PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D9

PROVIDER –
Maine Type 6 Medicaid Dual Eligible Days DSH Groups

Provider Nos.: Various – See Appendix I

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ National Government Services

DATE OF HEARING -
April 15, 2011

Cost Reporting Periods Ended -
Various - See Appendix I

CASE NOs.: 09-0480G, 09-0383G, 09-0491G, 09-0487G, 07-2217G, 07-2291G

INDEX

ISSUE:

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 adjustment was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended (Act), to provide health insurance to the aged and disabled. The Act was codified at 42 U.S.C., Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulations and interpretative guidelines published by CMS.[2]

Cost reports are required from providers on an annual basis with reporting periods based on the provider's fiscal year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs to be allocated to the Medicare program.[3] The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR).[4] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the receipt of the NPR.[5]

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). The statutory provisions governing PPS are located in 42 U.S.C. § 1395ww(d) and § 1395(d)(5) contains a number of provisions that adjust reimbursement under PPS based on certain hospital-specific factors. This case involves one of the hospital-specific adjustments, specifically the "disproportionate share hospital," or "DSH" adjustment. Pursuant to § 1395ww(d)(5)(F)(i)(I), the Secretary is required to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients."

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. § 1395h and § 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 405.1837.

Whether a hospital qualifies for the DSH adjustment and how large an adjustment it receives depends on the hospital's "disproportionate patient percentage."[6] The "disproportionate patient percentage" is the sum of two fractions expressed as a percentage for a hospital's cost reporting period.[7] The Board will refer to these two fractions as the Medicare and Medicaid fractions. A provider whose DSH percentage meets certain thresholds receives an adjustment which results in increased PPS payment for inpatient hospital services.[8]

The Medicare fraction is also referred to as the Medicare proxy or the SSI fraction. The Medicare fraction's numerator is the number of hospital patient days for patients entitled to both Medicare Part A and Supplemental Security Income (SSI), excluding patients receiving state supplementation only, and the denominator is the number of hospital patient days for patients entitled to Medicare Part A.[9]

The Medicaid fraction is also referred to as the Medicaid proxy. The Medicaid fraction's numerator is the number of hospital patient days for patients who were "eligible for medical assistance under a State plan approved under ... [Title] XIX [*i.e.*, 42 U.S.C. Ch. 7, Subch. XIX]" for such period but not entitled to benefits under Medicare Part A, and the denominator is the total number of the hospital's patient days for such period.[10]

The issue in this case concerns the inclusion of inpatient days in the DSH formula for "dually eligible" patients, that is, inpatient days for patients who were eligible for Medicaid and entitled to Medicare Part A.

The regulations governing the DSH adjustment are found at 42 C.F.R. § 412.106. Prior to 1997, these regulations specified, in pertinent part, that the Medicaid fraction is computed as follows:

> (b) *Determination of hospital's disproportionate patient percentage*—(1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing the sum as a percentage. . . .
> (4) *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 that same period. . . .[11]

In February 1997, the CMS Administrator issued HCFA Ruling 97-2 revising the original interpretation of the statutory provision and prospectively mandated that in calculating the disproportionate patient percentage, the Medicaid numerator must include all Medicaid-

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[6] 42 U.S.C. § 1395ww(d)(5)(F)(v).
[7] 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(ii).
[9] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[10] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).
[11] 42 C.F.R. § 412.106(b)(1) and (4) (1997) (italics in original).

eligible inpatient days "whether or not the hospital received payment for those inpatient hospital services." Subsequent to issuance of HCFA Ruling 97-2, CMS issued to its Associate Regional Administrators memorandum dated June 16, 1997 and entitled "HCFA Ruling 97-2 Instructions."[12] Concerning the dual eligible issue, it stated the following:

> The definition of Medicaid days for purposes of the 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 . . . . However, 42 C.F.R. [§]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.[13]

On July 31, 1998, CMS issued a final rule revising the regulations governing the DSH adjustment.[14] Specifically, CMS revised 42 C.F.R. § 412.106, in pertinent part, as follows:

> (b) *Determination of a hospital's disproportionate patient percentage*—(1) *General rule.* A hospital's disproportionate patient percentage is determined by adding the results of two computations and expressing the sum as a percentage. . . . (4) *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. . . .[15]

In December 1999, CMS issued further instructions in Program Memorandum Transmittal No. A-99-62 ("PM No. A-99-62")[16] to clarify that the definition of Medicaid eligible days in the Medicare DSH formula includes only "days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan." Notwithstanding, the Agency decided to hold harmless, for cost reporting periods beginning before January 1, 2000, those hospitals which had received additional DSH payments resulting from the erroneous inclusion of general assistance or State-only paid days.[17]

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[12] Intermediary Exhibit I-7.
[13] *Id.* at 2.
[14] 63 Fed. Reg. 40954 (July 31, 1998).
[15] *Id.* at 41004; 42 C.F.R. § 412.106(b)(1) and (4) (1999) (italics in original).
[16] HCFA Pub. 60A, Transmittal No. A-99-62 (Dec. 1, 1999) ("PM No. A-99-62"). *See* Intermediary Exhibit I-15.
[17] *Id.*

The case involves an alleged overpayment of DSH adjustment payments. Congress has allowed for waiver of liability of overpayments in certain circumstances. In this regard, 42 U.S.C. § 1395gg specifies, in pertinent part:

> (b) Where—
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> (1) more than the correct amount is paid under this subchapter 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, . . .
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> proper adjustments shall be made, under regulations prescribed . . . by the Secretary, by decreasing subsequent payments . . . . 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 subchapter.
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> (c) There shall be no adjustment as provided in subsection (b) of this section (nor shall there be recovery) in any case where the incorrect payment has been made . . . with respect to an individual who is without fault . . . .

Also at issue in this case is the timeliness of the reopening of the NPRs. The reopening regulations applicable to this case are contained in 42 C.F.R. §§ 405.1885 and 405.1887 and, during the time at issue, stated in pertinent part:

> § 405.1885 Reopening a determination or decision.
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> (a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, 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 or Board hearing decision, or where there has been no such decision, any such request to reopen must be made within 3

> years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.
> (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—
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> (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
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> (ii) Explicitly directs the intermediary to reopen and revise the intermediary determination or the intermediary hearing decision. . . .
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> § 405.1887 Notice of reopening.
> (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. Notices of reopening by the Board shall also be sent to the Secretary.
> (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.[18]

The Provider Reimbursement Manual, Part 1 (CMS Pub. 15-1), further delineates requirements for a proper notice of reopening. Specifically, CMS Pub. 15-1 § 2931 entitled "Reopening and Correction" specifies in Subsection A, in relevant part, that: "[T]he term 'reopening' means an affirmative action taken by an intermediary . . . to reexamine or question the correctness of a determination or decision otherwise final. Further, § 2931.1 entitled "Time Limits for Reopening" specifies in Subsection A that: "An intermediary's initial determination on the amount of program payment contained in a notice of amount of program reimbursement, which is otherwise final, may be reopened by the intermediary within 3 years of the date of such notice."

Regarding the content of notices of reopening and correction, CMS Pub. 15-1 § 2932(A) specifies that: "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." Further, § 2932(A) states that, when a correction is made in a determination following the reopening, the notice of correction will bear the legend "Notice of Correction-Program Reimbursement."

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[18] 42 C.F.R. §§ 405.1885 and 405.1887 (2003).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case is a consolidated group appeal involving the 10 hospitals listed in Appendix I (Providers) which are all located in the State of Maine.[19] Appendix I also lists the various cost reporting periods at issue. These cost reporting periods begin in calendar years 1993, 1995, and 1997 to 2000.

For the cost reporting periods at issue, National Government Services (formerly Associated Hospital Service) (Intermediary) initially included non-Supplemental Security Income (SSI) Type 6 Medicare/Medicaid dual-eligible days ("non-SSI Type 6 days")[20] in the Medicaid fraction when calculating the Providers' DSH adjustment payment.

The Intermediary subsequently determined that it was incorrect to include the non-SSI Type 6 days in the DSH adjustment, and reopened the Providers' cost reports to disallow these days and recalculate the DSH payments. The Providers disagreed with the Intermediary recalculations of the DSH adjustments and timely filed a group appeal with the Board, which met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-1841.

The Providers were represented by William H. Stiles, Esq. of Verrill Dana, LLP. The Intermediary was represented by James R. Grimes, Esq. of the BlueCross BlueShield Association.

PARTIES' CONTENTIONS:

The Providers contend that the statute contemplates that the non-SSI Type 6 days at issue should be included in the DSH calculation provided that such days are not counted twice.[21] Failure to include these days in either the Medicare or Medicaid fraction would neglect counting a group of low income patient days in the DSH calculation. In the event the Board finds to the contrary, the Providers assert that PM No. A-99-62 applies to these cases and allows some of the Providers to be held harmless for inclusion of non-Medicaid days in the DSH calculation.[22] This is especially true considering that the days at issue are readily verifiable Medicaid-eligible days which were not counted in the numerator of either fraction of the DSH calculation.

Next, the Providers state that the overpayment should be waived under 42 U.S.C. § 1395gg(b)(1) because they were "without fault" with respect to the alleged overpayment.[23] The Providers reasonably believed that the payment was correct, considering that they had made full disclosure of all material facts and fully vetted the issue with the Intermediary. Indeed, the Intermediary created and disseminated written instructions to all Maine hospitals

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[19] Based on the common issues of law and facts in each case, and for administrative efficiency, this decision consolidates the following case numbers: 09-0480G, 09-0383G, 09-0491G, 09-0487G, 07-2217G, and 072291G

[20] *See* Consolidated Group Post Hearing Brief at 10-11; Transcript (Tr.) at 40-42.

[21] Providers Consolidated Group Final Position Paper (Providers Final Position Paper) at 19; Tr. at 11-12.

[22] Providers Final Position Paper at 33 -34; Tr. at 16-17.

[23] Providers Final Position Paper at 29-32; Tr. at 12-15.

to include non-SSI Type 6 days in the DSH calculations when filing their cost reports, and the Intermediary continued to include the days in the DSH calculation for 6 years.[24] Hence, the Providers should be found "without fault" and liability for the alleged overpayment should be waived.

Finally, the Providers contend that the Intermediary's reopening of its determinations was improper. First, the Providers note that, for some of the cost reports at issue, the determinations were based on a fully executed administrative resolution ("AR").[25] Considering that an AR represents the parties' unequivocal intent to settle all of the issues, the Intermediary should be prohibited from reopening something that it had agreed to settle.[26]

More importantly, the Providers assert that the Intermediary's notices of reopening were invalid because the Intermediary failed to issue the proper notices within the 3 year period.[27] Specifically, while the Intermediary issued a series of letters in 2003 and 2004 that purport to reopen the cost reports at issue, these letters do not satisfy the regulatory or manual requirements as the letters did not specify the reason for the reopening nor give the Providers an opportunity to comment or submit evidence in rebuttal. Moreover, since the Intermediary had instructed the Providers to include the days as part of the DSH calculation, the only type of reopening that applies is a mandatory one, which under 42 C.F.R. § 405.1885(b) requires CMS to notify the Intermediary that its determination is inconsistent with the applicable law and policies, and explicitly directs the Intermediary to reopen and revise the determination. The Providers contend this was not done in these cases.

In response, the Intermediary acknowledges that it made an error in including the non-SSI Type 6 days when calculating the Providers' DSH payments.[28] A plain reading of the DSH statute and regulations states that the Medicaid fraction consists of the number of patient days for patients eligible for medical assistance under a State Medicaid plan but who are not entitled to benefits under Medicare Part A. In these cases, the Type 6 days represent patients with crossover Medicare/Medicaid benefits and who, therefore, are entitled to Medicare Part A.[29] Since the Type 6 days represent patients who are entitled to Medicare Part A, a plain reading of the statute excludes these days from the Medicaid proxy.[30] Prior Board and Administrator decisions have upheld the plain reading of the DSH statute and regulation.[31] The Intermediary asserts that despite the error, the Providers are responsible for knowing and following Medicare statutes and regulations and, therefore, should not be held harmless for the overpayment of the DSH adjustment.[32]

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[24] Providers Final Position Paper at 31; Providers Exhibit P-15. *See also* Tr. at 63-64, 70-72, 81-83, 91-94.
[25] Providers Final Position Paper at 25; Providers Exhibit P-20; Tr. at 122-129.
[26] Tr. at 18.
[27] Providers Final Position Paper at 28-29; Tr. at 17-18.
[28] Intermediary Final-Consolidated Position Paper (Intermediary Final Position Paper) at 5; Tr. at 29.
[29] Intermediary Final Position Paper at 3-4.
[30] *Id.* ; Tr. at 26 -27.
[31] Intermediary Final Position Paper at 4 (citing to *Edgewater Med. Ctr. vs. Blue Cross and Blue Shield Ass'n* (*"Edgewater"*), PRRB Dec. Nos. 2000-D44 & D45 (April 7, 2000), *aff'd* CMS Administrator (June 6, 2000)). *See also* Tr. at 25.
[32] Intermediary Final Position Paper at 8- 9.

The Intermediary also asserts that the hold harmless provision addressed in PM No. A-99-62 does not apply to these cases. This is because the memorandum applies only to certain states in which State program days were inadvertently commingled with allowable Medicaid days.[33] However, Maine was not one of those states that included these non-allowable State program days in their Medicaid lists.

The Intermediary also advises that the cost reports at issue were properly reopened pursuant to the regulations and CMS manual instructions.[34] Specifically, the Intermediary issued the reopening notices commencing June 2003, after being directed to do so by CMS and within 3 years of the NPR date. The notices indicate the reason for the reopening was to review the DSH calculation. Finally, considering the numerous meetings conducted between the Providers, Intermediary and CMS for two and a half years following the issuance of the reopening notices, the Intermediary maintains that the Provider had ample opportunity to comment, object and submit additional evidence in response to the notice.

The Intermediary acknowledged that some of the cost reporting years were settled by an AR.[35] However, the Intermediary contends that the mere fact that there is an AR does not void the reopening provisions of the CMS manuals. In rare instances, as in these cases, an AR may violate a law, ruling or policy that is binding on the Intermediary and, once discovered, such errors must be corrected. Upon signing of the AR, a revised NPR is issued, which gives the Provider appeal rights to request a hearing before the Board.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered the Medicare law and guidelines, the parties' contentions and evidence submitted. Set forth below are the Board's findings and conclusions.

The Providers assert that the DSH statute and regulation intend the non-SSI Type 6 days be included in the numerator of either the Medicaid or Medicare factor of the DSH calculation. The Board finds the Providers' assertion unsupported by the plain reading of the DSH statute and regulation. The days at issue, non-SSI Type 6, referred to as "dual eligible" days by the parties,[36] represent days for patients eligible for Medicaid and entitled to Medicare Part A. As reflected in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b)(4) and consistent with prior Board decisions,[37] dual eligible days are not included in the numerator of either the Medicare or Medicaid fraction for the DSH calculation.

Next, the Providers contend that they should be held harmless for the DSH overpayment under PM No. A-99-62. The Board finds PM A-99-62 does not apply to the dual eligible days at issue. As delineated in the memorandum, the hold harmless provision applies only to the following types of days: general assistance, State only health program, charity care, Medicaid DSH and/or waiver or demonstration population days. Also, as explained in a

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[33] Intermediary Final Position Paper at 10. *See also* Intermediary Exhibit I-15.
[34] Intermediary Final Position Paper at 7-8.
[35] Intermediary's Post Hearing Summary at 3-4.
[36] Providers Final Position Paper at 3; Intermediary Final Position Paper at 3.
[37] *Edgewater supra* note 31.

letter dated May 6, 2005 from the CMS Administrator to Senator Snow, "PM A-99-62 did not address dual-eligible days."[38] Although not binding on the Board, interpretative rules and general statements of policy by the agency are entitled to great weight.[39] It is beyond the Board's authority to expand the hold harmless provision of PM A-99-62 to include the dual eligible days at issue. Consequently, the Providers' request is denied.

The Providers further assert that, pursuant to 42 C.F.R. § 1395gg, they should be held "without fault" for the overpayment as they reasonably relied on the erroneous advice of the Intermediary to include the non-SSI Type 6 days in the DSH calculation. The Board however notes this statutory waiver provision pertains only to overpayments of individual claims and not aggregate payments. The Administrator in *Athens-Limestone Hospital v. BC/BS of Alabama*[40] included the following quote from a 1998 proposed rule to explain the statutory basis for CMS' policy of not applying the "without fault" provision to aggregate overpayment issues;

> 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.
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> 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.
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> Thus, the without fault provisions of this proposed rule would not apply to overpayments resulting from aggregate payment issues, such as cost report errors.[41]

The overpayments at issue do not involve individual claims, and instead pertain to aggregate payments related to DSH adjustments. Consequently, the waiver provision under 42 U.S.C.

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[38] Providers Exhibit P-16.
[39] 42 C.F.R. § 405.1867.
[40] *Athens-Limestone Hospital v. BC/BS of Alabama,* CMS Administrator Decision (Aug. 16, 1999) (modifying PRRB Dec. No. 99-D51). *See* Intermediary Exhibit I-14.
[41] *Id.* at 4-5 (quoting 63 Fed. Reg. 14506, 14510 (Mar. 25, 1998)).

§ 1395gg does not apply in this case, and the Providers request for relief under the statute is denied.

Finally, the Providers' assert that the overpayment should be waived because the Intermediary failed to follow the mandatory reopening provisions under 42 C.F.R. § 405.1885(b), and that the purported notices of reopening issued between 2003 and 2004 did not meet the regulatory requirements under 42 C.F.R. § 405.1887.

The reopening provisions under 42 C.F.R. § 405.1885 allow for either a discretionary or mandatory reopening process. The mandatory reopening provisions are addressed in 42 C.F.R. § 405.1885(b)(i), which apply when an intermediary's determination is inconsistent with "the applicable law, regulations, CMS ruling, or CMS general instructions." The facts demonstrate that the mandatory reopening provision under 42 C.F.R. § 405.1885(b) apply to these cases. Specifically, the Intermediary acknowledged that notices of reopening were issued in order to correct the DSH payment calculations consistent with the applicable statutory and regulatory provisions.[42] Similarly, the CMS Administrator's May 6, 2005 letter to Senator Snowe stated that "the cost reports must be reopened and a DSH payment adjustment be made in order to reflect consistent application of the DSH dual-eligible days calculation."[43]

For a mandatory reopening under 42 C.F.R. § 405.1885(b)(1), CMS must provide notice to the intermediary that the determination is inconsistent with the applicable law, regulations or rulings *and* "explicitly direct[] the intermediary to reopen and revise the intermediary determination." Pursuant to §§ 405.1885(a) and (e), the mandatory reopening must be done within the 3-year reopening period.[44] This regulatory structure reflects the Medicare program's balance between the need to pay claims correctly and administrative finality.[45]

The facts in these appeals indicate the regulatory requirements for a mandatory reopening were not satisfied. Specifically, there is no evidence to support that CMS sent a notice to the Intermediary stating the determinations were incorrect and that they were to be re-opened. While the record contains the CMS Administrator's letter dated May 6, 2005 stating that the cost reports must be reopened, the letter was issued and addressed to Senator Snowe rather than the Intermediary. Indeed, the Intermediary acknowledged that there is no documentation from CMS specifically directing the Intermediary to reopen the determinations.[46] Absent CMS instructions explicitly directing the Intermediary to reopen the determinations, the Board finds the regulatory provision of 42 C.F.R. § 405.1885(b) not satisfied.

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[42] Intermediary Final Position Paper at 8; Tr. at 30-31.
[43] Providers Exhibit P-16 at 2.
[44] The Board recognizes that 42 C.F.R. § 405.1885(e) allows an Intermediary to reopen an NPR beyond 3 years if "the determination or decision [*i.e.*,, NPR] is procured by fraud or similar fault by any party to the determination or decision." However, the Intermediary has not made any allegation or presented any evidence to the Board consistent with its burden of proof under this regulation to suggest that there was fraud or fault similar to fraud.
[45] *See* CMS Pub. 15-1 § 2930.
[46] Tr. at 152-53.

As to the notices of reopening issued between June 3, 2003 and September 27, 2004,[47] the Intermediary asserts that these notices of reopening were proper and were timely issued.[48] The Board finds otherwise. A review of these notices reveals that the cost report is reopened for the following purpose: "[T]o review and correct the disproportionate share hospital (DSH) payment calculation in accordance with section 1886(d)(5)(F) of the Social Security Act and 42 CFR 412.106." As required by 42 C.F.R. §405.1887 and program instructions CMS Pub. 15-1 § 2932(A), a notice of reopening shall be in writing and 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. While these written notices indicate that the reopening was to correct the DSH payment calculation, they lack a complete explanation as to the circumstances surrounding the purported reopening, *i.e.*, the exclusion of the Type 6 eligible days from the DSH calculation. Moreover, the written notices do 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 Intermediary acknowledged that, although the notices neither contained the circumstances surrounding the reopening, nor afforded the Providers the opportunity to submit evidence in rebuttal, the requisite information was furnished to the Providers before and after the issuances of the notices. For example, in the letter dated May 19, 2003, and before the issuance of the notices of reopening, the Intermediary advised the Providers that dual eligible days are excluded from the DSH calculation.[49] The Board notes that, while the May 19, 2003 letter makes reference to "... cost reports which are *currently* being processed for settlement, as well as those which many of you [Providers] are *currently* preparing,"[50] there is no mention that the Intermediary intended to reopen any closed cost reports to adjust the DSH payment calculation.

The Intermediary also advised that, subsequent to the issuance of notices of reopening, there were numerous meetings with the parties, which afforded the Providers ample opportunity to comment, object, and rebut the Intermediary's review of the DSH payment calculation. However, the Intermediary's reliance on its actions taken before and after the issuance of the purported written notices of reopening does not satisfy the requirements of 42 C.F.R. § 405.1887 or the program instructions at CMS Pub. 15-1 § 2932(A). The regulations and program instructions explicitly 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. The Board finds the purported written notices of reopening lack the requisite information as required by the regulations and, therefore, do not constitute proper notices of reopening.

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[47] While several of the notices were not submitted in response to the Board's request, the record nevertheless contains a sufficient sample representing the notices of reopening issued by the Intermediary. *See* Providers Exhibit P-21. *See also* letter from NGS Audit & Reimbursement to the Board dated March 15, 2012. ("Intermediary letter dated March 15, 2012").

[48] Intermediary Position Paper at 7-8.

[49] Intermediary Position Paper at 8; Intermediary Exhibit I-10.

[50] Intermediary Exhibit I-10 (emphasis added.)

The record also contains written notices with the legend "Medicare Cost Report Reopening-DSH Payment." These notices were issued by the Intermediary following the May 6, 2005 CMS Administrator letter.[51] The Intermediary explained that the purpose of these letters was to inform the Providers that the previously issued notices of reopening were being effectuated and to give the Providers an opportunity to submit additional documentation to help offset the recoupment of monies associated with the re-calculation of the DSH adjustment. [52]

The Board finds the Intermediary's notices issued following the Administrator letter of May 6, 2005 satisfy the regulation and program instructions for notices of reopening. This is because the notices include complete explanation for the reopening (*i.e.* to exclude all dual eligible (Type 6) patient days from the DSH calculation) and afforded the Providers the opportunity to comment or submit additional evidence in a form of rebuttal. Thus, the Board finds that, unlike the purported notices issued during the period June 3, 2003 through September 27, 2004, these post-May 6, 2005 notices "perfected" the notice of reopening. While the post-May 6, 2005 notices contain the requisite information, the Board must determine whether these "perfected" notices were timely and issued within 3 years of an otherwise final NPR.

The Board finds that the Intermediary issued timely notices of reopening only for the following Providers and the specified cost reporting periods:[53]

A **Provider/ Provider No.**	B **Cost Reporting Period Ended**	C **Date of Previous NPR**[54]	D **Date of "Perfected" Notice of Reopening: Medicare Cost Report Reopening-DSH Payment**[55]	E **Years from NPR to Reopening**
Eastern Maine Medical Center 20-0033	09/30/1995	12/05/2002	06/20/2005	2 ½
Mercy Hospital 20-0008	12/31/1998	12/30/2002	06/20/2005	2½
MaineGeneral Medical Center 20-0039	06/30/2000	09/30/2002	06/20/2005	2¾

Based on the proper and timely notices of reopening for these 3 Providers and the specified cost reporting periods, the Board finds the Intermediary's reopening adjustment excluding the Type 6 Medicaid dual eligible days from the DSH payment calculation was proper.[56]

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[51] Provider Exhibit P-21; letter from William Stiles, Esq. to the Board dated November 2, 2011 ("Provider letter November 2, 2011"); Intermediary letter dated March 15, 2012.

[52] Intermediary letter dated March 15, 2012.

[53] *See* Appendix II.

[54] These dates were obtained from the Schedule of Providers. *See* Providers Exhibits P-3 through P-8.

[55] This column refers to the notices of reopening issued by the Intermediary subsequent to the letter dated May 6, 2005 from the CMS Administrator to Senator Olympia Snowe. *See* Provider's Exhibit P-16.

[56] The Board recognizes that there was a settlement agreement for Eastern Maine Medical Center for the cost reporting period ending September 30, 1995; however, the settlement agreement is not relevant to this appeal as

The Board finds that, for the following two Providers and the specified cost reporting periods, a notice of reopening was unnecessary because the adjustment was made in the original NPR:

- Maine Medical Center for cost reporting period September 30, 2000, and
- MaineGeneral Medical Center for cost reporting period June 30, 1999.

The Board finds the Intermediary's adjustments were proper for these two Providers in the above-specified cost reporting periods because consistent with the law and previous Board decisions, Type 6 dual eligible days are not included in either numerator of the DSH calculation.

The Board also finds that for the following Providers and the specified cost reporting periods the "perfected" notices of reopening were untimely because they were issued more than 3 years from the date of the NPR:

A **Provider/ Provider No.**	B **Cost Reporting Period Ended**	C **Date of Previous NPR**	D **Date of Notice of Reopening: Medicare Cost Report Reopening-DSH Payment**	E **Years from NPR to Reopening**
Maine Medical Center 20-0009	9/30/1993 9/30/1994 9/30/1999	12/17/2001 1/23/2001 9/20/2002	6/20/2005 10/19/2005 3/5/2007	3½ 3¾ 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 5¾ 3 1/3 5
Mid-Coast Hospital 20-0021	9/30/1993 9/30/1997	10/25/2000 9/26/2000	6/20/2005 10/19/2005	4¾ 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- 3¾ 3¾
Brighton Medical Center 20-0017	8/31/1991 9/30/1995	12/07/2000 5/17/2002	06/20/2005 10/19/2005	4½ 3½
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	06/20/2005	4¾
Southern Maine Medical Center 20-0019	4/30/1998 4/30/1999	7/20/2001 8/31/2001	6/20/2005 10/20/2005	4¾ 3 5/6
Kennebec Valley Medical	6/30/1993	10/25/2000	6/20/2005	4 2/3

the terms of the settlement agreement were fulfilled with the issuance of the revised NPR within the specified time period. *See* Provider Exhibit P-15 at 1-9.

A	B	C	D	E
Provider/ Provider No.	**Cost Reporting Period Ended**	**Date of Previous NPR**	**Date of Notice of Reopening: Medicare Cost Report Reopening-DSH Payment**	**Years from NPR to Reopening**
Center 20-0015	6/30/1997	9/26/2000	10/19/2005	5

Further, with respect to Maine Medical Center for the cost reporting periods ending September 30, 1997 and September 30, 1998 (FYs 1997 and 1998), the Intermediary acknowledged that "perfected" notices were not issued to this provider because it had previously submitted the necessary documentation for FYs 1997 and 1998.[57] The only notices of reopening for these FYs were issued on June 9, 2003.[58] As previously explained, the Board finds these notices of reopening lack the requisite information, and therefore do not constitute a proper notice of reopening. Consequently, the Intermediary did not satisfy its burden in showing that a proper and timely notice of reopening was issued to Maine Medical Center for FYs 1997 and 1998.

DECISION AND ORDER:

The Board finds the Intermediary's reopening adjustments excluding the non-SSI Type 6 Medicaid dual eligible days from the DSH payment calculations were proper for the following Providers and cost reporting periods:

Provider/ Provider No.	Cost Reporting Period Ended
Eastern Maine Medical Center 20-0033	09/30/1995
Mercy Hospital 20-0008	12/31/1998
MaineGeneral Medical Center 20-0039	06/30/2000
Maine Medical Center 20-0009	9/30/2000
MaineGeneral Medical Center 20-0039	6/30/1999

The Board finds the Intermediary's reopening adjustments excluding the Type 6 Medicaid dual eligible days from the DSH payment calculations were improper for the following Providers and cost reporting periods ending:

Provider/ Provider No.	Cost Reporting Period Ended
Maine Medical Center	9/30/1993

[57] Intermediary letter dated March 15, 2012.
[58] *Id.*

Provider/ Provider No.	Cost Reporting Period Ended
20-0009	9/30/1994 9/30/1997 9/30/1998 9/30/1999
Central Maine Medical Center 20-0024	6/30/1993 6/30/1995 6/30/1996 6/30/1997 6/30/1998 6/30/1999
Mid-Coast Hospital 20-0021	9/30/1993 9/30/1997
Eastern Maine Medical Center 20-0033	9/30/1995 9/27/1997 9/26/1998 9/26/1999
Brighton Medical Center 20-0017	8/31/1991 9/30/1995
Mercy Hospital 20-0008	12/31/1997
Northern Maine Medical Center 20-0052	09/30/1997
Southern Maine Medical Center 20-0019	4/30/1998 4/30/1999
Kennebec Valley Medical Center 20-0015	6/30/1993 6/30/1997

The Intermediary's adjustments are denied in part and affirmed in part.

BOARD MEMBERS PARTICIPATING:

Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
Michael W. Harty (recused)

FOR THE BOARD:

K. E. Braganza

Keith E. Braganza,
Board Member

DATE: MAR 29 2013

APPENDIX I

Provider/ Provider No.	Cost Reporting Period Ended
Maine Medical Center 20-0009	9/30/1993 9/30/1994 9/30/1997 9/30/1998 9/30/1999 9/30/2000
Central Maine Medical Center 20-0024	6/30/1993 6/30/1995 6/30/1996 6/30/1997 6/30/1998 6/30/1999
Mid-Coast Hospital 20-0021	9/30/1993 9/30/1997
Eastern Maine Medical Center 20-0033	9/30/1995 9/27/1997 9/26/1998 9/26/1999
Brighton Medical Center 20-0017	8/31/1991 9/30/1995
Mercy Hospital 20-0008	12/31/1997 12/31/1998
Northern Maine Medical Center 20-0052	09/30/1997
Southern Maine Medical Center 20-0019	4/30/1998 4/30/1999
MaineGeneral Medical Center 20-0039	6/30/1999 6/30/2000
Kennebec Valley Medical Center 20-0015	6/30/1993 6/30/1997

APPENDIX II

A Provider/ Provider No.	B Cost Reporting Period Ended	C Date of Previous NPR[59]	D Date of Original Medicare Cost Report Reopening Issued by MAC	E Date of Notice of Reopening: Medicare Cost Report Reopening-DSH Payment[60]
Maine Medical Center 20-0009	9/30/1993	12/17/2001[61]	Not Submitted	6/20/2005[71]
	9/30/1994	1/23/2001[62]	Not Submitted	10/19/2005[72]
	9/30/1997	9/28/2000[63]	6/9/2003[67]	Not Submitted[73]
	9/30/1998	5/13/2003[64]	6/9/2003[68]	Not Submitted[74]
	9/30/1999	9/30/2002[65]	6/9/2003[69]	3/5/2007[75]
	9/30/2000	9/29/2004[66]	Not Reopened[70]	Not applicable
Central Maine Medical Center 20-0024	6/30/1993	01/28/2002[76]	Not Submitted	6/20/2005[85]
	6/30/1995	6/28/2002[77]	9/27/2004[82]	2/23/2006[86]
	6/30/1996	9/29/2000[78]	9/27/2004[83]	6/13/2006[87]
	6/30/1997	10/16/2003[79]	Not Submitted	11/13/2006[88]
	6/30/1998	10/13/2003[80]	Not Submitted	2/12/2007[89]
	6/30/1999	08/16/2002[81]	6/9/2003[84]	8/2/2007[90]

[59] These dates were obtained from the Schedule of Providers. *See* Providers Exhibits P-3 through P-8.
[60] This column refers to the notices of reopening issued by the Intermediary subsequent to the letter dated May 6, 2005 from the CMS Administrator to Senator Olympia Snow. *See* Providers Exhibit P-16.
[61] Providers Exhibit P3, Tab 1A.
[62] Providers Exhibit P3, Tab 5A.
[63] Providers Exhibit P5, Tab 4A.
[64] Providers Exhibit P6, Tab 4A.
[65] Provider letter dated November 2, 2011, Tab A.
[66]Providers Exhibit P-8, Tab 1A.
[67] Provider letter dated November 2, 2011, Tab C.
[68] *Id.* at Tab D.
[69] Intermediary letter dated March 15, 2012.
[70] For this cost reporting period, a reopening was unnecessary as the DSH adjustment was made in the original NPR. *See* Provider Exhibit P-8, Tab 1A.
[71] Providers Exhibit P-21.
[72] *Id.*
[73] The Intermediary acknowledged that a notice for cost reporting period ended 9/30/1997was not issued because the Provider had previously submitted the necessary documentation. *See* Intermediary letter dated March 15, 2012.
[74] *Id.*
[75] *Id.*
[76] Providers Exhibit P-3, Tab 2A.
[77] Providers Exhibit P-4, Tab 2A.
[78] Providers letter dated November 2, 2011 Tab B.
[79] Providers Exhibit P-5, Tab 2A.
[80] Providers Exhibit P-6, Tab 2A.
[81] Email correspondence from the Providers' representative Renae LeFay to the Board dated November 29, 2011 (attaching NPR dated Aug. 16, 2002).
[82] Providers letter November 2, 2011, Tab G.
[83] Intermediary letter dated March 15, 2012.
[84] Providers letter November 2, 2011, Tab G.
[85] *Id.* at Tab F.
[86] Intermediary letter dated March 15, 2012.

A	B	C	D	E
Mid-Coast Hospital 20-0021	9/30/1993 9/30/1997	10/25/2000[91] 9/26/2000[92]	Not Submitted Not submitted	6/20/2005[93] 10/19/2005[94]
Eastern Maine Medical Center 20-0033	9/30/1995 9/27/1997 9/26/1998 9/26/1999	12/05/2002[95] 11/30/2001[96] 6/14/2002[97] 9/30/2002[98]	Not Submitted 9/27/2004[99] Not Submitted Not Submitted	06/20/2005[100] 10/20/2005[101] 02/23/2006[102] 06/13/2006[103]
Brighton Medical Center 20-0017	8/31/1991 9/30/1995	12/07/2000[104] 5/17/2002[105]	Not Submitted Not Submitted	06/20/2005[106] 10/19/2005[107]
Mercy Hospital 20-0008	12/31/1997 12/31/1998	9/28/2000[108] 12/30/2002[109]	Not Submitted Not Submitted	10/19/2005[110] 06/20/2005[111]
Northern Maine Medical Center 20-0052	09/30/1997	9/19/2000[112]	Not Submitted	06/20/2005[113]
Southern Maine Medical Center 20-0019	4/30/1998 4/30/1999	7/20/2001[114] 8/31/2001[115]	Not Submitted Not Submitted	6/20/2005[116] 10/20/2005[117]
Maine General Medical Center 20-0039	6/30/1999 6/30/2000	9/28/2001[118] 9/30/2002[119]	Not reopened.[120] Not submitted	Not applicable 06/20/2005[121]

[87] Providers Exhibit P-21.
[88] *Id.*
[89] *Id.*
[90] Intermediary letter dated March 15, 2012.
[91] Providers Exhibit P-3, Tab 3A.
[92] Providers Exhibit P-5, Tab 6A.
[93] Providers Exhibit P-21.
[94] *Id.*
[95] Providers Exhibit P-4, Tab 1A.
[96] Providers Exhibit P-5, Tab 1A.
[97] Providers Exhibit P-6, Tab 1A.
[98] Providers Exhibit P-7, Tab 2A.
[99] Providers Exhibit P-21.
[100] Providers letter dated November 2, 2011, Tab H.
[101] Intermediary letter dated March 15, 2012.
[102] Providers Exhibit, P-21.
[103] *Id.*
[104] Providers Exhibit P-4, Tab 4A.
[105] Providers Exhibit P-4, Tab 3A.
[106] Providers Exhibit P-21.
[107] *Id.*
[108] Providers Exhibit P-5, Tab 7A.
[109] Providers Exhibit P-6, Tab 5A.
[110] Providers Exhibit P-21.
[111] Providers letter dated November 2, 2011, Tab J.
[112] Providers Exhibit P-5, Tab 8A.
[113] Providers Exhibit P-21.
[114] Providers Exhibit P-6, Tab 3A.
[115] Providers Exhibit P-7, Tab 4A.
[116] Providers Exhibit P-21.
[117] *Id.*
[118] Providers Exhibit P-7, Tab 3A.
[119] Providers Exhibit P-8, Tab 2A.

A	B	C	D	E
Kennebec Valley Medical Center 20-0015	6/30/1993 6/30/1997	10/25/2000[122] 9/26/2000[123]	Not submitted. Not submitted.	6/20/2005[124] 10/19/2005[125]

[120] For this cost reporting period, a reopening was unnecessary as the DSH adjustment was made in the original NPR. *See* Providers Exhibit P-7, Tab 3A.
[121] Providers Exhibit P-21.
[122] Providers Exhibit P-3, Tab 4A.
[123] Providers Exhibit P-5, Tab 6A.
[124] Providers Exhibit P-21.
[125] Providers Exhibit P-21.