PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D26

PROVIDER –
University of Pittsburgh Medical Center (UPMC) (formerly Mercy Hospital of Pittsburgh)

Provider No.: 39-0028

vs.

INTERMEDIARY –
Highmark Medicare Services (formerly Blue Cross of Western Pennsylvania)/ Blue Cross and Blue Shield Association

DATE OF HEARING -
December 14, 2012

Cost Reporting Period Ended -
June 30, 1985

CASE NO.: 99-1340R

INDEX

ISSUE:

Whether pursuant to 42 C.F.R. § 405.378[1], or otherwise, and in view of the Intermediary's ten year delay in fully implementing PRRB Dec. No. 1998-D26 for PRRB Case No. 91-2673M, interest is due on the underpayments which were otherwise at issue in PRRB Case No. 99-1340.

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 Act[2] to provide health insurance to eligible individuals. The Centers for Medicare and 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[3] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[4]

Providers are required to submit cost reports annually, with reporting periods based on each provider's accounting period. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[5] Each 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").[6] 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.[7]

42 U.S.C § 1395g(d) provides for the accrual of interest on the balance of overpayment or underpayment specified in a "final determination" as follows:

> Whenever a *final determination* is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) *within 30 days of the date of the determination*, interest shall accrue on the balance of such excess or deficit not paid or offset. . . [8]

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[1] Because the remand order requires that the Board's decision be based upon pre-1991 42 C.F.R. § 405.378, this decision will reference 42 C.F.R. § 405.376 (1990) as the previously codified regulation.
[2] The Act was codified at 42 U.S.C. Ch. 7, Subch. XVIII.
[3] FIs and MACs are hereinafter referred to as intermediaries.
[4] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[5] *See* 42 C.F.R. § 413.20.
[6] *See* 42 C.F.R. § 405.1803.
[7] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 - 405.1837.
[8] (Emphasis added.)

42 C.F.R. § 405.376 (1990) provides the rules under which interest will be paid on underpayments to providers. The regulation states:

> (a) *Basis and purpose*. This section, which implements sections 1815(d) and 1833(j) of the Social Security Act, and authority granted under the Federal Claims Collection Act, provides for the charging and payment of interest on overpayments and underpayments to Medicare providers, suppliers, and physicians and other practitioners.
> (b) *Basic Rules*. (1) HCFA will charge interest on overpayments, and pay interest on underpayments, to providers and suppliers of services (including physicians and other practitioners), except as specified in paragraphs (f) and (h) of this section.
> (2) Interest will accrue from the date of the final determination as defined in paragraph (c) of this section, and will either be charged on the overpayment balance or paid on the underpayment balance for each 30-day period that payment is delayed. (Periods of less than 30 days will be treated as a full 30-day period, and the 30-day interest charge will be applied to any balance.)
> (c) *Definition of final determination.* (1) For purposes of this section, a final determination is deemed to occur—
> (i) Upon the issuance of both a Notice of Amount of Program Reimbursement (NPR), as discussed in § 405.1803, and either (A) a written demand for payment is made; or (B) a written determination of an underpayment by the intermediary after a cost report is filed;
> (ii) When an NPR is not utilized as a notice of determination (that is, primarily under Part B), upon the issuance of either (A) a written determination that an overpayment exists and a written demand for payment, or (B) a written determination of an underpayment. . . .

42 C.F.R. § 405.1803 discusses the requirements for an NPR after receipt of a cost report. Subsection (a) provides that the written notice must reflect "the intermediary's determination of the total amount of reimbursement due the provider" and must also "relate this determination to the provider's claimed total program reimbursement due to the provider for this period." There is no explicit reference to underpayments; however, subsection (c) explicitly provides for the notice to be used as the basis for Intermediary recoupment of overpayments.

The Provider Reimbursement Manual, CMS Pub. No. 15, Part I ("PRM 15-1"), § 2906 discusses the requirements for an NPR. In particular, § 2906(C) states: "Inform the provider (hospital) or other entity as to applicable interest charges/payments on overpayment and underpayment, in accordance with existing policy and instructions."

This case involves the propriety of assessing interest where the intermediary does not pay a provider within 30 days of a Board decision.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The University of Pittsburg Medical Center (formerly known as Mercy Hospital of Pittsburgh and hereinafter "UPMC" or "Provider") is a not-for-profit, acute care, teaching hospital located in Pittsburgh, Pennsylvania. Blue Cross Blue Shield of Western Pennsylvania (d/b/a Highmark Medicare Services and hereinafter "Intermediary") completed a reaudit of the Provider's GME base year, pursuant to the requirements of the Omnibus Budget Reconciliation Act of 1986,[9] and issued an adjusted "average per resident amount" ("APRA") on February 26, 1991.

The Provider appealed the APRA and obtained a favorable decision from the Board on January 28, 1998 (PRRB Dec. No. 98-D26) ("Board's *Mercy I* decision"). On April 6, 1998, the Administrator declined to review the Board's decision.[10]

Shortly thereafter, on July 22, 1998, the Intermediary issued a "Notice of Intent to Reopen" including revised GME ("RGME") adjustments to the Provider's cost report based upon the Intermediary's interpretation of the Board's decision.[11] On September 9, 1998, after it had recalculated the APRA, the Intermediary and sent a Notice of Revised Average per Resident Amount.[12] On September 21, 1998, the Intermediary paid the Provider based upon the revised APRA.[13]

However, on February 23, 1999, the Provider challenged the Intermediary's implementation of the Board's *Mercy I* decision and filed a second appeal with the Board (Case No. 99-1340) ("*Mercy II*").[14] Subsequent to the filing of *Mercy II*, the Intermediary notified the Provider that it could not recalculate its hospital specific rate ("HSR") for the same time period based on a lack of documentation justifying the adjustment.[15] The Provider again appealed and requested consolidation of this issue with the APRA issue in *Mercy II*.[16]

On January 28, 2008, the Provider added to *Mercy II* the issue of whether it was entitled to interest under 42 C.F.R. § 405.378, citing the ten-year delay in the final implementation of the Board's original decision.[17] A hearing date was set for February 20, 2008, however, on February 8, 2008 the parties administratively resolved both the APRA and the HSR issues leaving the interest issue unresolved.[18]

On May 8, 2009, the Board issued PRRB Dec. No. 2009-D22 ("Board's *Mercy II* decision") finding that the Board's *Mercy I* decision was not a "final determination" of an underpayment for the purposes of the interest provisions. Rather, the Board concluded that, although it had identified specific amounts for reallocation in its *Mercy I* decision, the final determination of the

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[9] Pub. L. No. 99-272, 42 U.S.C. §1395 ww(h).
[10] *See* Provider Exhibit P-3.
[11] *See* Provider Exhibit P-4.
[12] *See* Provider Exhibit P-5.
[13] *See* Provider Exhibit P-25.
[14] *See* Provider Exhibit P-10.
[15] *See* Provider Exhibit P-13.
[16] *See* Provider Exhibit P-14.
[17] *See* Provider Exhibit P-22.
[18] *See* Provider Exhibit P-24.

amount due could only be determined by the Intermediary via revisions to the cost report and issuing a revised NPR. Because the Intermediary paid the Provider within 30 days of issuing the revised NPR in 1998, the Board concluded that the statute's interest provision had never been triggered and the Provider was due no interest.

The Provider appealed the Board's *Mercy II* decision to the U.S. District Court for the District of Columbia ("D.C. District Court"). In the 2011 decision for *UPMC Mercy v. Sebelius* ("*UPMC Mercy*"),[19] the D.C. District Court found that an amendment to the applicable interest-payment regulation, 42 C.F.R. § 405.378, violated Administrative Procedures Act ("APA") requirements and granted summary judgment for the Provider. The D.C. District Court remanded the Board's *Mercy II* decision to the Secretary stating:

> Finally, the Court notes that vacatur is necessary here not because the result reached by the Board would be an impermissible construction of the *pre*-amendment regulation; the Court expresses no opinion as to that question. Rather, vacatur is necessary because the Board appeared to believe that the result it reached was *compelled* by text of the regulation as amended. ... Any future Board interpretations of the interest-payment regulation will [be] judged by the strength of the rationales offered by the Board at that time.[20]

The Provider was represented by Stephen P. Nash, Esq., of Patton Boggs, LLP. The Intermediary was represented by Bernard M. Talbert, Esq., of Blue Cross and Blue Shield Association.

The single issue before the Board is whether interest is due the Provider under 42 C.F.R. § 405.378. The estimated amount in dispute is in excess of $8,000,000.[21]

PROVIDER'S CONTENTIONS:

The Provider contends that the Board's *Mercy I* decision unambiguously required the Intermediary to reclassify specific amounts of physician compensation from operating cost centers, where they had originally been reported in the Provider's GME based year cost report, as GME costs. The Provider argues that the Intermediary had no justification for failing to fully implement these changes in 1998.[22]

The Provider believes that the Board's *Mercy I* decision was final upon issuance pursuant to 42 C.F.R. § 405.1871(b), and that it remained final as CMS declined to review the decision.[23] The Provider asserts that the Board's *Mercy I* decision was a "final determination" either under 42

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[19] 793 F. Supp. 2d 63 (D.D.C. 2011).
[20] *Id.* at 71-72 (emphasis in original).
[21] Provider's August 17, 2012 Final Position Paper at Tab A.
[22] Provider Exhibit P-1 at 44, 58-59, 77, 79, 80; Provider's Post Hearing Brief at 7-8 and citations therein; Tr. at 59-60, 65, 67-69, 73-74, 77-78, 80-81, 142-143. Provider Exhibits P-6, P-9.
[23] *See* Provider Exhibit P-3.

C.F.R. § 405.376(c)(1)(i) in that it followed an NPR and was a written determination of an underpayment, or under 42 C.F.R. § 405.376(c)(1)(ii) which does not require an NPR. As a final determination under 42 C.F.R. § 405.376(c)(1), the Provider believes interest must be paid on underpayment amounts not settled within 30 days of the Board's *Mercy I* decision. Specifically, it argues that it should be paid interest from September 1998 to February 2008.

The Provider argues courts have interpreted "final determination" to include a number of administrative determinations including a determination "made by the PRRB in an appeal of a fiscal intermediary's NPR"[24] and a determination "by the Secretary upon review of the PRRB's Decision."[25] The Provider contends that the D.C. District Court's holding and subsequent remand of this case in *UPMC Mercy* invalidated the language "is made" in the then existing regulation which, through the addition of that language, had "narrow[ed] the range of possible actors who can make a written determination [under Subsection (c)(1)(i) of the regulation] to one—the intermediary alone."[26] Consequently, as corrected by the Court, the interest regulation may comfortably be read to include Board decisions within the meaning of "final determination"[27] that triggers the imposition of interest if it is not timely and properly implemented. Further, the Provider argues that the courts have uniformly concluded that the statute at 42 U.S.C. §1395g(d) does not require the calculation of an amount of the underpayment to trigger interest, but merely a determination that the provider has been underpaid.[28]

The Provider stresses neither the interest statute or regulation requires a determination of a "sum certain" as a pre-condition to triggering the obligation to liquidate an underpayment within 30 days or be subject to interest. Instead, there need only be a "final determination" of an underpayment.[29]

The Provider rejects the Intermediary's interpretation of 42 C.F.R. § 405.376(c)(1) which would require a letter to trigger interest payments. The Provider believes this interpretation would place the regulation in conflict with the enabling statute. The Provider specifies this conflict as the statute requires payment within thirty days of a final determination while the Provider does not see a deadline for the Intermediary writing the letter triggering interest payments.

The Provider argues that the Intermediary has presented no testimonial or other record evidence to demonstrate that the computation or the underpayment amount could not have been completed within 30 days of the Board's *Mercy I* decision. The Provider asserts that the record evidence in

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[24] *National Med. Enterprise, Inc. v. Sullivan*, 960 F.2d. 866, 869 (9th Cir. 1992).
[25] *Id.*
[26] 793 F. Supp. 2d at 68.
[27] UPMC Mercy Post-Hearing Brief, at 10.
[28] *See United States v. Idaho Falls Assocs.*, 81 F. Supp. 2d 1033, 1041 (D. Idaho 1999).
[29] *Id.* (holding that "interest on overpayment due accrues from the date of a final determination that such overpayment has occurred"); *Cosgrove v. Sullivan*,783 F. Supp. 769, 778 (S.D.N.Y. 1991) (noting that " the court in *National Medical Enterprises* specifically rejected the Secretary's contention that 42 U.S.C. § 1395g(d) required a final determination of the amount of the underpayment owed for Part A services before interest could accrue. The Interest Statute 'merely requires a determination that there was a miscalculation; it does not require a recalculation as part of the final decision'"), *rev'd on other grounds*, 999 F.2d 630 (2nd Cir. 1993).

this case clearly establishes that the Provider did, and the Intermediary could have, completed the calculations within two days.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that, even though the remand requires the Board to use an earlier version of 42 C.F.R. § 405.378, it should have no effect on the Board's previous decision.[30] The Intermediary stresses that a Board decision issued under 42 C.F.R. § 405.1871 is not the same as an NPR addressed in 42 C.F.R. § 405.1803. Therefore, Intermediary contends interest calculations under 42 C.F.R. § 405.378(c)(1)(i) would not apply to a Board decision.[31] The Intermediary also maintains that a Board decision would not fit under the "catchall" of 42 C.F.R. § 405.378(c)(1)(ii) as an interest triggering event.

The Intermediary contends that the Board's *Mercy I* decision was complex to implement as highlighted by fact that it was an 84-page decision with subparts.[32] The Intermediary argues that "there was no easy job coming up with the payment" in the revised NPR that was issued by the Intermediary 6 months after the CMS Administrator declined to review the Board's *Mercy I* decision.[33] The Intermediary notes that the revised NPR was issued and payment made to the Provider 8 months after the Board's *Mercy I* decision and argues that any delay was, in part, caused by the Provider's request for the CMS Administrator's review of the Board *Mercy I* decision.[34] The Intermediary does not believe the 6-month time period to issue the revised NPRs from the 84-page Board decision for the first main settlement was unreasonable.

The Intermediary states that additional delay in payment is further attributable to the Provider. The Intermediary notes that, following the Board's *Mercy I* decision, the Provider filed a new appeal with the Board in February 1999, *i.e.*, *Mercy II*, to dispute the first APRA adjustments issued to implement *Mercy I* and this appeal was later consolidated with a second appeal that was filed in September 2000 to dispute the Provider's HSR. As a result, the *Mercy II* appeal languished until February 8, 2008 when the parties signed a partial administrative resolution on the APRA and HSR issues.[35] On January 28, 2008, just prior to the execution of the partial administrative resolution, the Provider added the interest issue related to the delay in implementing the Board's *Mercy I* decision as it relates to the APRA. The Intermediary argues that a significant part of the delay was caused by the Provider's pursuit of this second appeal and not simply caused by the Intermediary's delay in issuing a revised NPR and making payment as the Provider argues.

The Intermediary concludes that there is no regulatory basis to award interest. The Provider has no valid argument on interest flowing from the alleged untimely issuance of the first payment. Nothing wrong was done. As to the delay on the two initially unresolved issues, at best, the

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[30] Tr. at 75-76.
[31] Tr. at 77.
[32] Tr. at 81.
[33] Tr. at 82.
[34] Tr. at 79. *See* Provider Exhibit P-2 for letter from CMS indicating the Provider requested the Administrator review the PRRB decision.
[35] Intermediary's Position Paper on Remand at 8 (citing to Provider Exhibit P-24 (copy of partial administrative resolution)).

Provider has a marginal equity argument over which the Board has no legal basis to make an award.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the evidence, and the parties' arguments, consistent with the D.C. District Court's remand order and absent reliance on the post-1991 amended 42 C.F.R. § 405.378,[36] the Board majority has set forth below its findings and conclusions.

At the outset, the Board majority notes that a provider's right to interest on an underpayment that has not been paid with 30 days of the date of a "final determination" is derived from 42 U.S.C. § 1395g(d). This statutory provision is one of several in § 1395g that address how "payment to providers of services" is to be made (*e.g.*, interim payments). Further, this statutory provision is separate from those statutory provisions governing the "amount paid" for inpatient hospital services which is governed by 42 U.S.C. § 1395ww through the operation of 42 U.S.C. § 1395f.

The relevant portions of the enabling statute addressing Board jurisdiction[37] are limited to determinations made *on* the Medicare cost report. Specifically, 42 U.S.C. § 1395oo states in relevant part:

> (a) Any provider of service which has filed a required cost report within the time specified in regulations may obtain a hearing *with respect to such cost report* by a Provider Reimbursement Review Board. . .
>
> (d) . . . . The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary *with respect to a cost report* and to make any other revisions *on matters covered by such cost report* (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.[38]

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[36] Previously 42 C.F.R. § 405.376. The D.C. District Court in *UPMC Mercy* noted that UPMC initially challenged the regulation that was initially promulgated in the 1982 Final Rules but found that the Provider had both abandoned this challenge and conceded to the Secretary's arguments because the Provider had failed to address the question of the validity of the regulation's original promulgation in subsequent court filings notwithstanding the Secretary's arguments that the original promulgation was valid under the APA. *See UPMC Mercy*, F. Supp. 2d at 67-68. Thus, while the Court held the 1991 modification of the regulation which added the language "is made" in violation of the APA, the original regulation, with the noted preamble comments, remains valid and is the basis for the Board's findings in this matter.

[37] The Medicare reimbursement underlying the Provider's interest issue relates to the cost report and, as such, the provisions relating to 42 U.S.C. § 1395ww(b) or (d) (*i.e.*, TEFRA and IPPS respectively) are not applicable in this case.

[38] (Emphasis added.)

The Board majority finds that payment of interest pursuant to 42 U.S.C. § 1395g(d) does not impact the "amount paid" for hospital services because the assessment of interest whether for an overpayment or underpayment is not part of the Medicare cost report which determines the "amount paid" for hospital services. Accordingly, the Board majority finds that, pursuant to 42 U.S.C. § 1395oo(a),[39] it does not have jurisdiction over the assessment of interest whether for an overpayment or an underpayment.[40]

Assuming *arguendo* that the Board were to have jurisdiction, it would be bound by the processes of 42 C.F.R. § 405.1803(d)(2) (2008) and 42 C.F.R. § 405.376(c)(1)(i) (1990) and would find that no interest payment is due the Provider. Specifically, the Board would find that, as relevant to the appeal, the "final determination" defined in 42 C.F.R. § 405.376(c)(1) (1990) encompasses only a determination made by the fiscal intermediary.[41]

The statute and regulations give the Board the "full power and authority to make rules and establish procedures, not inconsistent with the provisions of this title or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section."[42] Historically, the Board has issued decisions that inform the parties whether the Board affirms, modifies, or reverses the appealed Intermediary determinations to a Medicare cost report.[43] The Board decisions instruct the Intermediary as to how to adjust the Medicare cost report. The Intermediary incorporates the Board's decision into a revised NPR usually within 180 days. Except on rare occasions, the exact amount of reimbursement owed to Provider cannot be determined until the revised NPR is created by incorporating the Board decisions into the previous NPR in the possession of the Intermediary. The Board itself neither calculates nor effectuates a Board decision through the issuance of a revised NPR. This historical process was codified into regulations as part of the final rule published on May 23, 2008.[44] Specifically, as part of this final rule, CMS added 42 C.F.R. § 405.1803(d) (2008) which states:

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[39] The regulatory definition of final determination for purposes of Board appeals is delineated in 42 C.F.R. § 405.1803(a) and is consistent with the Board majority's interpretation and application of that term as that term is used in 42 U.S.C. § 1395oo(a). Moreover, setting aside the issues relating to "final determination," there would be procedural/mechanical issues with the Provider's addition of the interest issue on January 28, 2008 because any alleged interest determination under 42 U.S.C. § 1395g(d) that the Provider would be contesting could only have occurred subsequently around the time that the Intermediary issued an RNPR to implement the partial administrative resolution that the parties executed in February 2008 and that RNPR is not the one that was appealed in this case.

[40] The Board majority recognizes that, once jurisdiction is established under 42 U.S.C. § 1395oo(a) for at least one issue, the Board may exercise discretion under § 1395oo(d) "to make any other revisions on *matters covered by such cost report* . . . even though such matters were not considered by the intermediary in making such final determination." (Emphasis added.) *See St. Vincent Hospital and Health Center v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2013-D39 (Sep. 13, 2013), *declined review*, CMS Administrator (Oct. 25, 2013). Even though the Provider in this case has established jurisdiction with the Board for other issues (which were later administratively resolved and withdrawn), the Board has no authority under § 1395oo(d) to exercise discretion to hear the interest issue because interest assessed under § 1395g(d) is clearly not one of the "matters covered by such cost report." Rather, it is a matter considered outside of and subsequent to the settlement of the cost report and issuance of the NPR.

[41] The Board notes that 42 C.F.R. § 405.376 applies to both providers and suppliers.

[42] 42 U.S.C. § 1395oo(e). *See also* 42 C.F.R. § 405.1868(a)(2008).

[43] 42 U.S.C. § 1395oo(d).

[44] 73 Fed. Reg. 30190 (May 23, 2008).

(d) *Effect of certain final agency decisions and final court judgments; audits of self-disallowed and other items.* (1) This paragraph applies to the following administrative decisions and court judgments:
(i) **A final hearing decision by** the intermediary (as described in § 405.1833 of this subpart) or **the Board (as described in § 405.1871(b) of this subpart).**
(ii) A final decision by a CMS reviewing official (as described in § 405.1834(f)(1) of this subpart) or the Administrator (as described in § 405.1875(e)(4) of this subpart) following review of a hearing decision by the intermediary or the Board, respectively.
(iii) A final, non-appealable judgment by a court on a Medicare reimbursement issue that the court rendered in accordance with jurisdiction under section 1878 of the Act (as described in § 405.1842 and § 405.1877 of this subpart).
(2) **For any final agency decision or final court judgment specified in paragraph (d)(1) of this section, the intermediary must promptly, upon notification from CMS—**
(i) **Determine the effect of the final decision or judgment on the intermediary determination for the cost reporting period at issue in the decision or judgment; and**
(ii) **Issue any revised intermediary determination, and make any additional program payment, or recoup or offset any program payment (as described in § 405.371 of this subpart),** for the period that may be necessary to implement the final decision or judgment on the specific matters at issue in the decision or judgment.
(3) CMS may require the intermediary to audit any item, including any self-disallowed item, at issue in an appeal or a civil action, before any revised intermediary determination or additional Medicare payment, recoupment, or offset may be determined for an item under paragraph (d)(2) of this section.
(4) **For any final settlement agreement**, whether **for an appeal** to the intermediary hearing officer(s) or the Board or for a civil action before a court, the intermediary must implement the settlement agreement in accordance with paragraphs (d)(2) and (d)(3) of this section, unless a particular administrative or judicial settlement agreement provides otherwise.[45]

Thus, while the Board's decision may be the "final agency decision," it is the intermediary that: (1) "[d]etermine[s] the effect of the final decision . . . on the intermediary determination for the cost reporting period at issue in the decision"; and (2) "[i]ssues any revised intermediary determination, and make[s] any additional program payment . . . (as described in § 405.371 of this subpart), for the period that may be necessary to implement the final decision . . . on the

[45] *Id.* at 30244 (italics in original and bold emphasis added). This regulation was promulgated subsequent to the filing of this case but prior to the issuance of the Board's *Mercy II* decision in May 2009. The regulation was effective August 21, 2008, 90 days after its publication in the Federal Register, and therefore, is binding on the Board in this case. *See id.* at 30240.

specific matters at issue in the decision." The Board majority further notes this regulation does not express a specific time limit for the Intermediaries to issue a revised payment amount only that it must be done promptly.[46] Again, the Board majority notes that the process outlined in this regulation is consistent with Board practices, including during the periods covered by this appeal.

The Board majority would find that 42 U.S.C § 1395g(d) can be read consistently with the Intermediary's interpretation of 42 C.F.R. § 405.376(c)(1) (1990) which would require the revised NPR to be issued to trigger interest payments. The Board majority would further find that the regulatory language compels a reading of "final determination" of "the amount of payment made" to be the point at which the Intermediary determines a specific amount is due to/from a provider and issues a revised NPR and written determination of underpayment under § 405.376(c)(i) or through written determination of an underpayment that is issued without a NPR under § 405.376(c)(ii).

The Board majority bases its finding on language found in the preambles of two final rules — the final rule published on December 6, 1982 ("1982 Final Rule")[47] and the final rule published on September 14, 1984 ("1984 Final Rule").[48] Both of these final rules clearly predate the 1991 final rule that was found by the D.C. District Court to violate the APA. Commenters to 1982 Final Rule regarding the "point of final determination" from which interest might accrue on overpayments or underpayments suggested that it be established from the exhaustion of "administrative and judicial avenues of appeal."[49] This suggestion was rejected by HCFA stating that such an approach might encourage appeals to avoid or delay the payment of interest. Instead, HCFA adopted the language which became the basis for § 405.376(c) which imposes interest on "overpayments beginning with the issuance of both a Notice of Program Reimbursement (NPR) and a written demand for payment, or when an NPR is not utilized, upon the issuance of a written determination that an overpayment exists and a written demand for payment."[50] Significantly, in connection with this adopted language, HCFA states:

> We believe this latter interpretation is consistent with section 1878(a) of the Social Security Act, which refers to the decision of an intermediary as a point of final determination, and may avoid unnecessary appeals by providers and suppliers.[51]

Thus, this language suggests that, for purposes of the assessment of interest under § 405.376 (whether for an overpayment or underpayment), HCFA fully intended the point of the final determination to be when the Intermediary issued the NPR and/or a written determination of overpayment/underpayment (rather than, for example, when the Board issued its *Mercy I* decision in 1998).

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[46] 42 C.F.R. § 405.1803(d)(2)(2008).
[47] 47 Fed. Reg. 54811 (Dec. 6, 1982).
[48] 49 Fed. Reg. 36097 (Sept. 14, 1984).
[49] 47 Fed. Reg. at 54812-13.
[50] *Id.*
[51] *Id.*

The discussion in the preamble to the 1984 Final Rule addresses the Provider's argument that interest accrual on overpayments and underpayments should be treated the same. Specifically, in the preamble to the 1984 Final Rule, HCFA responds to twenty-four comments and discusses the revisions it was making to the regulation that established different treatment of overpayments and underpayments.

> Although it may appear that there is an inconsistency in the treatment of overpayments and underpayments when they appear on a cost report, we believe the different treatment is justified.[52]

And following a longer discussion about why interest on overpayments and underpayments on a cost report might be treated differently, HCFA concludes with the following statement:

> In either case, the amount of the debt must be reasonably certain before it becomes due and payable.[53]

This statement confirms that, before the amount of interest on an underpayment or overpayment can be determined, HCFA intended to require that the debt be established or "certain" before 30 day clock to trigger interest can begin to tick. To this end, 42 C.F.R. § 405.1805(d)(2) specifies_

> For any final agency decision or final court judgment specified in paragraph (d)(1) of this section, the intermediary must promptly, upon notification from CMS—
> (i) Determine the effect of the final decision or judgment on the intermediary determination for the cost reporting period at issue in the decision or judgment; and
> (ii) Issue any revised intermediary determination, and make any additional program payment, or recoup or offset any program payment (as described in § 405.371 of this subpart), for the period that may be necessary to implement the final decision or judgment on the specific matters at issue in the decision or judgment.

Determining the effect of the "final decision on the intermediary determination" is not always an easy administrative function. Indeed, § 405.1803(d)(3) permits CMS to require that an intermediary audit "any item . . . at issue in an appeal . . . before any revised intermediary determination . . . may be determined for an item." This supports the Board's conclusion that the "final determination" of "the amount of payment made" to be the point at which the Intermediary determines a specific amount is due to/from a provider and issues a revised NPR and written

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[52] 49 Fed. Reg. 36097-01, 36099 (Sept. 14, 1984). In an unreported case cited by UPMC, a federal district court in *Bertschland Family Practice Clinic, P.C. v. Thompson*, responds to Bertschland's objection to the inconsistent treatment of interest accruals on overpayments and underpayments by stating Bertschland "...seeks to read a symmetry into the regulation that simply is not there. Bertschland is correct that the regulation would have required it to pay interest on the overpayment after 30 days even while Bertschland was challenging the overpayment. However, the converse is not true for the government." *Bertschland Family Practice Clinic, P.C. v. Thompson*, No. IP01-562-CH/F, 2002 WL 1364155, at *6 (S.D. Indiana 2002).

[53] 49 Fed Reg. at 36099.

determination of underpayment under § 405.376(c)(i) or through written determination of an underpayment that is issued without a NPR under § 405.376(c)(ii).

Thus, assuming *arguendo* that the Board had jurisdiction in this case the Board would find that it was not until the administrative settlement on February 8, 2008 that the Intermediary established the amount of the underpayment. As this settlement amount was fully paid within the 30-day period that began on February 8, 2008 as required by the regulation, the Board would uphold the Intermediary's determination that no interest was due to the Provider. In this regard, the Board would find that both the Board's *Mercy I* decision and the partial administrative resolution signed February 8, 2008 were properly paid under the process described in 42 C.F.R. § 405.1803(d)(2) (2008). The Board notes that a Notice of the Intent to Reopen and a subsequent Notice of Revised Average Per Resident Amount were issued within 180 days from the time the Intermediary was notified the CMS Administrator was declining to review the Board's *Mercy I* decision.[54] The Provider acknowledged this Notice and objected to the Intermediary's finding by letter dated October 15, 1998. The Intermediary responded to the Provider's objection on October 26, 1998 advising the Provider that it should go back to the Board and request a "reopening" pursuant to 42 C.F.R. § 405.1885, including a copy of the regulation in the letter.[55] Instead of following the Intermediary's directive, the Provider filed a new appeal on February 23, 1999—*Mercy II*.[56] This new appeal placed the resolution of the case on a "slow track" of the Board appeal process instead of bringing the conflict regarding the interpretation of the Board's decision back to the Board in October 1998 through the reopening process. Thus, much of the extended period of time that the Provider was owed the underpayment was due to the Provider's choice of strategy to not to seek reconsideration from the Board through the reopening but rather to file a new appeal.

DECISION AND ORDER:

The Board majority finds it lacks subject matter jurisdiction over interest payments made under 42 C.F.R. § 405.376(b) (1990). Assuming *arguendo* the Board had jurisdiction the Board majority would find the revised NPR is the final determination date triggering interest payments under 42 C.F.R. § 405.376(c)(1)(i) (1990). Therefore, the Intermediary paid the Provider within the 30 payment period.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq. (dissenting in part)

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[54] The Board also notes that the Parties to the partial administrative resolution signed on February 8, 2008 agreed that the Intermediary will issue a Revised Notices of Program Reimbursement for the 21 Medicare hospitals included in the appeal within 180 days of the date the Intermediary receives a fully executed Partial Administrative Resolution. *See* Provider Exhibit P-24 at 2.
[55] *See* Provider Exhibit P-9.
[56] *See* Provider Exhibit P-10.

FOR THE BOARD

Michael W. Harty
Chairman

DATE: SEP 23 2014

OPINION OF L. SUE ANDERSEN, DISSENTING IN PART:

I dissent from the Board majority finding that it lacks subject matter jurisdiction to review a determination of interest on an underpayment. I agree with the Board majority's finding that the revised NPR was the "final determination" as required under 42 U.S.C. § 1395g(d) for purposes of triggering the 30-day period for Intermediary payment of the underpayment. As a result, the Intermediary paid the underpayment within the 30-day period and no interest is due the Provider in this case.

The Board majority denied jurisdiction on the basis that "payment of interest pursuant to 42 U.S.C. § 1395g(d) does not impact the "amount paid" for hospital services because the assessment of interest whether for an overpayment or underpayment is not part of the Medicare cost report which determines the "amount paid" for hospital services."[57] I disagree with this conclusion.

I find this interpretation a narrow and cramped interpretation of the Board's jurisdiction under the statute. I am persuaded that the Board jurisdictional statute should be read more broadly in order to support the strong presumption that Congress intends for judicial review of the administrative action. Direct graduate medical education payments are reported on the Worksheet E of the cost report following the methodology outlined in 42 C.F.R. § 413.86. Subsections (e)(1)(v) and (j)(1)(ii) clearly allow appeal of disputes involving the per resident amount, classification of costs and the hospital specific rate within 180 days of the written notice by the Intermediary. The Secretary has acknowledged the right to appeal disputes on these issues to the Board.[58] None of the parties in this case dispute that the Provider properly exercised its appeal rights on these issues.

I find that the interest issue is "integrally related"[59] to the amount of direct graduate medical education payment reported on the cost report which, if and when any interest which is determined to be owed to the provider, this interest becomes part of the "*total* program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter... "[60] and is, therefore, appealable to the Board under 42 U.S.C. § 1395oo(a).[61] In effect, interest, if the prerequisites of §1395g(d) are met, becomes indistinguishable from the reporting of the direct graduate medical education payment on the cost report.

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[57] *supra*, at 9.

[58] *See* 54 Fed. Reg. 40286, 40303 (Sept. 29, 1989) (made clear that "[u]pon receipt of this notification [the NAPRA], the hospital has 180 days in which to appeal the intermediary's determination" and "must appeal to the PRRB"). *See also Abbott Northwestern Mem'l Hosp. v. Blue Cross and Blue Shield Ass'n*, HCFA Administrator Dec. (Feb. 02, 1995), *aff'd*, PRRB Dec. No. 1995-D10 (Dec. 7, 1994).

[59] *National Med. Enterprises Inc. v. Sullivan*, 1990 WL 169276 (C.D. Cal. 1990) (unreported in F. Supp).

[60] 42 U.S.C. § 1395oo(a) (emphasis added).

[61] The dissent recognizes that the Board majority also takes issue with whether there has been a "final determination" required under § 1395oo sufficient to establish jurisdiction and argues that this final determination is distinct from the "final determination" of § 1395g(d). The dissent agrees that the definition of "final determination" under these two statutes is different but argues that the Intermediary made a final determination as to the merits of both the underpayment and on the interest issue sufficient to give rise to jurisdiction under § 1395oo(a). As to the question of whether there has been a "final determination" per the requirements of § 1395g(d) that is the central issue in this case before the Board.

In an early Final Rule concerning interest rates on overpayments and underpayments, CMS stated in pertinent part:

> Interest is charged or paid only on an overpayment or underpayment that results from a final determination. The definition of final determination is based on the premise that the decision made is a result of the cost report settlement process, such as a desk review, initial retroactive adjustment, or final audit.[62]

This statement seems to support the view that interest on an underpayment is derived from an action by the Intermediary in review and audit of the cost report and is integrally related to the Intermediary's decisions about some aspect of the cost report.

Interesting to note, the Board has denied jurisdiction over interest on an underpayment in numerous cases and in all cases, the CMS Administrator or a federal court has reversed the Board's decision and found that the Board should have exercised jurisdiction.[63] There is no case that supports the Board's jurisdictional position in this case.

Nor has the Board's position on jurisdiction over the interest issue been entirely consistent. In 2008, the Board, in *Oakwood Healthcare System v Blue Cross Blue Shield Association*,[64] accepted jurisdiction without comment and denied payment of interest to the provider.

Two cases illustrate the Administrator's dissatisfaction over the Board's unwillingness to exercise jurisdiction. In *Francis A. Bell Mem'l Hosp. v. Blue Cross and Blue Shield Ass'n*,[65] CMS' Center for Medicare noted that the Board has taken a "narrow view" of its authority under § 1395oo(d) with respect to the interest issue compared to a "broader view of the scope of the Board's authority to review the interest issue with respect to underpayments" taken by the Administrator and various courts. In *Edgewater v. Blue Cross and Blue Shield Ass'n*, the Administrator asserted jurisdiction over the interest issue and stated that the Board had acted "improperly in not taking the required action" by denying jurisdiction (for a second time) after the Secretary had agreed in a federal court settlement to remand the interest issue so that the Board could exercise jurisdiction.[66]

The Administrator distinguished the Board's role in deciding the interest issue on an underpayment from its role, or lack thereof, on interest on an overpayment in *Athens-Limestone Hosp. v. Blue Cross and Blue Shield Ass'n*.[67] The Administrator made the following distinction:

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[62] 56 Fed. Reg. 31332, 31335 (July 10, 1991), corrected at 56 Fed. Reg. 41726 (Aug. 22, 1991).
[63] *See Edgewater v. Intermediary Blue Cross Blue Shield Ass'n,* HCFA Administrator Dec. (Aug. 28, 2000), *rev'g*, PRRB Dec. No. 2000-D65 (June 28, 2000). *See also Francis A. Bell Mem'l Hosp. v. Blue Cross and Blue Shield Ass'n*, HCFA Administrator Dec. (July 3, 2000), *rev'g*, PRRB Dec. No. 2001-D23 (May 3, 2001); *OSF Healthcare System v. Sullivan*, 820 F. Supp. 390 (C.D. Ill. 1993).
[64] PRRB Dec. No. 2008-D42 (Sept. 29, 2008).
[65] HCFA Administrator Dec. (July 3, 2000), *rev'g*, PRRB Dec. No. 2001-D23 (May 3, 2001).
[66] HCFA Administrator Dec. (Aug. 28, 2000), *rev'g*, PRRB Dec. No. 2000-D65 (June 28, 2000).
[67] HCFA Administrator Dec. (Aug. 16, 1999), *modifying*, PRRB Dec. No. 1999-D51 (June 16, 1999).

> The Administrator recognizes that certain courts have found that interest under 1815(d) of the Act is integrally related to the provider's cost report. Thus, these courts have determined that the Board has jurisdiction over a provider's claim of interest against the government. However, the Administrator notes that, in contrast to when interest is claimed to be owed by the government, the case here involves interest *due* the government as a result of an overpayment.... Unlike the agency's authority to pay interest on underpayment, the agency's authority to charge and collect interest on overpayments is further controlled by the authority set forth under the Federal Claims Collection Act.[68]

Thus, it is clear from this statement that CMS considers interest on an underpayment to be an appealable issue and the Board has jurisdiction over the issue.[69]

Finally, as noted, although the undersigned Board member maintains that the Board has the authority under 42 U.S.C. § 1395oo(a) to hear an appeal of interest on an underpayment, this jurisdiction may also be exercised under subsection (d) which provides Board jurisdiction:

> to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report....[70]

Here, interest on an underpayment can credibly be considered one of the "matters covered by such cost report" without actually being a line item on the cost report. This language was the basis for the federal district court's decision in *OSF Healthcare Sys. v. Sullivan*, which found Board jurisdiction over interest on an underpayment based on language in subsection (d).[71]

The court reasoned that if CMS intended to exclude Board review of the interest issue, it could have—but did not—include it as a specific matter not subject to the Board review in 42 C.F.R. § 405.1873(b). The court also noted that a provider would have no legal remedy absent administrative and judicial review which would be contrary to the "strong presumption that Congress intends judicial review of administrative action."[72] This strong presumption in favor

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[68] *Id.* (emphasis added).

[69] It appears that this distinction between interest on overpayments and underpayments is supported in the regulation, § 405.373, which precedes the interest regulation, §405.378 at issue in this case. There, the Secretary, specifically, states that requirement for written notice of the intent to offset or recoup the overpayment and opportunity for rebuttal under section (a) of the regulation does not apply "if the intermediary, after furnishing a provider a written notice of the amount of program reimbursement in accordance with § 405.1803, recoups payment under § 405.1803" and highlights provider rights in this circumstance under § 405.1809, § 405.1811, § 405.1815, § 405.1835 and § 405.1843. Most notably, this language demonstrates that the Secretary thought about the potential conflict between the process of recoupment of an overpayment under § 405.373 and recoupment through the cost report process and drafted language to exclude the application of the regulation to the cost reporting process. If she had intended to exclude or distinguish the issue of interest on an underpayment from the cost reporting process, she could have made a similar distinction in § 405.378. She did not.

[70] (Emphasis added.)

[71] *OSF Healthcare Sys. v. Sullivan*, 820 F. Supp. 390 (C.D. Ill. 1993).

[72] *Id.* at 394.

of Board review of interest on underpayments is reflected in CMS Transmittal No. 416, dated June 1, 2000, updating the Provider Reimbursement Manual, CMS Pub. No. 15-1, Chapter 29 regarding a Provider's right to Board hearing which states: "A provider may request and receive a hearing before the Provider Reimbursement Review Board to determine appropriate payment amounts that emanate from cost reports." Clearly, the determination of the appropriate payment of an amount of interest on an underpayment of direct medical education payments emanates from the cost report and Board review should be available to a provider.

Based on the review of the courts' and CMS Administrator's determinations of Board jurisdiction over this issue, I dissent from the Board majority's findings in the matter of its jurisdiction to review interest due on an underpayment to this provider. I do, however, concur with the Board majority on its decision that the revised NPR was the "final determination" of the underpayment as required by 42 U.S.C. § 1395g(d) and payment of the underpayment was made within 30 days of this determination. As a result, no interest was due to the Provider.

L. Sue Andersen, Esq.