CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
University of Pittsburgh Medical Center (UPMC) (formerly Mercy Hospital of Pittsburgh) **Provider** **vs.** **Highmark Medicare Services (formerly Blue Cross of Western Pennsylvania/ Blue Cross and Blue Shield Association** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Report Ending: June 30, 1985** **Review of:** **PRRB Dec. No. 2014-D26** **Dated: September 23, 2014**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in §1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. §1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Provider commented, requesting that the Board's decision be reversed. Accordingly, this case is now before the Administrator for final agency review.

The Provider is a not-for-profit, acute care, teaching hospital located in Pittsburgh, Pennsylvania. The Intermediary completed a reaudit of the Provider's graduate medical education (GME) base year, pursuant to the requirements of the Omnibus Budget Reconciliation Act of 1986, and issued an adjusted "average per resident amount" (APRA) on February 26, 1991.

The Provider appealed the APRA and obtained a partially favorable decision from the Board on January 28, 1998[1] (Board's *Mercy I* decision). Shortly thereafter, on July 22, 1998, the Intermediary issued a "Notice of Intent to Reopen" including revised GME adjustments to the Provider's cost report based upon the Intermediary's interpretation of the Board's decision. On September 9, 1998, after it had recalculated the APRA, the Intermediary sent a

[1] PRRB Dec. No. 98-D26.

Notice of Revised Average per Resident Amount. On September 21, 1998, the Intermediary paid the Provider based upon the revised APRA.

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[2] (*Mercy II*). 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. The Provider again appealed and requested consolidation of this issue with the APRA issue in *Mercy II*.

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. 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.

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 was the issuing of a revised Notice of Program Reimbursement (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. The D.C. District Court found in *UPMC Mercy v. Sebelius*[3] 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.

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[2] PRRB Case No. 99-1340.
[3] 793 F. Supp. 2d 63 (D.D.C. 2011).

The case was remanded by the Administrator for further action by the Board.

The issue is whether interest is due the Provider under 42 C.F.R. § 405.378.

The Provider argued that the Board's *Mercy I* decision 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, and that the Intermediary had no justification for failing to fully implement these changes in 1998. The Provider believed that the Board's *Mercy I* decision was final upon issuance, and remained final as CMS declined to review the decision. The Provider asserted that the Board's *Mercy I* decision was a "final determination"[4] and as such, interest must be paid on underpayment amounts not settled within 30 days of the Board's *Mercy I* decision.[5]

The Intermediary contended that a Board decision issued under 42 C.F.R. § 405.1871 is not the same as an NPR which is addressed in 42 C.F.R. § 405.1803, and therefore, interest calculations under 42 C.F.R. § 405.378(c)(1)(i) would not apply to a Board decision. The Intermediary argued that the Board's *Mercy I* decision was complex to implement[6] and that it was difficult to come up with the payment in the revised NPR that was issued by the Intermediary six months after the CMS Administrator declined to review the Board's *Mercy I* decision (thus, eight months after the Board's *Mercy I* decision). The Intermediary did not believe the six month time period it took to issue the revised NPRs from the 84-page Board decision was unreasonable. The Intermediary stated that additional delay in payment was attributable to the Provider, as following the Board's *Mercy I* decision, the Provider filed a new appeal with the Board in February 1999[7] to dispute the first APRA adjustments issued to implement Mercy I. This appeal was later consolidated with a second appeal that was filed in September 2000 to dispute the Provider's HSR. On February 8, 2008, the parties signed a partial administrative resolution on the APRA and HSR issues. 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.

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[4] The Provider relies either on 42 C.F.R. § 405.376(c)(l)(i), in that it followed an NPR and was a written determination of an underpayment, or on 42 C.F.R. § 405.376(c)(l)(ii) which does not require an NPR.

[5] Specifically, the Provider argued that it should be paid interest from September 1998 to February 2008.

[6] The Intermediary pointed out that this was highlighted by fact that it was an 84-page decision with subparts.

[7] Mercy II.

On remand, the Board[8] held that it lacked subject matter jurisdiction over interest payments made under 42 C.F.R. § 405.376(b) (1990).

The Board noted that a provider's right to interest on an underpayment that has not been paid within 30 days of the date of a "final determination" is derived from § 1815(d) of the Social Security Act, and that further, this statutory provision is separate from those statutory provisions governing the "amount paid" for inpatient hospital services.

The Board stated that the relevant portions of the enabling statute addressing Board jurisdiction are limited to determinations made on the Medicare cost report, specifically, 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…"[9]

The Board found that the payment of interest pursuant to § 1815(d) of the Act 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, and accordingly, the Board lacks jurisdiction over the assessment of interest, whether for an overpayment or an underpayment.

The Board noted that the definition of final determination at 42 C.F .R. § 405.1803(a) is consistent with its interpretation, and that even 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 that the Provider would be contesting could only have occurred subsequently around the time that the Intermediary issued an revised NPR to implement the partial administrative resolution that the parties executed in February 2008 and that revised NPR is not the one that was appealed in this case.

The Board found that even though the Provider in this case established jurisdiction with the Board for other issues (which were later administratively resolved and withdrawn), the Board has no authority to exercise discretion to hear the interest issue because interest assessed is clearly not one of the "matters covered by such cost report", but rather, it is a matter considered outside of and subsequent to the settlement of the cost report and issuance of the NPR.

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[8] One member of the Board dissented from the Board's finding that it lacked subject matter jurisdiction, but agreed with the Board's finding that that the revised NPR was the "final determination" for purposes of triggering the 30-day period for Intermediary payment of the underpayment and thus because the Intermediary paid the underpayment within the 30-day period, no interest is due to the Provider.

[9] Section 1878 of the Social Security Act.

After determining that it lacked jurisdiction, the Board went on to note that 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)(l)(i) (1990) and would find that no interest payment is due the Provider. Specifically, the Board noted, it would find that, as relevant to the appeal, the "final determination" defined in 42 C.F.R. § 405.376(c)(l) (1990) encompasses only a determination made by the fiscal intermediary.

The Board noted that 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." Thus, Board decisions may instruct an intermediary as to how to adjust the Medicare cost report, and the intermediary will then incorporate the Board's decision into a revised NPR, usually within 180 days. The Board stated that except on rare occasions, the exact amount of reimbursement owed to a provider cannot be determined until the revised NPR is created by incorporating the Board decision 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. The Board noted that this historical process was codified into regulations as part of the final rule published on May 23, 2008[10], and that as part of this final rule, CMS added 42 C.F.R. §405.1803(d) (2008) which states:

> (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:
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> (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).
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> (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.
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> (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).

[10] 73 Fed. Reg. 30,190 (May 23, 2008). "We amended Sec. 405.1803(d) to state that CMS may require the intermediary to audit any 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 that section." (Emphasis added). *Id.* at 30,234.

> (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—
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> (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
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> (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.
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> (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.
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> (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.

Thus, while the Board's decision may be the "final agency decision", it is the intermediary that "determine[s] the effect of the final decision...on the intermediary determination for the cost reporting period at issue in the decision"; and "issues any revised intermediary determination, and make[s] any additional program payment...for the period that may be necessary to implement the final decision ... on the specific matters at issue in the decision."[11]

The Board further noted that the regulation does not express a specific time limit for the Intermediaries to issue a revised payment amount, only that it must be done promptly.

The Board noted that § 1815(d) of the Act 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. Further, the Board stated, 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

[11] 42 C.F.R. §405.1803(d) (2008).

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

The Board based its finding on language found in the preambles of two final rules - the final rule published on December 6, 1982[12] (1982 Final Rule) and the final rule published on September 14, 1984[13] (1984 Final Rule). Both of these final rules 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."[14] This suggestion was rejected by CMS (formerly named HCFA), stating that such an approach might encourage appeals to avoid or delay the payment of interest. Instead, CMS adopted the language which became the basis for 42 C.F.R. § 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."[15] Significantly, in connection with this adopted language, CMS stated:

> 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.[16]

Thus, the Board stated, this language suggests that, for purposes of the assessment of interest under 42 C.F.R. § 405.376 (whether for an overpayment or underpayment), CMS 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).

Next, the Board noted that the discussion in the preamble to the 1984 Final Rule addressed 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, CMS responded to twenty-four comments and discussed the revisions it was making to the regulation that established different treatment of overpayments and underpayments.

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[12] 47 Fed. Reg. 54,811.
[13] 49 Fed. Reg. 36,097.
[14] 47 Fed. Reg. at 54,812-13.
[15] *Id.*
[16] *Id.*

> 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.[17]

Following a longer discussion about why interest on overpayments and underpayments on a cost report might be treated differently, CMS concluded with the following statement:

> In either case, the amount of the debt must be reasonably certain before it becomes due and payable.[18]

The Board concluded that this statement confirmed that, before the amount of interest on an underpayment or overpayment can be determined, CMS intended to require that the debt be established or "certain" before the 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-
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> (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.

The Board noted that determining the effect of the "final decision on the intermediary determination" is not always an easy administrative function. 42 C.F.R. § 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." The Board found that this supported its conclusion that the "final determination" of "the amount of payment made" is 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).

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[17] 49 Fed. Reg. 36,097, 36,099 (Sept. 14, 1984).
[18] *Id.*

Thus, the Board concluded assuming, *arguendo*, that it had jurisdiction in this case, it 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 noted 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. 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 request that the Board reopen the case pursuant to 42 C.F.R. § 405.1885. Instead of following the Intermediary's directive, the Provider filed a new appeal on February 23, 1999--*Mercy II*. 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.

The Provider commented, requesting reversal of the Board's decision. The Provider argued that the Board's ruling that it lacked jurisdiction over claims for interest under 42 C.F.R. § 405.376 was issued *sua sponte*, as the Board's jurisdiction has never previously been questioned by the agency, in the Board's previous determination on the merits, or by the district court prior to remand. The Provider argued that the Board incorrectly reasoned that its jurisdiction is limited to determinations that are actually made by the intermediary on the Medicare cost report. The Provider stated that this reasoning is contrary to the appeal rights statute and to established precedent, and that the very reason the interest statute was enacted was to prevent overpayments or underpayments of the amount due a provider relating to the loss of the time value of money which occurs when debts are not promptly liquidated.

The Provider also argued that the Board erred in ruling that intermediary decisions are the only type of decision which comprise a "final determination" triggering interest under the Hurry-Up-and-Pay Interest Statute. The Provider noted that it has already presented detailed argument, authority, and record support demonstrating that the Board's Decision in PRRB Dec. No. 1998-D26 was a "final determination" of an underpayment, triggering interest under § 1815(d). The Provider stated that under bedrock cannons of construction, the interest regulations must be construed, if at all possible, consistently with the Hurry-Up-and-Pay Statute, and the Board ignored this requirement. The Provider noted that the agency has repeatedly acknowledged that the Hurry-Up-and-Pay Statute expressly contemplates interest charges on both overpayments and underpayments, and further, neither the Statute nor

HHS's relevant rulemakings related to 42 C.F.R. § 405.376 require the final determination of a sum certain to trigger interest. However, the Provider noted, the Board interpreted the interest regulation as requiring, as a precondition to the triggering of interest, the determination of a sum certain made solely by the intermediary. The Provider argued that this interpretation invalidly abrogates one-half of the statutory mandate, because it improperly cedes to intermediaries the ability to determine if and when interest is triggered on underpayments as determined by the Board (or CMS Administrator), regardless of when the intermediary actually liquidates the sum owing.

The Provider commented that the Board mistakenly bootstrapped its invalid reading of the interest regulation, which was promulgated in 1984, with the regulation at 42 C.F.R. § 405.1803(d), which did not go into effect until August 2008. This regulation sets forth a process for intermediaries to determine the effect of, and to implement promptly, final agency decisions or court judgments. The Provider pointed out that it was improper for the Board to seek to apply this regulation retroactively, and also that the regulations does not answer the question of whether a final Board decision triggers interest. The Provider argued that Board decisions are final upon issuance and therefore the intermediary had no discretion as to whether or how it is implemented. The Provider stated that the undisputed record evidence, which the Board "inexplicably disregarded", was that it would have taken the intermediary at most two days to implement PRRB Dec. No. 1998-D26 properly and fully, but the intermediary refused to do so.

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

The Administrator finds that jurisdiction is properly found for the Providers over this issue. Accordingly, the jurisdictional decision of the Board is reversed. However, the Administrator concurs with the Board's conclusion that the revised NPR was the "final determination" of the underpayment as required by § 1815(d) of the Social Security Act and payment of the underpayment was made within 30 days of this determination. As a result, no interest was due to the Provider. The Administrator finds in response to the Provider's comments concerning the language set forth in 42 C.F.R. § 405.1803(d), that the Board's reference to that regulation was not improper. As the Board explained, this regulatory text merely codified the pre-existing process for effectuating payment pursuant to a final Board decision. It did not create a new process. Moreover, the core holding of the Board's decision, that a Board decision requires effectuation by the Intermediary through the issuance of a Notice of Program Reimbursement to determine a sum certain amount stands on its own and fully supports the Board's decision finding no interest is to be allowed.

DECISION

The Administrator modifies the Board's decision in accordance with the foregoing decision.

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

Date: 11/10/14 /s/

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services