH) a. Medicaid eligible days, b. Capital (Capital DSH adjustment). The record indicates that only the Providers' December 22, 2010 consolidated final position paper raised the challenge of the timeliness of the reopenings, because of the alleged insufficiency of the notices for all six groups, which for those providers that had not raised the issue earlier, would be after the timeframe for adding issues under the 2008 Board rules. This fact also

explains the delayed and incomplete supplementation of the record with such reopening notices.

Finally, if certain cost report reopenings were to be found invalid in this group appeal, the reopening challenge is fundamental to any other issues raised by the providers in those same individual appeals. Those same reopenings and revised NPRs were used as the basis for the respective Providers' appeals of other DSH issues (dually eligible exhausted days, etc.) listed in their individual requests for hearings. Consequently, assuming *arguendo,* that certain of the Intermediary reopenings and revised NPRs were found invalid in this group appeal, a remand would be needed, in effect, to reconstruct the individual cases.[38] That is, it would be procedurally incongruent and legally incorrect, to prohibit the exclusion of non-SSI type 6 days based on a finding that a particular reopening and hence revised NPR was not proper in this group appeal, while allowing the Providers to use that same reopening determination and revised NPRs to revisit and challenge the other aspects of the DSH calculation that may have been transferred to multiple other group appeals.

Reopening Issue

However, assuming arguendo the reopening issue is properly and timely raised in this case, the Administrator finds that in accordance with the regulation, the notices were within the three year period,[39] the notices were sufficient to notify the Providers as to the nature of the reopenings, the Providers were given ample opportunity to submit additional evidence and arguments, and Providers were on notice as to the basis for the revisions for the issued revised NPRs.

The Providers contended that the Intermediary initially allowed the Providers to include these days in the numerator of the Medicaid fraction.[40] The Providers argued that those NPRs that were the subject of the reopening and adjustment excluding the non-SSI Type 6 days were the result of an administrative resolution[41] and, therefore, could not be subject to the reopening without CMS direction. The Intermediary countered that it had self-

[38] Most of the Providers have used the broadly word DSH reopening to revive the appeal of other DSH issues. In those issues it is not generally to those Providers' benefit to object to the reopening. The appropriateness of using the revised NPR issued pursuant to the reopening notices to appeal those issues is not being addressed here.
[39] *See* Administrator Decision attached Appendix I and II.
[40] *See, e.g.*, PPP at 15-16.
[41] The record shows the "sample" administrative resolution at Provider Exhibit P-20.

reported to CMS and corrected the erroneous inclusion of the '"non-SSI Type 6" days in the numerator of the Medicaid fraction of the DSH calculation.[42]

The record shows that, in May 2003, the Providers were made aware that the Intermediary had revisited this issue and determined that these days should not be included in the Medicaid fraction.[43] The Intermediary issued reopening letters in 2003-2004,[44] which the Providers acknowledged, put them on notice at that time, *inter alia,*[45] that a liability to repay the DSH amounts related to the erroneously included non-SSI Type 6 days may be incurred.[46] The Intermediary's notice, titled '"Medicare Cost Report Reopening" identified the cost year and stated that:

> The above referenced Medicare cost report 1s reopened to address the following issue:
>
> To review and correct the disproportionate share hospital (DSH) payment calculation accordance with section 1886(d)(5)(F) of the Social Security Act and 42 C.F.R. 412.106.
>
> Please contact me at xxx-xxx-xxxx, if you have any questions regarding this reopening.

The Providers stated they began to have meetings with the Intermediary shortly after the letters were issued.[47] The Providers explained that the Maine hospital representatives and the Intermediary met with program authorities at the CMS Regional Office Boston in July

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[42] As the statute prohibited the inclusion of these days, the Intermediary would not have been authorized by law to pay for these days and, thus, would not have had the authority to pay for these days in the administrative resolution.

[43] PPP at 15.

[44] Not all of the 2003-2004 letters for all Providers were included in the record. The Provider at n. 1 *T* of its Final Position paper maintained that all the 2003-2004 letters used the same language as the sample provided in Provider Exhibit P-21 and could provide them if needed. In addition, the Provider has never maintained that these 2003-2004 reopening letters were not issued within the three-year reopening period.

[45] *See e.g.* Tr. at 85-86.

[46] *See, e.g.,* PPP at 17; Tr. at 103-104 ('[I]t is common practice when a hospital receives a notice of reopening that Medicare funding is going to be taken away that that would be booked as a reserve ..... . *so that is what happened with those 2003 reopening letters.* But please don't let that confuse you, that we still felt very strongly that these days should be included ... "); Tr. at 108 ("Well *we didn't know* that the monies were going to be repaid *until the reopening for 2003."* (Emphasis added.))

[47] *See, e.g.,* Tr. at 86.

22, 2003[48] and, subsequently, met with the Acting Deputy Director of CMS in Washington DC on April 20, 2004. The subject of the discussion included whether the section 3708.1 'without fault" analysis could be applied. The CMS official determined that the Providers did not qualify for the without fault/hold harmless provision. By letter dated May 6, 2005 the CMS Administrator replied to Senator Snowe regarding the inclusion of these days and the without fault/hold harmless provision.[49]

The 2005 Intermediary letters to the Providers memorialized that, after several years of discussion with CMS and the Providers, the previously issued cost report reopening(s) were to be effectuated with respect to the removal of non-SSI Type 6 days.[50] The letters also included a proposed list of Medicaid days for review to which the Provider was invited to identify any other Medicaid beneficiaries with Medicare Part A coverage. In addition, the Providers were invited to submit a supplemental updated list of additional Medicaid days, with appropriate documentation, that had not been included in the enclosed Intermediary's listing.

The Administrator finds that the Intermediary's reopening of the subject cost reports in 2003 and 2004 met the requirements of the regulation and were timely and proper. The regulation provides that "[a]ll parties to any reopening described above shall be given written notice of the reopening," which the subject reopening letters accomplished. As noted, the reopening was not overly broad in specifying that the reopening was to "review and correct the disproportionate share hospital (DSH) payment calculation accordance with section 18869d)(5)(F) of the Social Security Act and 42 C.P.R. §412.106." The reopenings in fact not only reviewed the non-SSI Type 6 days but also, *inter alia*, allowed additional Medicaid days to be included.

In addition, under the regulation "*[w]hen such reopening results in any revision* in the prior decision notice of said revision or revisions will be mailed to the parties *with a complete explanation of the basis* for the revision or revisions .... " That is, when the revised NPR is issued, an explanation of the revision is to be contained in the revised NPR. The record shows that no final adjustment was being made at the time of issuance of the reopening letter and that an explanation of the final adjustment was provided in the subsequently issued revised NPR.

In addition, pursuant to the regulation, "in any such reopening, the parties to the prior decision shall be allowed a reasonable period of time in which to present any additional evidence or argument in support of their position." As memorialized by both the Intermediary and the Providers, and testified to by Providers' witnesses, contemporaneous

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[48] *See, e.g.* p PP at 17, Tr. at 58.
[49] Provider Exhibit P- 16.
[50] *See e.g.* Provider Exhibit P-21; Intermediary's March 15, 2010 Response to Board request.

with the reopening notices and prior to the issuance of the revised NPRs, extensive discussions occurred between the Providers, the Maine Hospital Association, the Intermediary and CMS. The record also shows that the Providers had substantial opportunities to submit supplemental argument and information on the issue of the non-SSI Type 6 days and the opportunity to present other days, prior to the revised NPRs being issued. The Providers was also specifically given an opportunity to respond to the Intermediary's findings as to the Medicaid listing, once they were made, and before the Intermediary calculated the revised settlement. Thus, with respect to the regulatory provisions in this case the Administrator finds that the notices were within the three year period,[51] the notices were sufficient to notify the Providers as to the nature of the reopenings, the Providers were given ample opportunity to submit additional evidence and arguments, and Providers were on notice as to the basis for the revisions for the issued revised NPRs.

[51] *See* Administrator Decision attached Appendix I and II.

DECISION

The decision of the Board is modified consistent with the foregoing opinion.

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

Date: May 30, 2013

/s/
Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

Administrator Decision 20013-D9
Appendix I

Provider/Provider No.	Cost Reporting Period Ending	Date of Previous NPR	Date of Notice of Reopening[52]	Date of Supplemental Request	Years from NPR to Reopening
Eastern Maine Medical Center 20-0033	09/30/1995	12/05/2002**	9/27/2004	6/20/2005	1 ¾
Mercy Hospital 20-0008	12/31/1998	12/30/2002	9/27/2004	6/20/2005	1 ¾
MaineGeneral Medical Center 20-0039	06/30/2000	9/30/2002	6/09/2003	6/20/2005	¾
Maine Medical Center 20-0009	9/30/2000	NA	NA*	NA	NA
MaineGeneral Medical Center 20-0039	6/30/1999	NA	NA*[53]	NA	NA

*Notice of reopenings were unnecessary because the adjustment was made in the original NPR.

Appendix II

Provider/Provider No.	Cost Reporting Period Ending	Date of Previous NPR	Date of Notice of Reopening[54]	Date of Supplemental Request	Years from NPR to Reopening
Maine Medical Center 20-0009	09/30/1993 09/30/1994 09/30/1997 09/30/1998 09/30/1999	12/17/2001 9/24/1997 9/28/2000 9/27/2001 9/30/2002	9/27/2004 9/27/2004[55] 6/9/2003** 6/9/2003** 6/9/2003	6/20/2005 10/19/2005 NA NA 3/5/2007	2 ¾ NA 2 ¾ 1 ¾ ¾
Central Maine Medical Center 20-0024	6/30/1993 6/30/1995 6/30/1996 6/30/1997	1/28/2002 6/28/2002 9/29/2000 10/16/2003	6/13/2003 9/27/2004 6/13/2003 6/9/2003	6/20/2005 2/23/2006 6/13/2006 11/13/2006	1 5/12 2 ¼ 2 ¾ 2 ¾

[52] Only some of the original notices of reopening were included in the record. However the Provider never contended that the notices of reopening issued in 2003-2004 were not timely. The issue in these reopening notices centered on whether they gave sufficient notice. Therefore, the Provider only submitted one sample of the reopening letter in Provider Exhibit P-21. *See also* Providers' Consolidated Final Position Paper at n.l7.

[53] No reopening as there was no DSH adjustment.

[54] *See n* 51.

[55] The Intermediary explained that the reopening process pursuant to the Administrative Resolution to adjust DSH days had been started and a final revised NPR had not yet been issued when the non-SSI Type 6 issue was identified. Therefore, an additional "reopening" was not needed.

	6/30/1998 6/30/1999	(9/29/2000)[56] 8/30/2001 8/16/2002	6/9/2003 6/9/2003	2/12/2007 8/2/2007	1 10/12 10/12
Mid-Coast Hospital 20-0021	9/30/1993 9/30/1997	10/25/2000 9/26/2000	6/13/2003 6/9/2003	6/20/2005 10/19/2005	2 2/3 2 ¾
Eastern Maine Medical Center 20-0033	9/27/1997 9/26/1998 9/26/1999	11/30/2001 6/14/2002 (9/26/2001)[57] 9/30/2002	9/27/2004 6/9/2003 6/9/2003	10/20/2005 2/23/2006 6/13/2006	2 10/12 1 ¾ ¾
Brighton Medical Center 20/0017	8/31/1991[58] 9/30/1995	12/07/2000 (11/13/2000)[59] 5/17/2002	10/14/2003 9/27/2004	6/20/2005 10/19/2005	2 11/12 2 1/3
Mercy Hospital 20-0008	12/31/1997	9/28/2000	7/2/2003	10/19/2005	2 5/6
Northern Maine Medical Center 20-0052	9/30/1997	9/19/2000	6/9/2003	6/20/2005	2 ¾
Southern Maine Medical Center 20-0019	4/30/1998 4/30/1999	7/30/2001 8/31/2001	6/9/2003 6/9/2003	6/20/2005 10/20/2005	1 11/12 1 10/12
Kennebec Valley Medical Center 20-0015	6/30/1993 6/30/1997	10/25/2000 9/13/2000[60]	9/25/2003 6/9/2003	6/20/2005 10/19/2005	2 11/12 2 ¾

**The Intermediary's supplemental request was not sent as the Provider's consultant had already provided an updated list of Medicaid days in response to the process initiated by the reopening notice.

[56] The Intermediary stated the Board's recording of the NPR date was incorrect according to STARS. Generally, the Board's dates are based on the respective revised NPR(s) notation of the date of the NPR being corrected. The original NPRs that were corrected for the most part are not included as part of the supporting documentation for the schedule of providers. However, any differences in the dates are not critical to a finding of whether the reopenings for those cost years were timely.

[57] The Intermediary stated the Board's recording of the NPR date was incorrect according to STARS. *See n* 55.

[58] By letter dated January 14, 2009, the Provider Representative requested that the non-SSI-Type6 days issue in the Brighton Medical Center, FYE 1991, be made part of the 1995 Maine non-SSI Type 6 days Group Appeal, PRRB Case No 09-0383G. The supporting documentation for the schedule of providers does not include the Board order approving the transfer of the issue from this appeal.

[59] The Intermediary stated that the Board recorded NPR date was incorrect according to STARS. *See n.* 55.

[60] The Intermediary stated the Board recorded date of 9/26/2000 was incorrect according to STARS. *See n.* 55