PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2024-D28

PROVIDER –
University of Illinois Medical Center at Chicago

Provider No.: 14-0150

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

HEARING DATE –
May 10, 2022

Cost Reporting Period Ended –
June 30, 2007

CASE NO. – 15-2868

INDEX

ISSUE STATEMENT:

Whether the Medicare Contractor ("Medicare Contractor") determined the Medicare reimbursement of the operating and capital outliers, and the corresponding time value of money ("TVM"), through the outlier reconciliation process properly.[1] This issue relates to the Provider's fiscal year ending June 30, 2007 ("FY 2007") and has the following four (4) subparts:

1. Whether the Medicare Contractor's use of non-patient specific data (which was not run through the Lump Sum Utility in the Fiscal Intermediary Shared System ("FISS")) in the calculation of the outlier reconciliation amount and the corresponding TVM amount for FY 2007 was made in accordance with 42 C.F.R. § 412.84(i)(4) and Medicare Claims Processing Manual, CMS Pub. 100-04 ("MCPM"), Ch. 3, § 20.1.2.7;

2. Whether the Medicare Contractor's selection of the Provider for the outlier reconciliation process for FY 2007 and the Medicare Contractor's calculation of the Outlier Reconciliation amount with the corresponding TVM amount was proper and in accordance with 42 C.F.R. § 412.84(i)(4) and MCPM, Ch. 3, § 20.1.2;

3. Whether the FY 2007 TVM amount established and assessed under the outlier regulation at 42 C.F.R. § 412.84(m) for FY 2007 is invalid; and

4. Whether the Medicare Contractor's calculation of the FY 2007 TVM was overstated due to the delay of the Centers for Medicare and Medicaid Services ("CMS") in publishing the Revised 2006 SSI ratios.[2]

DECISION:

After considering Medicare law, regulations, and program guidance, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds:

1. The Medicare Contractor properly selected the Provider's FY 2007 cost report for the outlier reconciliation process and properly reopened the Provider's cost report on March 22, 2012 to reconcile outlier payments without regard to CMS' delay in publication of the revised 2006 SSI ratios;

2. The Medicare Contractor has validated the overpayment assessment of $6,531,151 in connection with the Provider's FY 2007 outlier claims by establishing that this assessment, which was based on 47 percent of the FY 2007 outlier claims, is lower than the overpayment amount associated with 98 percent of the FY 2007 cost outlier claims; and

3. In exercising its discretion under 42 C.F.R. § 412.84(m), the Medicare Contractor failed to assess a TMV adjustment that complied with that regulation and assessing a compliant TMV adjustment in the unique circumstance of this case would be improper.

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[1] Transcript of Proceedings ("Tr.") at 6 (May 10, 2022).
[2] *Id.* at 6-8; Provider's Final Position Paper (hereinafter "Provider's FPP") at 2 (Feb. 9, 2022).

Accordingly, the Board: (A) reverses the TMV adjustment and orders the Medicare Contractor to refund this amount; and (B) pursuant to its authority under 42 U.S.C. § 1395oo(d) and 42 C.F.R. §§ 405.1845(h) and 405.1869(a), remands this appeal to the Medicare Contractor and directs the Medicare Contractor to 1) run the 98 percent of the outlier claims (as identified by the Medicare Contractor) through the FISS Lump Sum Utility, 2) reconcile the claims through the applicable IPPS Pricer software to formally arrive at the overpayment assessment based solely on that 98 percent (which is estimated to total $6,795,440 per the Medicare Contractor Workpapers at Exhibit C-2), and then 3) issue the new overpayment assessment to the UI Medical Center.

INTRODUCTION:

The University of Illinois Medical Center at Chicago ("UI Medical Center" or "Provider") is an acute care hospital located in Chicago, Illinois.[3] The Medicare contractor[4] assigned to the UI Medical Center is National Government Services, Inc. ("Medicare Contractor" or "NGS").

The Medicare Contractor issued the Provider's Notice of Program Reimbursement ("NPR") on June 4, 2009.[5] On March 22, 2012, the Medicare Contractor issued a Notice of Reopening to review outlier payments in accordance with 42 C.F.R. § 412.84.[6] On December 31, 2014, the Medicare Contractor issued a second Revised Notice of Program Reimbursement ("R2NPR").[7]

The UI Medical Center disputes the Medicare Contractor's Audit Adjustment No. 4 in its R2NPR for FY 2007.[8] This adjustment reduced the operating outlier payments by $6,507,394, reduced the capital outlier payments by $23,757, and assessed a "time value of money" or TMV adjustment[9] in the amount of $1,537,952.[10] As a result, the total amount at issue is $8,069,103. The UI Medical Center timely appealed its R2NPR to the Board and met the jurisdictional requirements for a hearing.

The Board conducted a live video hearing on May 10, 2022. The UI Medical Center was represented by Floyd D. Perkins, Esq. of Nixon Peabody, LLP. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[3] Provider's FPP at 1.
[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[5] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 2 (Mar. 10, 2022).
[6] *Id.* at 5; Exhibit ("Ex.") C-6.
[7] The Medicare Contractor issued a first revised notice of program reimbursement ("R1NPR") for FYE 06/30/2007 to the UI Medical Center on March 4, 2013. *Id*. at 2; Ex. C-1.
[8] Provider's FPP at 1.
[9] The Provider and Medicare Contractor frequently refer to the "time value" of money, or TVM, calculation as interest. The Board will refer to this amount as the "time value of money" as it was determined based on 42 C.F.R. § 412.84(m) (referring to time value of any under payments or over payments") and the Medicare Claims Processing Manual, CMS Pub. 100-04 ("MCPM"), Ch. 3, § 20.1.2.6 (referring to "time value of money").
[10] Provider's FPP at 1. *See also* Ex. C-1 at 7.

STATEMENT OF FACTS AND PROCEDURAL HISTORY:

This case focuses on the operating and capital cost-to-charge ratio ("CCR"). The following information gives some context on the origins of the UI Medical Center's operating and capital CCRs that were used to identify and make FY 2007 outlier payments at issue in this case:

1. In a letter dated June 15, 2006, the Medicare Contractor gave notice to the UI Medical Center that, effective June 15, 2006, the operating and capital CCRs had been updated to 0.495 and 0.014 respectively, based upon the FY 2004 revised cost report. As a result, these updated CCRs were used to calculate the cost outliers from June 15, 2006 forward.[11]

2. In a letter dated September 19, 2007, the Medicare Contractor notified the UI Medical Center that, effective October 1, 2007, the operating and capital CCRs had been updated to 0.365 and 0.017, respectively, based on the FY 2006 as-filed cost report. As a result, these updated CCRs were used to calculate the cost outliers effective October 1, 2007.[12]

Thus, throughout the UI Medical Centers' FY 2007 (*i.e.,* from July 1, 2006 to June 30, 2007), the cost outlier payments at issue were identified and calculated using the operating and capital CCRs of 0.495 and 0.014, respectively.

On June 4, 2009, the Medicare Contractor issued an NPR for UI Medical Center's FY 2007 cost report which provided the basis for settled operating and capital CCRs of 0.346 and 0.015, respectively, but did not include any outlier reconciliation.[13] The Medicare Contractor's witness at the hearing indicated that, when the June 4, 2009 NPR was issued, the Medicare Contractor was aware of the potential for outlier reconciliation for FY 2007 but it had not solidified its procedures for when such reconciliation needed to be completed.[14]

The Medicare Contractor points to subsequent guidance that CMS issued in 2010 and 2011 that directed its attention to review outlier reconciliations further.[15] As a result, the Medicare Contractor suggests that it conducted further review of the UI Medical Center's FY 2007 cost report[16] and determined that it should be subject to the outlier reconciliation process because: (1) the operating CCR of 0.495 that was used to make the UI Medical Center's operating outlier payment during the FY 2007 cost reporting period was more than 10 percentage points above the UI Medical Center's actual FY 2007 operating CCR of 0.346; and (2) the UI Medical Center's total outlier payments exceeded $500,000.[17] Specifically, on March 22, 2012, the Medicare Contractor formally initiated its review by notifying the UI Medical Center that its FY 2007 cost report was being reopened "[t]o reconcile outlier payments in accordance with 42 CFR 412.84."[18] The Medicare Contractor

[11] Ex. C-5.
[12] Ex. P-11.
[13] Medicare Contractor's FPP at 5; Ex. C-4.
[14] Tr. at 191-92.
[15] Medicare Contractor's FPP at 4, n.1 (citing to: (1) MCIM Transmittal 2111, Change Req. 7192 (Dec. 3, 2010); and (2) MCIM Transmittal 2242, Change Req. 7464 (Jun. 17, 2011)).
[16] *Id.* at 4.
[17] *Id.* at 4-5.
[18] Ex. C-6 (copy of the Mar. 22, 2012 Notice of Reopening).

maintains that sometime after this notice but before November 20, 2014 it referred the FY 2007 outlier reconciliation to CMS and received approval from CMS to conduct this reconciliation.[19]

Following the asserted CMS referral and approval, the Medicare Contractor completed the outlier reconciliation with the data available.[20] On November 20, 2014, the Medicare Contractor notified the UI Medical Center that its FY 2007 outlier payments "will be reconciled in accordance with [CMS] Change Request 7192, dated December 3, 2010 instructions" where "Outlier reconciliation means that the Acute IPPS claims *will be* ***reprocessed*** using the [CCR] determined from this cost report prior to finalization."[21] Significantly, the Medicare Contractor carbon copied both the CMS Central and Regional Offices on the November 20, 2014 notice.[22]

On December 31, 2014, the Medicare Contractor completed the reconciliation process and issued R2NPR for the UI Medical Center's FY 2007 cost reporting period. In R2NPR, the Medicare Contractor: (1) reduced the UI Medical Center's operating outlier payments by $6,507,394, and the capital outlier payments by $23,757; and (2) assessed a TVM audit adjustment in the amount of $1,537,952, where $1,532,358 related to the TVM calculated for the operating outlier overpayment and $5,594 related to the TVM calculated for the capital outlier overpayment. The Medicare Contractor calculated the TVM adjustment by assessing interest from the midpoint of the cost reporting period (*i.e.*, December 30, 2006) to March 22, 2012, the date that the Medicare Contractor issued its reopening notice to the UI Medical Center.[23]

STATUATORY AND REGULATORY BACKGROUND:

42 U.S.C. § 1395ww(d) established an inpatient prospective payment system ("IPPS") to pay hospitals[24] for the *operating* costs of inpatient hospital services associated with inpatient hospital discharges covered under Medicare Part A.[25] Under IPPS, each such case is categorized into a diagnostic-related group ("DRG") and each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.[26] In addition to the DRG payment, hospitals can receive other adjustments or add-on payments, one of which is an *operating* outlier payment for certain cases which are unusually costly.[27]

Additionally, 42 U.S.C. § 1395ww(g) requires the Secretary to pay for the *capital*-related costs of hospital inpatient services with a prospective payment system ("Capital PPS"). Under Capital PPS, payments are adjusted by the same DRG for the case, as they are under IPPS. Similarly, a case may also qualify, under Capital PPS, to receive a *capital* outlier payment.[28]

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[19] Medicare Contractor's FPP at 5; Tr. at 182-83. *See also* Ex. C-11 (Nov. 20, 2014 letter from the Medicare Contractor to the UI Medical Center with carbon copies to the CMS Central and Regional Offices).
[20] Medicare Contractor's FPP at 5.
[21] Ex. C-11 (emphasis added). *See also* Medicare Contractor's FPP at 15.
[22] Ex. C-11 (Nov. 20, 2014 letter from the Medicare Contractor to the UI Medical Center with carbon copies to the CMS Central and Regional Offices).
[23] Medicare Contractor's FPP at 12-13; Ex. C-1 at 7.
[24] As used here, the term "hospital" is limited to a "subsection (d) hospital" defined at 42 U.S.C. § 1395ww(d)(1)(B).
[25] 42 U.S.C. § 1395ww(d)(1)(A).
[26] 42 C.F.R. § 412.60.
[27] 42 C.F.R.§ 412.80 - 412.86.
[28] 42 C.F.R. § 412.312(c).

To receive an outlier payment, the *combined* operating and capital cost associated with a case (*i.e*., a Medicare-covered hospital inpatient discharge) must exceed the fixed–loss outlier threshold amount established by CMS, *i.e.,* the specific dollar amount which this cost must exceed in order for the case to qualify for an outlier payment.[29] The operating cost and capital cost associated with a case are computed separately by multiplying the total covered charges by the provider's operating and capital CCRs. The Secretary set this policy as part of the final rule published on September 30, 1988. Specifically, the Secretary chose to use hospital-specific CCRs, rather than a nationwide CCR, to determine hospitals' costs for assessing whether a case qualified for payment as a cost outlier.[30] The Secretary's rationale for adopting hospital-specific CCRs essentially focuses on the need for "reasonably reliable factors to estimate costs from charges" and enhancing the accuracy of identifying and computing outlier payments:

> We proposed to use hospital-specific [CCRs] to adjust charges for the purpose of computing cost outlier payments. The use of hospital-specific [CCRs] should *greatly enhance the accuracy* with which outlier cases are identified and outlier payments are computed, since there is wide variation among hospitals in these [CCRs]. The increased emphasis on cost in computing outlier payments heightens *the need to use* ***reasonably reliable*** *factors* to *estimate costs from charges*. Therefore, we believe the use of hospital-specific [CCRs] is essential to ensure that outlier payments are made for cases that have extraordinarily high costs, and not merely high charges.[31]

The regulations at 42 C.F.R. § 412.84(h) provide the rules for applying CCRs in outlier reconciliation determinations. Prior to 2003, this regulation stated:

> The operating cost-to-charge ratio and, effective with cost reporting periods beginning on or after October 1, 1991, the capital cost-to-charge ratio used to adjust covered charges are *computed* ***annually*** by the intermediary for each hospital *based on the latest available* ***settled*** *cost report for that hospital* and charge data for the same time period as that covered by the cost report. Statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets forth these parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published under §412.8(b).[32]

On June 9, 2003, the Secretary published a final rule solely addressing cost outliers and, to that end, it was entitled "Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and

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[29] 68 Fed. Reg. 34494, 34495 (Jun. 9, 2003).
[30] 53 Fed. Reg. 38476, 38503 (Sept. 30, 1988).
[31] *Id.*
[32] (Emphasis added.)

Long-Term Care Hospital Prospective Payment Systems" ("June 2003 Final Rule").[33] In the preamble to the June 2003 Final Rule, the Secretary explains that outlier payments made for discharges on or after October 1, 2003 are "subject to possible reconciliation" when hospitals' cost reports are settled:[34]

> [I]n light of the gross abuses of the current methodology by some hospitals and the negative impact such overpayments ultimately have on other hospitals due to their effect on the threshold, we believe the option of *reconciling outlier payments based on the settled cost report for hospitals* that have been initially paid using a significantly inaccurate cost-to-charge ratio compared to the actual ratio from the cost reporting period is now appropriate. In our view, *reconciling outlier payments* because they were originally paid on the basis of a significantly inaccurate cost-to-charge ratio is similar to recovering outlier payments when adjustments are made to covered charges for any services that are not found to be medically necessary or appropriate Medicare services upon medical or other review. This review is explicitly provided for at § 412.84(d). This provision was established when the IPPS was first implemented for FY 1984 (48 FR 39785). . . .
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> [I]f we deem it necessary as a result of a hospital-specific data variance to reconcile outlier payments of an individual hospital, such action on our part would not affect the predictability of the entire system. Rather, because ***each hospital is on notice*** *as to our revised methodology* for determining cost-to-charge ratios ***and*** *that outlier payments are* ***subject to possible reconciliation***, and because each hospital has the necessary data regarding its own costs and charges to predict its actual cost-to-charge ratio, we are able to maintain the predictability of the system as a whole. Further, because reconciliation of outlier payments will affect only certain hospitals, the administrative burden of implementing such a policy is minimized.[35]

Accordingly, as part of the June 2003 Final Rule, the Secretary modified 42 C.F.R. § 412.84, in relevant part, to address CCRs applicable to outlier determinations on a going-forward basis in a new subsection (i). In pertinent part, this regulation as revised states:

> (i)(1) For discharges occurring on or after August 8, 2003, CMS may specify an alternative to the ratios otherwise applicable under paragraphs (h) or (i)(2) of this section. A hospital may also request that its fiscal intermediary use a different (higher or lower) cost-to-

[33] 68 Fed. Reg. at 34494.
[34] *Id.* at 34501 (implementing the regulations at issue).
[35] *Id.* at 34502 (emphasis added).

> charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS Regional Office.
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> (2) *For discharges occurring* ***on or after October 1, 2003***, the operating and capital cost-to-charge ratios applied at the time a claim is processed are *based on either the most recent* ***settled*** *cost report* ***or*** *the most recent* ***tentative settled*** *cost report, whichever is from the latest cost reporting period*.
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> ****
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> (4) *For discharges occurring on or* ***after August 8, 2003***, any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.[36]

Therefore, this 2003 modification of 42 C.F.R. § 412.84(i)(4) allows for reconciliation and final settlement of outlier payments using actual CCRs based on the cost reporting period being settled.

Finally, as part of the June 2003 Final Rule, the Secretary adopted a "time value of money" or TVM adjustment because a hospital that receives *excess* outlier payments would have access to those funds until the amount was repaid to the Medicare trust fund (or, in the case of an underpayment, would not have had access to the appropriate amount during the same period).[37] The Secretary gave the following explanation regarding the TVM adjustment:

> [O]utlier payments are uniquely susceptible to manipulation because hospitals set their own level of charges and are able to change their charges without notification to, or review by, their fiscal intermediary. Such changes by a hospital directly affect its level of outlier payments, unlike IME or DSH where the fiscal intermediary must agree to a change to the underlying data. Therefore, even though the money may be recouped if the outlier payments are reconciled, the hospital would essentially be able to unilaterally increase its charges and acquire an interest-free loan in the meantime. For that reason, we believe it is appropriate to apply an adjustment for the time value of overpayments or underpayments identified at cost report reconciliation. Because the other changes we are making in this final rule will largely ensure the payments hospitals receive for outlier cases are accurate, ***we do not anticipate it will be necessary to apply this adjustment broadly***. Therefore, the actual total impact of this adjustment should be relatively small.[38]

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[36] *See id.* at 34515 (emphasis added).
[37] *Id.* at 34504.
[38] *Id.* (emphasis added).

Accordingly, the June 2003 Final Rule promulgated the time value of money adjustment at 42 C.F.R. § 412.84(m) which states:

> Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under paragraph (i)(4)[39] of this section, outlier payments *may be adjusted to account for* ***the time value*** *of any underpayments or overpayments*. Any adjustment will be based upon a widely available index to be established ***in advance*** by the Secretary, and will be applied from the midpoint of the cost reporting period to the date of reconciliation.[40]

In adopting the CCR reconciliation process, the Secretary specified in the preamble to the June 2003 Final Rule that she would issue additional instructions on the threshold that would trigger mandatory reconciliation, and confirmed that Medicare contractors have "administrative discretion" to perform reconciliation "when analysis indicates the outlier payments made . . . are significantly inaccurate":

> In addition, most of the changes in this regulation will apply for approximately the last 2 months of FY 2003. We intend to limit the impact of this provision during FY 2003 to ensure that the limited resources of fiscal intermediaries are focused upon those hospitals that appear to have disproportionately benefited from the time lag in updating their [CCRs] and to maintain the overall predictability of FY 2003 payments for most hospitals. Accordingly, we intend to issue a program instruction in the near future to assist fiscal intermediaries in implementing this provision during the remainder of FY 2003.
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> ***In the same program instruction***, *we will issue thresholds for fiscal intermediaries to reconcile outlier payments for other hospitals during FY 2003*.
>
> For cost reporting periods beginning during FY 2004, we are *considering* instructing fiscal intermediaries to conduct reconciliation for hospitals whose actual cost-to-charge ratios are found to be ***plus or minus 10 percentage points*** from the [CCR] used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed $500,000. We believe these thresholds would appropriately capture those hospitals whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period. Hospitals exceeding these thresholds during their applicable cost reporting periods would become subject to reconciliation of their outlier

[39] The regulation originally cross-referenced paragraph (h)(3); however, it was later amended in 2006 to reference paragraph (i)(4). *See id.*; 71 Fed. Reg. 47870, 48098 (Aug. 18, 2006).
[40] 68 Fed. Reg. at 34515 (emphasis added).

> payments. These thresholds would be reevaluated annually and, if necessary, modified each year. However, *fiscal intermediaries would also* ***have the administrative discretion*** *to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are significantly inaccurate*.[41]

A. CMS Program Instructions Addressing Outlier Reconciliation

Consistent with the above preamble discussion in the June 2003 Final Rule, CMS issued Program Memorandum Intermediaries ("PMI") Transmittal A-03-058 on July 3, 2003[42] to provide guidance to Medicare contractors on the reconciliation process and, in particular, finalizing the 10 percent threshold discussed in the June 9, 2003 Final Rule. This Transmittal states, in pertinent part:

> [F]or discharges occurring in cost reporting periods beginning on or after October 1, 2003 for all other IPPS hospitals, fiscal intermediaries are to reconcile outlier payments at the time of cost report final settlement if:
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> 1) Actual operating or capital CCRs are found to be plus or minus 10 percentage points from the CCRs used during that time period to make outlier payments, and
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> 2) Total outlier payments in that cost reporting period exceed $500,000.[43]

On October 12, 2005, CMS issued Transmittal 707 for the MCPM, to "tell[] FIs how to implement the policies of IPPS reconciliation and how to apply the time value money to the reconciliation."[44] Through Transmittal 707, CMS essentially incorporated PMI Transmittal A-03-58 dated July 3, 2003 into the MCPM, Ch. 3, § 20. In particular, this Transmittal added the provisions to MCPM, Ch. 3, § 20.1.2.7 to detail the seven (7) steps that, effective November 7, 2005, Medicare Contractors were to follow when performing an outlier reconciliation. These provisions were slightly modified in October 2006 such that, at the time the June 4, 2009 NPR was issued, the seven (7) steps detailed at MCPM, Ch. 3, § 20.1.2.7 read:

> The following is a step-by-step explanation of how FIs are to notify CMS and hospitals that reconciliation should be performed and to record reconciled outlier claims for hospitals that meet the criteria for reconciliation:

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[41] *Id.* at 34503 (emphasis added).
[42] CMS, Program Memorandum Intermediaries, Transmittal A-03-058, Change Req. 2875 (Jul. 3, 2003) (copy at Ex. C-9 and *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03058.pdf (last visited May 29, 2024)). CMS later incorporated this memorandum's instructions into MCPM, Ch. 3, § 20.2 (Rev. 707, Oct. 12, 2005).
[43] *Id.* at 4.
[44] MCPM Transmittal 707, Change Req. 3966 at 1 (Oct. 12, 2005) (available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R707CP.pdf (last visited Aug. 12, 2024)).

1) The FI sends notification to the CMS central office (not the hospital), via the street address and email address provided in §20.1.2.1 (B)) and regional office that a hospital has met the criteria for reconciliation.

2) If the FI receives approval from the CMS central office that reconciliation is appropriate, the FI follows steps 3-8 below.

3) The FI shall notify the hospital and copy the CMS regional office and central office in writing and via email (through the addresses provided in §20.1.2.1 (B)) that the hospital's outlier claims are to be reconciled.

4) The FI shall submit to the central office PSF data that were used for discharges to compute outlier payments during the cost reporting year being final settled as well as new CCR data that have been determined as part of the settlement process of that cost report. The FI submits this data (preferably in electronic format) to the central office via the addresses provided above. Data fields that shall be submitted include PSF fields 23, Intern to Bed Ratio, 24, Bed Size, 25, all relevant Operating Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report), 27, SSI Ratio, 28, Medicaid Ratio, 47, all relevant Capital Cost to Charge Ratios (including CCRs from the date of discharge of claims being reprocessed as well as updated CCRs that has been determined as part of the settlement process of that cost report) 49, Capital IME and 21, Case Mix Adjusted Cost Per Discharge.

5) Central office will use data from National Claims History (NCH) to reprocess claims in a Pricer utility program to determine the correct outlier payment amounts.

6) CMS will calculate the time value of money attributable to the adjustment. CMS will provide the FI with a log of individual claims on which the total adjustment was determined.

7) The FI shall record the reconciled amount, the original outlier amount from Worksheet E, Part A line 2.01, the time value of money and the rate used to calculate the time value of money on lines 50-53, of Worksheet E, Part A of the cost report.

8) The FI shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.

> The central office will work as quickly as possible to reconcile these claims in order to allow FIs to finalize the cost report and issue an NPR within the normal CMS timeframes. If an FI has any questions regarding this process it should contact the central and regional office, using the address and email address provided in §20.1.2.1 (B).[45]

So initially, any outlier reconciliation was to be performed ***by CMS*** *upon referral by the relevant Medicare contractor*.

However, CMS later revised the outlier reconciliation process. Specifically, on December 3, 2010, CMS issued MCPM Transmittal 2111 "instruct[ing] the FISS to update the Lump Sum Utility . . . for IPPS . . . with additional output fields and to use the appropriate versions of Pricer" and instructing Medicare contractors to use the updated utility to re-price outlier claims offline when conducting outlier reconciliations.[46] This transmittal also revised MCPM, Ch. 3, § 20.1.2.7 to instruct Medicare contractors to conduct the outlier reconciliation using the following fourteen (14) steps:

> The following is a step-by-step explanation of the procedures that Medicare contractors are to follow if a hospital is eligible for outlier reconciliation:
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> 1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital), via the street address and email address provided in §20.1.2.1 (B)) and regional office that a hospital has met the criteria for reconciliation. Medicare contractors shall include in their notification the provider number, provider name, cost reporting begin date, cost reporting end date, total operating and capital outlier payments in the cost reporting period, the operating CCR or weighted average operating CCR from the time the claims were paid during the cost reporting period eligible for reconciliation and the final settled operating and capital CCR.
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> 2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor follows steps 3-14 below. **NOTE**: Hospital cost reports will remain open until their claims have been processed for outlier reconciliation.
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> 3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §20.1.2.1 (B)) that the hospital's outlier claims are to be reconciled.

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[45] MCPM, Ch. 3, § 20.1.2.7 (Rev. 1072, Issued Oct. 6, 2006).

[46] MCPM Transmittal 2111, Change Req. 7192 (Dec. 3, 2010) (providing, effective Apr. 1, 2011, certain "technical direction" on conducting outlier reconciliations) (available at: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2111cp.pdf (last visited Aug. 12, 2024)).

4) Prior to running claims in the *Lump Sum Utility, Medicare contractors shall update the applicable provider records in the Inpatient Provider Specific File (IPSF) by entering the final settled operating and capital CCR from the cost report in the operating and capital CCR fields. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the revised operating CCR in PSF field 25 -Operating Cost to Charge Ratio and the revised capital CCR in PSF field 47 -Capital Cost to Charge Ratio. No other elements in the IPSF (such as elements related to the DSH and IME adjustments) shall be updated for the applicable provider records in the IPSF that span the cost reporting period being reconciled aside from the elements for the operating and capital CCRs.

***NOTE**: The FISS Lump Sum Utility is a Medicare contractor tool that, depending on the elements that are input, will produce an extract that will calculate the difference between the original PPS payment amounts and revised PPS payment amounts into a Microsoft Access generated report. The Lump Sum Utility calculates the original and revised payments offline and will not affect the original claim payment amounts as displayed in various CMS systems (such as NCH).

5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g., appeal adjustments) are finalized for the applicable provider.

6) Medicare contractors shall only run claims in the Lump Sum Utility that meet the following criteria:

- Type of Bill (TOB) equals 11X
- Previous claim is in a paid status (P location) within FISS
- Cancel date is 'blank'

7) The Medicare contractor reconciles the claims through the applicable IPPS Pricer software and not through any editing or grouping software.

8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below. **NOTE**: The extract must be importable by Microsoft Access or a similar software program (Microsoft Excel).

9) Medicare contractors shall upload the extract into Microsoft Access or a similar software program to generate a report that

contains elements in Table 1. Medicare contractors shall ensure this report is retained with the cost report settlement work papers.

10) For hospitals paid under the IPPS, the Lump Sum Utility will calculate the difference between the original and revised operating and capital outlier amounts. If the difference between the original and revised operating and capital outlier amounts (calculated by the Lump Sum Utility) is positive, then a credit amount (addition) shall be issued to the provider. If the difference between the original and revised operating and capital amounts (calculated by the Lump Sum Utility) is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The difference between the original and revised operating outlier amounts and the difference between the original and revised capital outlier amounts are two distinct amounts calculated by the lump sum utility and are recorded on two separate lines on the cost report.

11) The operating and capital time value of money amounts are two distinct calculations that are recorded separately on the cost report. Medicare contractors shall determine the applicable time value of money amount by using the calculation methodology in §20.1.2.6. If the difference between the original and revised operating and capital outlier amounts is a negative amount then the time value of money is also a negative amount. If the difference between the original and revised operating and capital outlier amounts is a positive amount then the time value of money is also a positive amount. Similar to step 10, if the time value of money is positive, then a credit amount (addition) shall be issued to the provider. If the time value of money is negative, then a debit amount (deduction) shall be issued to the provider. **NOTE**: The time value of money is applied to the difference between the original and revised operating and capital outlier amounts.

12) For cost reporting periods beginning before May 1, 2010, under cost report 2552-96, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 50-56, of Worksheet E, Part A of the cost report (**NOTE**: the amounts recorded on lines 50-53 and 55 thru 56 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of

> money) shall be recorded on line 24.99 of Worksheet E, Part A. For complete instructions on how to fill out these lines please see § 3630.1 of the Provider Reimbursement Manual, Part II. **NOTE**: Both the operating and capital amounts are combined and recorded on line 24.99 of Worksheet E, Part A.
>
> For cost reporting periods beginning on or after May 1, 2010, under cost report 2552-10, the Medicare contractor shall record the original operating and capital outlier amounts, the operating and capital outlier reconciliation adjustment amounts (the difference between the original and revised operating and capital outlier amounts calculated by the Lump Sum Utility), the operating and capital time value of money and the rate used to calculate the time value of money on lines 90-96, of Worksheet E, Part A of the cost report (**NOTE**: the amounts recorded on lines 90-93 and 95 thru 96 can be positive or negative amounts per the instructions above). The total outlier reconciliation adjustment amount (the difference between the original and revised operating and capital outlier amount (calculated by the Lump Sum Utility) plus the time value of money) shall be recorded on line 69 of Worksheet E, Part A. **NOTE**: Both the operating and capital amounts are combined and recorded on line 69 of Worksheet E, Part A.
>
> 13) The Medicare contractor shall finalize the cost report, issue a NPR and make the necessary adjustment from or to the provider.
>
> 14) After determining the total outlier reconciliation amount and issuing a NPR, Medicare contractors shall restore the operating and capital CCR(s) elements to their original values (that is, the CCRs used to pay the claims) in the applicable provider records in the IPSF to ensure an accurate history is maintained. Specifically, for hospitals paid under the IPPS, Medicare contractors shall enter the original operating CCR in PSF field 25 - Operating Cost to Charge Ratio and the original capital CCR in PSF field 47 -Capital Cost to Charge Ratio.[47]

As a result of this change, Medicare contractors, rather than CMS, were directed to perform actual outlier reconciliation calculations with CMS oversight.

B. CMS Program Instructions Addressing the Time Value of Money ("TVM") Adjustment

Following the June 2003 Final Rule, CMS also issued program guidance on assessing a TMV adjustment. Specifically, at the time the June 4, 2009 NPR was issued, MCPM, Ch. 3, § 20.1.2.6

[47] *Id.*

confirmed that a Medicare contractor "may" assess a TMV adjustment and, if so, addressed how the Medicare Contractor determines the TMV adjustment:

> Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under § 20.1.2.5, outlier payment ***may*** *be adjusted* to account for the time value of money of any adjustments to outlier payments as a result of reconciliation. The time value of money is applied from the midpoint of the hospital's cost reporting period being settled ***to the date on which the CMS Central Office receives notification*** *from the FI that reconciliation should be performed*.
>
> If a hospital's outlier payments have met the criteria for reconciliation, CMS will calculate the aggregate adjustment using the instructions below concerning reprocessing claims and determine the additional amount attributable to the time value of money of that adjustment. The index that will be used to calculate the time value of money is the monthly rate of return that the Medicare trust fund earns. This index can be found at http://www.ssa.gov/OACT/ProgData/newIssueRates.html.
>
> The following formula will be used to calculate the rate of the time value of money.
>
> (Rate from Web site as of the midpoint of the cost report being settled / 365 or 366) * # of days from that midpoint until date of reconciliation.
>
> ***For purposes of calculating the time value of money***, *the "date of reconciliation" is the day on which the CMS Central Office receives notification*. This date is either the postmark from the written notification sent to the CMS Central Office via mail by the FI, or the date an email was received from the FI by the CMS Central Office, whichever is first.[48]

On June 17, 2011, CMS issued MCPM Transmittal 2242 "making a technical correct to the formula used to compute the [TMV adjustment] when Medicare contractors perform outlier reconciliation under IPPS."[49] Specifically, CMS moved the removed "<" from the TMV formula stated in MCPIM, Ch. 3, § 20.1.2.6 so that it read: "(Rate from Web site as of the midpoint of the cost report being settled / 365) * # of days from that midpoint until date of reconciliation."[50]

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[48] MCPM, Ch. 3, § 20.1.2.6 (Rev. 707, Issued Oct. 12, 2005) (emphasis added.)
[49] MCIM Transmittal 2242, Change Req. 7464 (Jun. 17, 2011) (providing effective Jul. 1, 2011 a technical correction to the formula used to compute the TMV adjustment when Medicare contractors perform outlier reconciliation) (available at: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r2242cp.pdf (last visited Aug. 12, 2024)).
[50] *Id.*

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

A. Burden of Proof and Standard of Review

Pursuant to 42 C.F.R. § 405.1871(a)(3), a Board decision must include findings of fact and conclusions of law that "the provider carried its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue." Additionally, 42 U.S.C. § 1395oo(d) specifies that "[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the [Medicare contractor] and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole." Accordingly, in an appeal before the Board, a provider must prove by a preponderance of substantial, relevant evidence that it is entitled to the relief sought.

Finally, 42 U.S.C. § 1395oo(d) confirms that "[t]he 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*."[51]

B. The Medicare Contractor properly selected the Provider's FY 2007 cost report for the outlier reconciliation process and properly reopened the Provider's cost report on March 22, 2012 to reconcile outlier payments without regard to CMS' delay in publication of the revised 2006 SSI ratios.

1. *The Medicare Contractor properly selected the Provider's FY 2007 Cost Report for the outlier reconciliation process*.

The UI Medical Center "contends that the Outlier Reconciliation process' selection criteria established under the outlier regulation at 42 CFR §412.84(h) and in the [MCPM, Ch. 3,] §20.1.2.5 as described above is invalid because the process, *as applied*, has a discriminatory application and impact to Providers in general and that CMS provided no rationale for the established numeric threshold criteria."[52]

In the alternative, the UI Medical Center contends there is procedural error and argues that the reconciliation ought to be invalidated because the Medicare Contractor failed to follow the steps

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[51] (Emphasis added.) *See also Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399, 405-06 (1988) (stating: "Section 1395oo(d), which sets forth the powers and duties of the Board once its jurisdiction has been invoked, explicitly provides that in making its decision whether to affirm, modify, or reverse the intermediary's decision, the Board can '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.' This language allows the Board, once it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary. The only limitation prescribed by Congress is that the matter must have been 'covered by such cost report,' that is, a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed."); 42 C.F.R. § 405.1869(a).

[52] Provider's FPP at 16 (emphasis added).

of the reconciliation process set forth in the MCPM, Ch. 3.[53] The UI Medical Center argues the selection process for the outlier reconciliation "has a discriminatory application and impact."[54] Further, the UI Medical Center states:

> [H]ere the MAC did not follow the Manual or its process in doing the outlier reconciliation, the varied and rogue calculation and method set forth above. The Rule in the Manual issued by the Secretary here, directs that if the outlier reconciliation is to occur it is to be done pursuant to the Manual.[55]

The UI Medical Center similarly notes that the Medicare Contractor failed to conduct the reconciliation process at settlement, as specified in the MCPM, Ch. 3 reconciliation process and, instead, waited almost 3 years to issue a reopening. Similarly, the UI Medical Center further argues that the late start of the outlier reconciliation on March 22, 2012 (over 4 ½ years after the end of FY 2007 and almost 3 years after the June 2009 NPR) is arbitrary given that the criteria for doing an outlier reconciliation was fully known when the June 2009 NPR was issued.[56]

The Medicare Contractor contends that the intent of the regulation is that:

> Prior to 2003, the hospital specific cost-to-charge ratio was often based on outdated information. In addition, there was no mechanism available to adjust outlier payments to actual cost at the time the cost report was final settled. Because of these vulnerabilities in the outlier payment methodology, several hospitals received outlier payments for cases that were, in actuality, not high-cost cases. In addition, some hospitals did not receive outlier payments for cases that were unusually high-cost cases. It is clear that Congress intended this additional outlier payment to be made only for unusually high-cost cases, but due to its weaknesses, the methodology used to determine outlier payments prior to 2003 did not always conform to this intention.[57]

The Medicare Contractor additionally cites to 42 C.F.R. § 412.84(i)(4) which states, in relevant part:

> For discharges occurring on or after August 8, 2003, any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.[58]

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[53] *Id.*
[54] *Id*.
[55] *Id.* at 17.
[56] *Id*. at 16.
[57] Medicare Contractor's FPP at 6.
[58] *Id.* at 7-8; Ex. C-8 at 4.

The UI Medical Center further argues that the Medicare Contactor erroneously issued the March 22, 2012 Notice of Reopening because it failed to obtain approval from CMS *prior to* issuing the Notice of Reopening.[59] The UI Medical Center contends that the Medicare Contractor failed to comply with the following steps in the reconciliation process set forth in MCPM, Ch. 3, § 20.1.2.7:

> 1) The Medicare contractor shall send notification to the CMS Central Office (not the hospital, via the street address and email address provided in §20.1.2.1(B)) and regional office that a hospital has met the criteria for reconciliation. [*sic* . . .]
>
> 2) If the Medicare contractor receives approval from the CMS Central Office that reconciliation is appropriate, the Medicare contractor follows steps 3-14 below. [*sic* . . .]
>
> 3) The Medicare contractor shall notify the hospital and copy the CMS Regional Office and Central Office in writing and via email (through the addresses provided in §20.1.2.1 (B)) that the hospital's outlier claims are to be reconciled.[60]

At the hearing during cross-examination by the Provider's representative, the Medicare Contractor witness affirmed that the Medicare Contractor had not received CMS approval prior to issuance of the March 22, 2012 notice of reopening:

> MR. PERKINS: So, from March 22 to 2012, CMS hadn't given approval, but then in November of 2014, it did.
>
> THE WITNESS: Correct.
>
> MR. PERKINS: So, the M[AC] issued this [notice of reopening] letter on March 12 – [2012], knowing that the three years was coming up, right.
>
> THE WITNESS: Correct.
>
> MR. PERKINS: It didn't have permission [from CMS] to do it, correct?
>
> THE WITNESS: Correct.
>
> MR. PERKINS: And more than a year later, all the way to November 2014, CMS didn't give that permission. Correct?
>
> THE WITNESS: They gave it at some point in 2014.
>
> MR. PERKINS: Okay.

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[59] Provider's Responsive Position Paper (hereinafter, "Provider's Responsive FPP") at 17 (Apr. 11, 2022).
[60] *Id.* at 16-17 (quoting MCPM, Ch. 3, § 20.1.2.7).

> THE WITNESS: But up until that time, correct.
>
> MR. PERKINS: So NGS wasn't [*sic* was] putting a placeholder in, in case it got permission.
>
> THE WITNESS: Correct.
>
> MR. PERKINS: And what gives it a right to do that?
>
> THE WITNESS: That is the standard for reopening. If something comes to the MAC's attention if the Provider requests or even a CMS instruction, we will issue a Notice of Intent to Reopen to hold that cost report open until the review is completed, at which point we -- the MAC will either deny the reopening if they determine that it's not going to be reopened or they will issue the revised Notice of Program Reimbursement and reopen the cost report.[61]

Further, when questioned regarding the process, the Medicare Contractor's witness explained the Medicare Contractor's position that it did not have to have permission from CMS to issue a notice of reopening as placeholder for the outlier reconciliation at issue:

> THE WITNESS: No, we do not have to go to CMS to implement [r]eopenings. We can -- the MAC has the authority to review and reopen depending on the issue. As long – and documentation received, etc. And the review of it.
>
> MR. PERKINS: So, it's your impression that you don't have to get permission from CMS to reopen this Outlier . . . . Reconciliation.
>
> THE WITNESS: Sorry. We needed to get permission from CMS to complete the reconciliation. So, we issued the Notice of Reopening regarding outliers to hold open that cost report. We notified CMS and then we awaited CMS' response and instruction on whether or not we should reopen. Once we received that we issued the 11/20[/]2014 letter to the Provider notifying them that we were proceeding with the reconciliation.[62]

Unequivocally, the Board recognizes that the below criteria for conducting reconciliation of UI Medical Center's FY 2007 CCR were satisfied:

> 1. The actual operating CCR is found to be plus or minus 10 percentage points from the CCR used during that time period to make outlier payments, and

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[61] Tr. at 193-194.
[62] *Id.* at 196. *See also id*. at 182-83,

2. Total outlier payments in that cost reporting period exceed $500,000.[63]

As the preamble to the June 2003 Final Rule makes clear, this criteria is designed to flag "significantly inaccurate" outlier payments and Medicare contractors have the "administrative discretion to reconcile . . . based on analysis that indicates the outlier payments . . . are significantly inaccurate."[64] Here, the UI Medical Center exceeded that criteria, thereby indicating that its FY 2007 outlier payments were "significantly inaccurate." With respect to the first criterion, the UI Medical Center *hugely exceeded* the 10 percentage point threshold because there was a 30 percent difference between the operating CCR that was used to make the reconciliation payments at issue FY 2007 (*i.e.*, 0.495[65]) and the *actual* or settled CCR that was determined in the finalized FY 2007 cost report (*i.e.*, 0.346[66]). Similarly, the Board notes total operating and capital outlier payments during FY 2007 were *hugely in excess* of the $500,000 threshold since they totaled $10,793,334.[67] Indeed, the result of the reconciliation process (as discussed more fully below) show the UI Medical Center was overpaid in excess of $6 million and, as such, confirm, in this case, why the Medicare Contractor flagged the UI Medical Center for potentially "significantly inaccurate" outlier payments regardless of what thresholds are used to initiate an outlier reconciliation process (*e.g.*, outlier payments in excess of $2 million versus $500,000).

As to the timing of the reconciliation process, the Board agrees with the UI Medical Center that both the June 2003 Final Rule and MCPM, Ch. 3, § 20.1.2.7 contemplate reconciliation generally occurring around the settlement of the relevant cost report since, at that point in time, the relevant information used to apply the reconciliation selection criteria is known.[68] However, the fact that the Medicare Contractor did not apply it at that time, but rather later, is not a fatal flaw to the reconciliation process that was later initiated with the March 22, 2012 Notice of Reopening. As noted in the D.C. Circuit Court's 2017 decision in *Clarian Health West, LLC v. Hargan*, "the [MCPM] instructions embody a general statement of policy not a legislative rule,

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[63] MCPM, Ch. 3, § 20.1.2.5(A) (consistent with PMI Transmittal A-03-058, it specified that "outlier claims will be reconciled at the time of cost report final settlement if they meet the following criteria. . . .").

[64] 68 Fed. Reg. at 34503 ("For cost reporting periods beginning during FY 2004, we are *considering* instructing fiscal intermediaries to conduct reconciliation for hospitals whose actual cost-to-charge ratios are found to be ***plus or minus 10 percentage points*** from the [CCR] used during that time period to make outlier payments, and that have total FY 2004 outlier payments that exceed $500,000. We believe these thresholds would appropriately capture those hospitals whose outlier payments will be substantially inaccurate when using the ratio from the contemporaneous cost reporting period. Hospitals exceeding these thresholds during their applicable cost reporting periods would become subject to reconciliation of their outlier payments. These thresholds would be reevaluated annually and, if necessary, modified each year. However, *fiscal intermediaries would also* ***have the administrative discretion*** *to reconcile additional hospitals' cost reports based on analysis that indicates the outlier payments made to those hospitals are* ***significantly inaccurate***." (emphasis added)).

[65] Medicare Contractor's FPP at 5; Ex. C-5 (this ratio is based upon the revised FY 2004 cost report and was in effect starting June 15, 2006 and continued throughout FY 2007).

[66] Medicare Contractor's FPP at 5; Ex. C-4.

[67] Medicare Contractor's FPP at 4. *See also* Exs. C-1, C-2 (Total Operating Outlier Payments of $10,710,738 + Total Capital Outlier Payments of $82,596).

[68] As discussed below in Subsection D of the Decision, the Board discuss how this delay impacts the Medicare Contractor's exercise of discretion under 42 C.F.R. § 412.84(m) to assess a TMV adjustment in this case.

setting forth HHS's enforcement priorities" and "[p]olicy statements do not establish binding norms."[69] Here, the regulation at 42 C.F.R. § 412.84(i)(4) controls[70]:

> For discharges occurring on or after August 8, 2003, ***any reconciliation*** of outlier payments *will be* ***based*** on operating and capital cost-to-charge ratios calculated based on a ratio of costs to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled.

Significantly, this regulation does not require notice to CMS prior to initiating a reconciliation process. Similarly, it does not specify *when* "any reconciliation" is to occur but rather only that such reconciliation be based on the relevant settled CCRs.

The Board recognizes that it must give great weight to CMS' interpretive rules and policy and procedure[71] and the MCPM includes more detail that the regulation. However, the relevant MCPM provisions are audit protocols and here the purpose and intent of the regulation is to ensure payments are not based on significantly inaccurate CCRs and to prevent abuses in the outlier payment process.[72] Here, it is clear that the UI Medical Center's outlier payments were based on significantly inaccurate CCRs and this was the type of situation the outlier reconciliation regulation was intended to address. More specifically, the UI Medical Center's outlier payments met the criteria for reconciliation and the Medicare Contractor was correct in reconciling the UI Medical Center's outlier payments.[73] Accordingly, the outlier reconciliation regulation's purpose overrides the alleged deviances from the audit protocol[74] and the Board finds that the March 22, 2012 reopening for purpose of an outlier reconciliation was proper.

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[69] 878 F.3d 346, 349 (D.C. Cir. 2017). In citing to the *Clarian* decision, the Board notes that the UI Medical Center has ***not*** made the argument that the MCPM reconciliation process violates the Administrative Procedure Act or 42 U.S.C. § 1395hh(a). Indeed, its position papers only reference the APA in another context and do not even reference 42 U.S.C. § 1395hh(a) or even the D.C. Circuit's *Clarian West* decision. Rather, without any discussion or reference in its final or responsive position paper filings, the UI Medical Center includes, as Ex. P-15, a copy of the 2016 decision of the D.C. District Court in *Clarian* that the D.C. Circuit later reversed. *See also* Tr. at 242-45.

[70] *See Maine Med. Ctr. v. Burwell*, 841 F.3d 10, 18 (1st Cir. 2016) (stating: "The Hospitals do not seriously argue that the notices failed to satisfy the plain language of the regulation. They do argue, however—and the district court found—that the notices did not satisfy the more elaborate criteria limned in the PRM: although the notices advised the Hospitals of the circumstances surrounding the reopening by identifying DSH payments as the relevant issue, they failed to furnish any additional detail and did not offer the Hospitals the opportunity to comment, object, or submit evidence in rebuttal. . . . *The regulation itself does not require* that a notice of reopening include advice about the opportunity to present evidence and arguments. ***The regulation controls***: as we said in an earlier case discussing the PRM, *the PRM is nothing more than an interpretive guide and, as such, 'interpretive guides generally do not have the force of law*.'" (citation omitted)).

[71] 42 C.F.R. § 405.1867.

[72] *See supra* note 35 and accompanying text quoting 68 Fed. Reg. at 34502.

[73] The Board further notes that 31 C.F.R. § 901.1 require agencies to "aggressively collect" debts arising out of agency activities. *See also* 31 U.S.C. § 3711.

[74] *See Ascension Borgess Hospital v. Becerra*, 61 F.4th 999, 1003 (D.C. Cir. 2023) (stating that "routine audit instructions to Medicare contractors ordinarily fall outside of section 1395hh's rulemaking requirement" (citations omitted) and "here, the Secretary's audit protocol does not constitute a 'rule' or 'requirement' that changes a *substantive legal standard*, but is a statement of policy regarding the Secretary's procedural methodology"); *see also*

2. *There is insufficient evidence to establish to that the Medicare Contractor delayed its reopening to conduct the reconciliation due to the alleged delay in CMS' publication of the Revised 2006 SSI ratios.*

The Medicare Contractor contends it did not delay its issuance of the March 22, 2012 Notice of Reopening:

> The Medicare Contractor issued the Notice of Reopening on March 22, 2012, as soon as it determined that the Provider met the criteria for Outlier Reconciliation, which was before notifying CMS, as the purpose of the Notice of Reopening was to "hold" open the aforementioned cost report until the [Medicare Contractor] would be able to finish its reconciliation review after which either the [Medicare Contractor] issues an RNPR and reopens the cost report, or the [Medicare Contractor] "denies" the reopening, which closes out the cost report for further review of the topic in the Notice of Reopening.[75]

The UI Medical Center alleges that the outlier reconciliation was delayed/postponed due to CMS directives to Medicare contractors to delay reopenings and that "the reopening occur[ed] just six days after CMS lifted the hold on re-openings."[76] In support of this allegation, it cites to the following excerpt from a May 2015 report of the HHS Office of Inspector General ("OIG Report"):

> [I]n August 2008, CMS instructed Medicare contractors to hold for settlement, rather than settle, any cost reports affected by revised Supplemental Security Income (SSI) ratios. In addition, CMS instructed Medicare contractors to stop issuing final settlements on cost reports using the fiscal years 2006 and 2007 SSI ratios in the calculation of disproportionate share hospital (DSH) payments. CMS subsequently expanded the "DSH/SSI hold" to include cost reports using the fiscal years 2008 and 2009 SSI ratios. The DSH/SSI hold remained in effect until CMS published the updated SSI ratios in June 2012.[77]

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generally HHS OIG, Report A-07-14-02800 "Vulnerabilities Remain in Medicare Hospital Outlier Payments" (Sept. 2017) (available at: https://oig.hhs.gov/documents/audit/8663/A-07-14-02800-Complete%20Report.pdf (last visited Aug. 28, 2024)). The Board also notes that the Provider failed to recognize that Step 2 in reconciliation process set forth in MCPM, Ch. 3, § 20.1.2.7 includes a "NOTE" stating: "Hospital cost reports will remain open until their claims have been processed for outlier reconciliation." The Board finds that the Medicare Contractor's Notice of Intent to Reopen (Ex. C-6) serves to ensure the cost report remains open, consistent with this direction. Further, the regulations governing reopening requests at 42 C.F.R. § 405.1885(a)(1) make clear that Medicare contractors, in general, have discretionary authority to reopen an NPR it issued.

[75] Medicare Contractor's FPP at 18.

[76] Provider's FPP at 20.

[77] *Id.* at 21; Ex. P-18 (excerpt from OIG Report No. A-07-13-02791, "CGS Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments" (May 29, 2015) (full copy available at:

The Medicare Contractor contends that the March 22, 2012 notice of reopening was "coincidently close but completely unrelated to the 'DSH/SSI Hold on Settlements'"[78] and goes on to note that "[w]hen any 'Holds on Settlements' are placed on a single provider or a group of providers, the MAC continues to issue Notices of Reopening as soon as it determines that any reopenings may become necessary."[79]

At the outset, the Board notes that the above excerpt from an OIG Report addresses issuances of NPRs (*i.e.*, settlement of as-filed cost reports) and does not address reopenings and issuance of revised NPRs. Here, the Medicare Contactor had already issued the FY 2007 NPR on June 4, 2009. Further, the OIG Report from which that excerpt was taken is entitled "CGS Administrators, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments."[80] As such, it is clear that the OIG Report focused on *another* Medicare contractor, CGS Administrators, LLC and ***not*** the Medicare contractor in this case, NGS. Based on these to findings, it is unclear how the cited excerpt from the OIG Report is relevant or supportive of the UI Medical Center's position.

Regardless of whether there was such a hold in place related to DSH/SSI Settlements, such a hold would not have prevented the Medicare Contractor from issuing a notice of reopening at any point during this timeframe, pursuant to 42 C.F.R. § 405.1885, since the alleged "DSH/SSI hold" pertains to a separately calculated adjustment – the DSH adjustment.[81,82] More specifically, the outlier adjustment is a separate adjustment and any such hold related to the DSH adjustment would not impact a Medicare contractor's discretion on whether to issue a notice of reopening related to outlier reconciliation.[83]

3. *The record before the Board sufficiently establishes that the Medicare Contractor obtained approval from CMS prior to issuing its determination on the outlier reconciliation.*

The Board recognizes the Medicare Contractor maintains that: (1) it was required only to obtain CMS approval for the reconciliation itself and not to reopen a cost report for purposes of a potential reconciliation; and (2) it ultimately obtained approval from CMS to pursue the outlier reconciliation sometime *after* it issued its March 22, 2012 notice of reopening *but before* it issued R2NPR on December 31, 2014. The following testimony from the Medicare Contractor's witness highlights these contentions:

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https://oig.hhs.gov/reports/all/2015/cgs-administrators-llc-did-not-always-refer-medicare-cost-reports-and-reconcile-outlier-payments/ (last accessed Sept. 6, 2024)).

[78] Medicare Contractor's FPP at 18.

[79] *Id.*

[80] *See supra* note 77; Ex. P-18.

[81] The Medicare Contractor recognized this in its final position paper: "A 'Hold on Settlement' means that the MAC cannot yet issue the settlement in the form of an RNPR and a reopened cost report, but it does not mean that any 'Notice of Reopening' is prohibited from being issued." Medicare Contractor's Final Position Paper at 18.

[82] The Board recognizes that the revised SSI ratios may have been published on March 16, 2012 (*see, e.g.,* https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SE1225.pdf (last accessed Aug. 10. 2024); however, the Board again notes that the revised SSI ratios concern another adjustment, namely the DSH adjustment. The outlier adjustment is a separate adjustment and any such hold related to the DSH adjustment would not impact a Medicare contractor's discretion on whether to issue a notice of reopening related to outlier reconciliation.

[83] To this end, the record reflects that earlier on April 22, 2011, the Medicare Contractor had issued a *separate* notice of reopening "to revise the Medicare SSI fraction in the DSH calculation." Ex. P-8.

> MR. BERENDS: And there's been -- there was a lot of testimony about a requirement. Seemingly implied that the MAC in this case, NGS received permission from CMS prior to reopening with respect to outliers. And this seems to be a claim limited the outliers. Is it your understanding of -- is it your understanding the MAC had to receive permission from CMS before even notifying provider of an intent to reopen?
>
> THE WITNESS: No, the MAC needed permission from CMS to complete the Outlier Reconciliation. But the MAC routinely issues the notice of reopening in cases where the initial NPR has already been issued. And just to hold the cost report open for completion of its audit work.
>
> MR. BERENDS: Okay. And the MAC ultimately did get permission from CMS to compete the Outlier Reconciliation, correct?
>
> THE WITNESS: Correct. And then the MAC issued the standard letter. I believe it was November 20th, 2014, letting the Provider know that it was completing the final step. The actual reconciliation.[84]

Consistent with this testimony that CMS approval of the reconciliation at issue occurred ***prior to*** *November 20, 2014*, the Medicare Contractor carbon copied *both* the CMS Regional Office *and* CMS Central Office on the November 20, 2014 Notice of Outlier Reconciliation that it issued to UI Medical Center (which is Step 3 in MCPM, Ch. 3, § 20.1.2.7 that follows Step 2 addressing the need for CMS approval).[85] Accordingly, the Board finds that the record before it sufficiently establishes that Medicare Contractor obtained approval from CMS prior to issuing its determination on the outlier reconciliation.[86]

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[84] Tr. at 182-83.

[85] Ex. C-11.

[86] The Board notes that the UI of Illinois does not appear to contest that CMS approved the outlier reconciliation *prior to* the November 20, 2014 Notice of Outlier Reconciliation, but rather only appears to dispute *when* that occurred *prior to* that notice. *See* Provider's Responsive FPP at 4, 16-18. *See also* Tr. at 97 ("MR. PERKINS: It was a final determination by CMS, correct? THE WITNESS: Yes, yes."); Tr. at 192-93 ("MR. PERKINS: Now, you were asked about the [M]arch 22, 2012, Notice of reopening, correct? THE WITNESS: Correct. MR. PERKINS: And you said that ultimately, the MAC got permission from CMS, and the mac then issued it's 11/20, 2014 notice? THE WITNESS: Correct. MR. PERKINS: So, from March 22 to 2012, CMS hadn't given approval, but then in November of 2014, it did. THE WITNESS: Correct."). Regardless, the regulation governing outlier reconciliations itself did not require the Medicare Contractor to obtain CMS approval prior to issuing the reconciliation determination. *See supra* Subsection B.1 of the Decision.

C. The Medicare Contractor has validated the overpayment assessment of $6,531,151 in connection with the Provider's FY 2007 outlier claims by establishing that this assessment, which was based on 47 percent of the FY 2007 outlier claims, is lower than the overpayment amount associated with 98 percent of the FY 2007 cost outlier claims.

The UI Medical Center argues that, in calculating the $6,531,151 overpayment assessment, the Medicare Contractor "did not track or follow the mandated procedures and steps . . . which set forth Medicare's direction to its [Medicare Contractors] as to how to reconcile and calculate allowed and disallowed outlier claims."[87] The UI Medical Center notes that, in connection with performing the outlier reconciliation during the reopening, the Medicare Contractor requested a new run of claims; however, due to the age of the claims, the Medicare Contractor was only able to obtain roughly 47 percent of the claims for the fiscal year at issue.[88] Those claims were run through the FISS lump sum utility. The UI Medical Center, in review of the Medicare Contractor's workpapers, argues that the Medicare Contractor applied grouped percentage results with regard to a portion of the outlier claims, and used a group percentage of 39.24 percent of allowed operating outlier claims from the portion, to be used and applied to the full 100 percent of FY 2007 operating outlier claims amount as a group.[89] The UI Medical Center further argues that, by only using the sampled list of 47 percent of the total outliers paid, the Medicare Contractor "did not process the outlier claims analysis as required by the Manual" and did its own calculations.[90]

In support, the Medicare Contractor points to the FY 2004 IPPS Final Rule[91] and asserts that the Rule made two (2) important changes designed to ensure proper outlier payments are being made appropriately:

> The first change allowed the use of cost-to-charge data from the most recently tentatively settled cost report at the time the claim was processed, which would help ensure the outlier payments as processed on the claim were more accurate. The second change, allowed outlier payments to be recalculated at the time of cost report settlement based on actual cost data, which ensured outliers would be made for unusually high-costs cases. This new methodology would be much more effective in ensuring compliance with the Law.[92]

The Medicare Contractor further noted that the Final Rule also affords hospitals "the opportunity to request that a different CCR be applied in the event it believed that the CCR being applied was inaccurate."[93]

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[87] Provider's FPP at 10.
[88] *Id*.
[89] *Id.* at 11; Provider's Responsive FPP at 8.
[90] Provider's FPP at 11.
[91] 68 Fed. Reg. 34494 (excerpt at Ex. C-7).
[92] Medicare Contractor's FPP at 6.
[93] *Id. See also* 68 Fed. Reg. at 34511. *See also* MCPM, Ch. 3, § 20.1.2.1(D) (stating that "a hospital will have the opportunity to request that a different CCR be applied in the event it believes the CCR being applied is inaccurate."). In this regard, the Board notes that certain Medicare statutory, regulatory, and manual provisions address certain

Regarding the claims data requested and obtained for the UI Medical Center, the Medicare Contractor, in its final position paper, describes how it was able to restore archived claims and then use these additional claims to validate the original outlier reconciliation overpayment assessment:

> At the time of the review performed for the R2[]NPR, an estimate was used based upon the claims that were available to be retrieved from archive at the time, which was approximately 50%. The reconciliation team has now been able to restore the archived claims for the entire year, equal to 98% of total, to perform a more complete review; thus materially all of the claims from July 1, 2006, through June 30, 2007, were able to be processed through the FISS Lump Sum Utility. As a result of this more complete review in this appeal, it has been determined that the estimate utilized in the R2[]NPR issued on December 31, 2014, understated the amount owed by the Provider, so the Provider was not disadvantaged with the use of the estimate at the time of the issuance of the R2[]NPR.[94]

The Medicare Contractor included a summary of its revised adjustments at Exhibit C-2 and noted that the expanded review of 98 percent of the FY 2007 outliers resulted in an *additional* amount due from the UI Medical Center in the amount of $326,523.[95]

The UI Medical Center, in its responsive brief, questions the Medicare Contractor's re-calculation done seven (7) years after the R2NPR date, and further argues that the Medicare Contractor's final position paper and exhibits do not detail or document the reconciliation review results for this re-calculation.[96] The UI Medical Center contends that the Medicare Contractor's re-calculation[97], which occurred at the time the Medicare Contractor filed its final position paper, is untimely and is not appropriate for consideration, and concludes the work done by the Medicare Contractor in 2014 was erroneous.[98]

To this end, during the hearing, the UI Medical Center objected the inclusion of Exhibit C-2 in the record. However, in review of Exhibit C-2 and the Medicare Contractor's revised reconciliation, the Board overruled that objection and admitted Exhibit C-2 into the record finding that the

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provider obligations to report and return monies that it received in error from the Medicare program. *See, e.g.*, Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, § 6402(a), 124 Stat. 119, 755-56 (2010) (adding 42 U.S.C. 1320a-7k(d) entitled "Reporting and Returning Overpayments"). See also regulatory discussion in the CMS proposed rule entitled "Medicare Program; Reporting and Repayment of Overpayments" at 67 Fed. Reg. 3662, 3663 (Jan. 25, 2002) (addressing 42 U.S.C. § 1320a-7b(a)(3) stating that the proposed rule "would further memorialize the longstanding responsibility for all providers . . . to report overpayments and establish the time frame and process for making those reports" and stating that "failure to notify us of an overpayment within a reasonable period of time may, in certain circumstances, establish criminal liability, and result in a referral to the Office of Inspector General").

[94] Medicare Contractor's FPP at 6-7 (emphasis in original).

[95] *Id.* at 7.

[96] Provider's Responsive FPP at 3.

[97] Medicare Contractor's FPP at 14; Ex. C-2.

[98] Provider's Responsive FPP at 4.

arguments presented with the objection went to the weight of the document and not to any basis for excluding the document which had been offered as part of the normal position paper process.[99]

With regard to the weight of the document, the UI Medical Center contends that the matter at issue in this appeal should be limited to review of the calculations performed by the Medicare Contractor at the time R2NPR was issued, and should not encompass the new reconciliation work the Medicare Contractor performed in 2022. [100] Specifically, the UI Medical Center contends:

> Here the MAC was charged with doing a proper outlier claims analysis and calculation following the mandated protocol and programming of the Medicare Manual and using the Lump Sum Utility tool. It was required to retrieve and input all claims at audit reconciliation in 2014, but it did not do so. The failure of the MAC in not utilizing all the outliers for FY 2007 was not caused in any fashion by Provider. The MAC was tasked by the Medicare procedures with obtaining the data from Medicare. The Medicare Manual for calculating allowable and disallowed outlier claims is clear, the procedures and use of the Utility tool are mandatory for calculating outlier disallowed overpayments. Due to the MAC's failure to run the full year of outlier claims through the FISS Lump Sum Utility tool as per the above instructions, and due to the MAC's use of unauthorized grouping percentage calculations, which are clearly not only outside the step-by-step set of procedures that Medicare contractors are mandated to follow, but are clearly prohibited by the Manual, the MAC wrongly by its rogue extrapolation calculations disallowed Provider outlier claims in an excessive add on amount of $3,470,527 for operating outlier claims, and disallowed Provider in an excessive add on amount of $12,577 for capital outlier claims, all of which should be reversed.[101]

In reference to the Medicare Contractor's revised reconciliation work as submitted with its final position paper, the Medicare Contractor representative stated during the hearing that its review of the additional archived claims *validates* the original overpayment assessment:

> The MAC was faced with a situation where it struggled to recover all of the archived d[ata] that was explained in our position. The MAC annualized and projected, based on the data, that it had -- and came up with a disallowance of $[]6,507,394, in outliers -- in outlier

[99] Tr. at 10-17. The UI Medical Center was aware of the Medicare Contractor's efforts and the CMS email dated June 28, 2016 at Ex. P-12 confirms that, when the Medicare Contractor filed its preliminary position paper 2 days later on June 30, 2016, the Medicare Contractor still did not have available additional outlier claims beyond the 47 percent and the Provider was aware of this unavailability, consistent with Board Rule 25.2.2. Further, the Board notes that the UI Medical Center filed a Responsive Final Position Paper with three (3) additional exhibits on April 11, 2022.

[100] Provider's Responsive FPP at 5.

[101] *Id.* at 12.

> payments. Subsequent to, and in the MAC's final position paper, they note, that they were able to recover and annualize substantially all of the data for all of the claims, and they undercharged the provider for about $300,000. *In essence, the MAC got it right*, even on the extrapolation -- the MAC got it right and to the extent that the MAC got it wrong, that's a benefit to the provider. [102]

The Board recognizes the UI Medical Center contends that the Medicare Contactor's use of only 47 percent of available claim data when determining the outlier reconciliation hampers its ability to verify the *original* overpayment assessed:

> [T]he failure to run the outliers through the Utility tool one by one, leaves the Provider unable to make any analysis or review the adjustments for more than half the outlier claims, and further denies Provider the benefit of any positive outliers. [103]

Accordingly, the UI Medical Center has requested that the Board reduce the overpayment to that associated with the 47 percent claims for which the data was available:

> [i]f the outlier assessment is not reversed in its entirety[,] the disallowance of the operating outlier claims *should be reduced* to the amount shown in the Utility tool extract of no more than $3,036,867 and the disallowance of the capital outlier claims should be reduced to the amount shown in the Utility tool extract of no more than $11,180, with total disallowed outlier claims reduced to no more than $3,048,047.[104]

However, the Board disagrees with the UI Medical Center's rationale. In evaluating the Medicare Contractor's initial review utilizing the 47 percent of the claims data available to determine the UI Medical Center's overpayment, the Medicare Contactor utilized the data available to it in performing the review. Further, UI Medical Center's argument that its ability to verify the original overpayment was hampered by the Medicare Contractor's partial universe of 47 percent is unreasonable. The calculation of a claim's payment, including outliers, is a standard formula, and is based upon data that is submitted by the provider to the relevant Medicare contractor for payment. In most cases, the provider uses any one of numerous patient accounting software packages to submit claims and value them. In fact, many providers can, and do, value individual claims as part of their review of their accounts receivable from Medicare on a monthly basis, simply using Microsoft Excel. While the Medicare Contractor may have had trouble pulling up the complete claims data, it is certainly possible that it all existed within UI Medical Center's patient accounting system. At which point, UI Medical Center could have recalculated all of its available claims to compare with the Medicare Contractor's final overpayment. If it wanted to refute the Medicare Contractor's claims, such a calculation would have been of great use to it in doing so.

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[102] Tr. at 35.
[103] Provider's FPP at 13.
[104] *Id.* at 14.

The review of CMS standard practices for sampling during cost report audits show that, as discussed below, those practices align with guidelines in Chapter 9 of the Financial Management Manual, CMS Pub. 100-06 ("FMM"). It is clear the Medicare Contractor's goal, when it did not have all claims data available at the time it performed its review (prior to the issuance of R2NPR), was to project the overpayment based on the 47 percent of claims data which was available.[105] However, the MCPM[106] does not explicitly state that a Medicare contractor *must* run ***all*** encounters through the lump sum utility tool. As previously referenced, the Board notes that MCPM, Ch. 3, § 20.1.2.7 set forth the steps for a Medicare contractor to take when running claims data through the lump sum utility:

> 5) Medicare contractors shall ensure that, prior to running claims through the FISS Lump Sum Utility, all pending claims (e.g. appeal adjustments) are finalized for the applicable provider.
>
> 6) Medicare contractors shall ***only*** *run* claims in the Lump Sum Utility that meet the following criteria:
>
> - Type of Bill (TOB) equals 11X
> - Previous claim is in a paid status (P location) within FISS
> - Cancel date is 'blank'
>
> 7) The Medicare contractor reconciles the claims through the applicable IPPS Pricer software and not through any editing or grouping software.
>
> 8) Upon completing steps 3 through 7 above, the Medicare contractor shall run the claims through the Lump Sum Utility. The Lump Sum Utility will produce an extract, according to the elements in Table 1 below.[107]

Again, nowhere does it state in the instructions that a Medicare contractor *must* run *all*, *most, or substantially all* claims through the lump sum utility. Here, the Medicare Contractor simply took the claims available to it at the time, approximately 47 percent of the UI Medical Center's total claims during FY 2007 and projected the 47 percent to the universe of claims.[108] In essence, and

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[105] What is unclear, however, is whether additional procedures were employed by the Medicare Contractor, following receipt of only 47 percent of the claims data, when projecting the errors found in its review of UI Medical Center's 47 percent of claims to the universe when calculating an overpayment, including but not limited to a review of gross charges-per-inpatient claim billed that triggered the outlier payment, the case mix index of the Medicare claims found in the 47 percent of claims compared to the case mix index of all Medicare inpatient claims during the fiscal year, amongst other considerations. Undisputedly, though, when the Medicare Contractor did obtain nearly all of the claims data, as it demonstrated in its final position paper, the margin of error when it utilized only 47 percent of the universe in projecting the overpayment versus utilizing 98 percent of the universe was *low*, to the point that the Medicare Contractor *very closely* determined, in R2NPR, the UI Medical Center's overpayment for outlier claims.

[106] MCPM, Ch. 3, § 20.1.2.7 (Rev. 707, Oct. 12, 2005).

[107] (Emphasis added.)

[108] Medicare Contractor's FPP at 6-7.

while not its original intent, the Medicare Contractor utilized a "sample" of claims when making its determination.

Chapter 9 of the Financial Management Manual, CMS Pub. 100-06 ("FMM") addresses procedures that Medicare contractors use in auditing provider cost reports. These procedures address designing sampling or tests in FMM, Ch. 8, § 60.6 and describes how sampling may be statistical or nonstatistical:

> Design such tests as are necessary to accomplish your audit objectives. Your tests must aid you in reaching conclusions necessary to complete the audit. Use sampling when this would be more efficient in testing the universe of transactions, entries, or statistical data within an area of consideration.
>
> Sampling is the application of an audit procedure to less than 100 percent of the items within an account balance, class of transactions, or statistics (e.g., count of interns/residents) to evaluate some characteristic of the such balance, class, or statistics. On the basis of facts known to you, decide if all transactions, balances, or statistics that pertain to the issue/area being tested need to be reviewed in order to obtain sufficient evidence. In most cases, an auditor will test at a level less than 100 percent.
>
> There are two general sampling approaches, nonstatistical and statistical. Either approach, when properly applied, can provide sufficient evidential data related to the design and size of an audit sample, among other factors. A nonstatistical sample may support acceptance of findings, but findings must be scientifically established to support adjustments.
>
> Some degree of uncertainty is inherent in applying audit procedures and is referred to as ultimate risk. Ultimate risk includes uncertainties due both to sampling and other factors. Sampling risk arises from the possibility that when a compliance or a substantive test is restricted to a sample, the auditor's conclusions may be different had the test been applied in the same way to all items in the account balance, class of transactions, or statistics.
>
> If you use a sample to test certain issues scoped for audit, you must include a description of the sampling technique, all parameters used to select the sample, and confidence level in the audit working papers.[109]

[109] FMM, Ch. 8, § 60 (Rev. 60, Nov. 26, 2004).

While the Medicare Contractor's intent was *not* to "sample" the UI Medical Center's claims data, in this instance, the Board notes that sampling is relevant in that the Medicare Contractor was not able to recover all claims at the time of R2NPR; and, therefore, relied on a mechanism to identify the total overpayment for the universe of claims in FY 2007. As noted above, the FMM indicates there is no "one size fits all" approach regarding the determination of a sample.[110]

The UI Medical Center's request that the Board simply use the errors identified in the 47 percent of claims found and run through the lump sum utility, and reduce the amount owed to $3,048,047, is contrary to the existence of the outlier reconciliation in the first place, which is to reflect the ***correct payment*** on ***all*** outlier claims for the fiscal year at issue. As MCPM, Ch. 3, § 3.20.1.2.5(A) makes clear, the CMS' intent is that if it meets the two (2) criteria, then "a hospital's outlier claims ***will*** *be reconciled*." Here, it is undisputed that the UI Medical Center met that criteria for FY 2007, namely that the actual operating CCR is 10 percentage points (plus or minus) from the CCR used to make outlier payments during FY 2007 and the total outlier payment for FY 2007 exceeded $500,000.[111] Indeed, as a result of this criteria being well exceeded, it is undisputed that the UI Medical Center's original outlier payments for FY 2007 were based on significantly inaccurate CCRs and, as such, were the very type of situation that the regulation was intended to address as highlighted by the following excerpt from the preamble to the June 2003 Final Rule:

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[110] While not directly applicable, the Board notes that the Medicare Program Integrity Manual, CMS Pub. No. 100-08 ("MPIM") also addresses statistical sampling in Chapter 3 and states the following in § 3.10.4.3 regarding sample size:

> The size of the sample (i.e., the number of sampling units) will have a direct bearing on the precision of the estimated overpayment, but *it is not the only factor that influences precision*. The standard error of the estimator also depends on (1) the underlying variation in the target population, (2) the particular sampling method that is employed (such as simple random, stratified, or cluster sampling), and (3) the particular form of the estimator that is used (e.g., simple expansion of the sample total by dividing by the selection rate, or more complicated methods such as ratio estimation). It is neither possible nor desirable to specify a minimum sample size that applies to all situations. *A determination of sample size may take into account many things, including the method of sample selection, the estimator of overpayment, and prior knowledge (based on experience) of the variability of the possible overpayments that may be contained in the total population of sampling units*.
>
> In addition to the above considerations, real-world economic constraints shall be taken into account. As stated earlier, sampling is used when it is not administratively feasible to review every sampling unit in the target population. In determining the sample size to be used, the PSC BI unit or the contractor MR unit shall also consider their available resources. That does not mean, however, that the resulting estimate of overpayment is not valid, so long as proper procedures for the execution of probability sampling have been followed. A challenge to the validity of the sample that is sometimes made is that the particular sample size is too small to yield meaningful results. Such a challenge is without merit as it fails to take into account all of the other factors that are involved in the sample design.

(Emphasis added).

[111] MCPM, Ch. 3, § 20.1.2.5 (A) (Rev. 2111, Dec. 3, 2010) (emphasis added). Indeed, this MCPM provision further states: "Even if a hospital does not meet the criteria for reconciliation, subject to approval of the Regional and Central Office, the Medicare contractor has the discretion to request that a hospital's outlier payments in a cost reporting period be reconciled if the hospital's most recent cost and charge data indicate that the outlier payments to the hospital were significantly inaccurate."

> As noted above and in the proposed rule, in light of the gross abuses of the current methodology by some hospitals and the negative impact such overpayments ultimately have on other hospitals due to their effect on the threshold, we believe the option of reconciling outlier payments based on the settled cost report for hospitals that have been initially paid using a significantly inaccurate cost-to-charge ratio compared to the actual ratio from the cost reporting period is now appropriate. In our view, reconciling outlier payments because they were originally paid on the basis of a significantly inaccurate cost-to-charge ratio is similar to recovering outlier payments when adjustments are made to covered charges for any services that are not found to be medically necessary or appropriate Medicare services upon medical or other review. This review is explicitly provided for at § 412.84(d). This provision was established when the IPPS was first implemented for FY 1984 (48 FR 39785).
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> ****
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> We continue to believe that cost report reconciliation is the most appropriate way to ensure that outlier payments are made only for truly costly cases.
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> ****
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> The steps we are taking in this final rule to direct fiscal intermediaries to update cost-to-charge ratios using the most recent tentative settled cost reports and using actual cost-to-charge ratios rather than statewide average ratios will greatly reduce the opportunity for hospitals to manipulate the system to maximize outlier payments. However, these steps will not completely eliminate all such opportunity. A hospital would still be able to dramatically increase its charges far above its rate-of-increase in costs during any given year in order to obtain excessive outlier payments. Therefore, we believe reconciliation is necessary to ensure that outlier payments are appropriately paid in the future.[112]

Moreover, the universe of outlier payments being reconciled is fairly homogenous given that the CCRs upon which the original outlier payments were made were too low and the UI Medical Center was in an overpayment situation.[113] As explained in MCPM, Ch. 3, § 20.1.2, an outlier payment is determined as follows:

> The actual determination of whether a case qualifies for outlier payments is made by the fiscal intermediary (FI) using Pricer, which

[112] 68 Fed. Reg. at 34502-03.

[113] In contrast, if the UI Medical Center was in an underpayment situation, then the whole universe of claims for the fiscal year at issue would have had to have been rerun to see if additional claims qualified for an outlier payment. In an overpayment situation, the UI Medical Center had too many claims qualifying for an outlier payment and/or received too much for the qualifying outlier.

> takes into account both operating and capital costs and diagnostic related group (DRG) payments. That is, the combined operating and capital costs of a case must exceed the fixed loss outlier threshold to qualify for an outlier payment. The operating and capital costs are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios. The estimated operating and capital costs are compared with the fixed-loss threshold after dividing that threshold into an operating portion and a capital portion (by first summing the operating and capital ratios and then determining the proportion of that total comprised by the operating and capital ratios and applying these percentages to the fixed-loss threshold). The thresholds are also adjusted by the area wage index (and capital geographic adjustment factor) before being compared to the operating and capital costs of the case. Finally, the outlier payment is based on a marginal cost factor equal to 80 percent of the combined operating and capital costs in excess of the fixed-loss threshold (90 percent for burn DRGs). Any outlier payment due is added to the DRG adjusted base payment rate, plus any DSH, IME and new technology add-on payment. For a more detailed explanation on the calculation of outlier payments, visit our Web site at http://www.cms.hhs.gov/providers/hipps/ippsotlr.asp.[114]

A simple way to state it is that the calculation of outliers is based upon total charges, adjusted by a single CCR to reflect calculated costs which are then compared to a single threshold to determine whether an outlier will be paid. If yes, the payment is 80 percent of the amount that is in excess of the threshold. The outlier calculation is applied in the same way for every claim that exceeds the threshold.

The evidence provided by UI Medical Center in this appeal indicates that the CCR was changed to 0.495, effective June 15, 2006,[115] and then dropped by more than 25 percent to 0.365, effective October 1, 2007.[116] Thus, for the entire FY 2007 (*i.e.*, from July 1, 2006 to June 30, 2007), the outliers were paid using the same 0.495 CCR. Thus, any error would be consistent across the entire fiscal year. Therefore, the population is very homogenous, as the primary variant is the total charges.[117] As the calculations are identical, with only one real variant, it is reasonable that the outcome in 47 percent of the cases is indicative of the outcome in all cases.

Regardless, while the UI Medical Center disagrees with the Medicare Contractor's calculation methodology, the Board notes the Medicare Contractor did later recover *substantially* all,

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[114] (Rev. 707, Issued 10-12-05.)
[115] Ex. P-10.
[116] Ex. P-11.
[117] As noted by the UI Medical Center, the other variant is the outlier threshold amount given that the federal rate year runs from October 1st through September 30th and the outlier threshold amount decrease from $25,800 to $23,600, effective October 1, 2006 at the beginning of month 4 of the fiscal year at issue. Provider's FPP at 12. The UI Medical Center asserts that "[t]he MAC here used only the subset group claims of $4,998,481 shown in the Utility tool extract (Provider Ex. [P-3]), all with dates from only the last part of the fiscal year from February to June 2007."

specifically 98 percent, of patient records and re-ran the results within the lump sum utility tool.[118] This method determined that the Medicare Contractor's original calculation of the overpayment using 47 percent of claims data was *very close* to the overpayment calculated using 98 percent of the claims data. In essence, it validates the Medicare Contractor's original calculation methodology and confirms that, whether described as an "estimate,"[119] sample, or simply "the claims that were available to be retrieved from archive at the time,"[120] the overpayment calculation was *just*. Moreover, the Medicare Contactor actually determined an additional overpayment of $326,523[121] that should have been recovered, thereby reiterating that its original calculation was, in fact, appropriately identified as an overpayment and that the UI Medical Center "was not disadvantaged with the use of the estimate."[122] The Board agrees with the Medicare Contractor.

While the UI Medical Center further disagrees about this inclusion and transmission of new evidence,[123] the Board, as discussed during the hearing,[124] notes that this information was filed as part of the normal process of filing position papers, a time when both parties have the ability to enhance their positions and state material facts that support their respective position.[125] The Medicare Contractor's later calculations, performed during the preparation of its Final Position Paper, serve to support and validate the original adjustments by providing additional review of the remaining claims to show that the results of the original review (of 47 percent of the claims) were appropriate and resulted in a comparable overpayment amount when compared with the results of the later review (covering 98 percent of the claims). Though the rerun of the information occurred after the R2NPR, and over seven years following the date of the R2NPR, the Board finds the Medicare Contractor's actions to be proper.[126]

Accordingly, upon review, the Board has determined that, consistent with its authority under 42 U.S.C. § 1395oo(d) and 42 C.F.R. §§ 405.1845(h) and 405.1869(a), the appropriate action in this case is to remand this case back to the Medicare Contractor to run the 98 percent of the FY 2007 outlier claims (as identified by the Medicare Contractor) through the FISS Lump Sum Utility, reconcile the claims through the applicable IPPS Pricer software to formally arrive at the overpayment assessment for the UI Medical Center based solely on that 98 percent (which is estimated to total $6,795,440 per the Medicare Contractor Workpapers at Exhibit C-2), and then issue the new overpayment assessment to the UI Medical Center. It is clear that the UI Medical Center was overpaid but that the overpayment assessment did not represent the full overpayment. As a result, the correct overpayment amount should be formally determined and assessed based on a reprocessing of the 98 percent claims available.[127]

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[118] Medicare Contractor's FPP at 7.
[119] *Id.* at 6.
[120] *Id.* at 6-7.
[121] *Id.* at 7.
[122] *Id.*
[123] Provider's Responsive FPP at 2-3.
[124] *See supra* note 99.
[125] Board Rules 25.1, 27 (v. 1.3, July 1, 2015).
[126] In the alternative, the Medicare Contractor could have requested that the Board remand the case for a recalculation of the overpayment based on the additional claims identified.
[127] It is important to note that UI Medical Center does not argue that its outlier payments for FY 2007 are incorrect, but rather simply that not all of its FY 2007 outlier claims were reprocessed at the time of the reconciliation. This remand resolves that concern.

D. The TVM adjustment assessed for FY 2007 did not comply with 42 C.F.R. § 412.84(m).

When the Medicare Contractor issued its R2NPR on December 31, 2014, it assessed the UI Medical Center a TVM adjustment in the amount of $1,532,358 for operating outliers and $5,594 for capital outliers.[128] Pursuant to the formula for calculating a TMV adjustment specified in 42 C.F.R. § 412.84(m) and MCPM, Ch. 3, § 20.1.2.6, the Medicare Contractor needed to identify three different variables, namely: (1) the mid-point of the cost reporting period at issue; (2) the date of reconciliation; and (3) the monthly rate of return that the Medicare trust earns as of the determined mid-point.[129] The Medicare Contractor determined these three (3) variables as follows:

1. *The Mid-Point of the Cost Reporting Period*.—The UI Medical Center's FY 2007 (*i.e.*, July 1, 2006 through June 30, 2007) is the cost reporting period at issue. The Medicare Contractor identified the midpoint of FY 2007 as December 30, 2006.

2. *The Date of Reconciliation*.—For the date of reconciliation, the Medicare Contractor selected March 22, 2012, the date that the MAC issued its FY 2007 cost report reopening for the outlier reconciliation (which it recognizes is earlier than when it purportedly notified CMS).[130]

3. *The Monthly Rate of Return That the Medicare Trust Earns as of the FY Midpoint*.—To determine the monthly rate of return, the Medicare Contractor applied the rate of interest for December 2006, the midpoint of FY 2007. Per the Social Security website for Interest Rates on Social Security Investments, 4.5 percent was the monthly rate of return for December 2006.[131]

The selection of the December 30, 2006 and March 22, 2012 dates resulted in 1,910 days as the period of time over which the TMV adjustment was being assessed. Accordingly, based on these factors, Medicare Contractor applied a TVM rate of approximately 23.55 percent, as computed by taking 4.5 percent divided by 365 days in the cost reporting period, and multiplying that result by 1,910 days.[132]

The Medicare Contractor next calculated the operating outlier adjustment at $6,507,394 and computed the TVM adjustment enhancement for the operating outlier claims to be $1,532,358 (*i.e.*,

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[128] Ex. C-1 at 5.
[129] Per MCPM, Ch. 3, § 20.1.2.6, the formula is: "(Rate from Web site as of the midpoint of the cost report being settled / 365 or 366) * # of days from that midpoint until date of reconciliation."
[130] Ex. C-1 at 7.
[131] Medicare Contractor's FPP at 12; Ex. C-10 at 1. *See also* https://www.ssa.gov/OACT/ProgData/newIssueRates.html (last visited May 29, 2024). In reviewing the Social Security monthly rates of return at Ex. C-10 for each of the months in the UI Medical Center's FY 2007, the Board notes that December 2006 was the lowest rate of return at 4.500 percent. The other months were 5.250 for July 2006; 5.000 for August 2006 and June 2007; 4.750 for September and October 2006 and for January and April 2007; 4.625 for November 2006 and March and May 2007; and 4.875 for February 2007. Thus, the average rate of return across the UI Medical Center's FY 2007 was close to 4.8 percent. Had this average been used, the TMV rate would have been significantly higher. Thus, using the rate of return for the FY mid-point as specified in MCPM, Ch. 3, § 20.1.2.6 was to the benefit of the UI Medical Center.
[132] Medicare Contractor's FPP at 13; Ex. C-1 at 7. The TMV rate is 23.54794520547945 percent.

$6,507,394 multiplied by the TMV rate).[133] Similarly, the Medicare Contractor calculated the capital outlier adjustment at $23,757 and computed the TVM adjustment for the operating outlier claims to be $5,594 (*i.e.*, $23,757 multiplied by the TMV rate).[134] In assessing a TMV adjustment of $1,537,952 (*i.e.*, $1,532,358 + $5,594), the Medicare Contractor contends it "followed the regulations and instructions in determining the Providers' outlier reconciliation adjustments, which include the [TVM] added to any overpayments"[135] In particular, in establishing the regulation at 42 C.F.R. § 412.84(m), the Secretary explained the need for the addition to the reimbursement amount of a TVM adjustment to prevent Providers from obtaining a type of interest free loan, but assured in comments that the TVM enhancement amounts should be small.[136]

The UI Medical Center contends that the TVM adjustment is based on an invalid regulation and was erroneously assessed because the debt obligation was not established.[137] Further, the UI Medical Center contends 42 C.F.R § 412.84(m) is an invalid regulation in creating the TVM adjustment. In support of this contention, the UI Medical Center points to the regulation at 42 C.F.R. § 405.378 which is entitled "Interest charges on overpayment and underpayments to providers, suppliers, and other entities." The UI Medical Center maintains that this regulation should govern any interest due on overpayments arising from an outlier reconciliation and that no "TMV enhancement" should be assessed since it does not address TMV assessments.[138]

Regardless of the validity of the regulation, the UI Medical Center maintains that the Medicare Contractor TMV adjustment at issue is not valid because the Medicare Contractor failed to obtain CMS approval in a timely fashion, consistent with MCPM, Ch. 3, § 20.1.2.7:

> By its statements in its [final position paper] the MAC has shown that no timely Notice to reopening to reconcile the Provider's FY 2007 cost report outlier claims was made by the MAC. *There was no timely authorization from CMS to do the 2012 reopening for outlier claim reconciliation, and* ***there was no jurisdiction to do an outlier claim reconciliation or assessment****, and the assessment in its entirety should be reversed*. The Provider learned of the facts concerning communications between the MAC and CMS, and the fact the MAC did not timely seek authorization from CMS to do the outlier claim reconciliation reopening, from admissions of the MAC stated in the [Medicare Contactor's final position paper], and thus the Provider submits this further issue in this Response to the [Medicare Contractor's final position paper] to present and argue on the MAC's admissions made in the [Medicare Contactor's final position paper], and seeks to have the entire assessment reversed as

[133] Medicare Contractor's FPP at 13. More specifically, $6,507,394 x 23.54794520547945 = $1,532,358 rounded to the nearest dollar.
[134] *Id*. More specifically, $23,757 x 23.54794520547945 = $5,594 rounded to the nearest dollar.
[135] *Id*. at 16.
[136] 68 Fed. Reg. at 34504.
[137] Provider's FPP at 19.
[138] *Id.* (discussing and quoting the tile of 42 C.F.R. § 405.378).

> erroneous having been made by an untimely reopening and without proper Notice to Provider. [139]

Thus, in the alternative, the UI Medical Center has asked that the Board reverse the TMV adjustment based on the contention that the Medicare Contractor lacked the authority or jurisdiction under MCPM, Ch. 3, § 20.1.2.7 to issue the March 22, 2012 Notice of Reopening.

At the outset, the Board notes that, pursuant to 42 C.F.R. § 405.1867, it "must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder" and "shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS." Accordingly, the Board recognizes the UI Medical Center's challenge to the *substantive* validity of 42 C.F.R. § 412.84(m); however, the Board has no authority to address that challenge as it must comply with that regulation and further notes that the Secretary responded to such concerns/comments in the preamble to the final rule adopting that regulation.[140]

As a result, the Board turns its attention to the alternative argument made by the UI Medical Center which focuses on the procedural steps in MCPM, Ch. 3, § 20.1.2.7 and concerns whether the Medicare Contractor's failure to obtain initial approval from CMS under Steps 1 to 3 in MCPM, Ch. 3, § 20.1.2.7 prior to issuing the March 22, 2012 Notice of Reopening is a fatal procedural flaw that otherwise invalidates the subsequent TMV assessment. As explained above, the Board concludes that it does not.

Notwithstanding, for different reasons, the Board finds the assessment of the TMV was not in compliance with § 412.84(m) which states:

> Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under paragraph (i)(4) of this section, outlier payments ***may*** *be adjusted* to account for the time value of any underpayments or overpayments. *Any adjustment* will be based upon a widely available index to be established in advance by the Secretary, and ***will be applied*** from the midpoint of the cost reporting period ***to the date of reconciliation***.

Thus, the regulation specifies that, if a TMV adjustment is made, then it "will be applied . . . to the date of reconciliation." Here, from the face of the regulation, the date of reconciliation would appear to technically be December 31, 2014 when the Medicare Contractor issued the reconciliation determination at issue; however, under the interpretive guidance at MCPM, Ch. 3, § 20.1.2.6 specifies that the date of reconciliation is the date of CMS notification:

> ***For purposes of calculating the time value of money***, *the "date of reconciliation" is the day on which the CMS Central Office receives notification*. This date is either the postmark from the

[139] Provider's Responsive FPP at 4.
[140] 68 Fed. Reg. at 34504.

> written notification sent to the CMS Central Office via mail by the FI, or the date an email was received from the FI by the CMS Central Office, whichever is first.[141]

However, as discussed above, the Medicare Contractor cannot establish exactly when it notified CMS but only that it occurred sometime between the March 22, 2012 Notice of Reopening and the November 20, 2014 Notice of Reconciliation. Instead, the Medicare Contractor selected March 22, 2012 (the date the Notice of Reopening for reconciliation was issued) and the Medicare Contractor does not document why it chose this particular date (as opposed to another date, *e.g.*, June 4, 2009) but *implies* that it used the earlier date since it could not establish when it later notified CMS and this earlier date would be more equitable.[142]

In exercising its discretion to assess a TMV adjustment, the Medicare Contractor failed to comply with the directive in the regulation that the TMV adjustment "be applied . . . to the date of reconciliation" and instead selected a different date. Specifically, the Medicare Contractor chose an earlier date of March 22, 2012, more than 2½ years earlier in recognition of the fact that it waited so long to obtain authorization from CMS to complete the outlier reconciliation. Indeed, while not required (as discussed above), both the June 2003 Final Rule and the audit protocol in MCPM, Ch. 3, § 20.1.2.7 contemplate reconciliation occurring around the time of settlement of the relevant cost report since, at that point in time, the relevant information used to apply the reconciliation selection criteria is known.[143] Here that would have been on or about June 4, 2009. Indeed, during the hearing, the Medicare Contractor's witness confirmed that, *at the time the FY 2009 NPR was issued*, the Medicare Contractor was aware that the UI Medical Center was a candidate for outlier reconciliation review:

> MR. PERKINS: You were asked about the two criteria for the outlier review. And you said there was the 10 percent variance and you said it was a 500,000-dollar amount. In this case, would that have been known when the NPR issued in June 4, 2009?
>
> THE WITNESS: Yes.
>
> MR. PERKINS: So, at that point in time, it was -- there was almost nothing to calculate. Everybody knew that this was a candidate for outlier review.
>
> THE WITNESS: Correct.
>
> MR. [PERKINS]: And what would be the reason that it wasn't either addressed before that was closed? Why wasn't it addressed before it closed?

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[141] (Emphasis added.)

[142] *See* Medicare Contractor's FPP at 16, 18.

[143] Specifically, since the June 4, 2009 FY 2007 NPR included the data to determine the settled operating and capital CCRs of 0.346 and 0.015, respectively, the Medicare Contractor had sufficient information during or around June 2009 to determine the disparity between the CRRs used to calculate the UI Medical Centers outlier payments for FY 2007 and the *actual* or settled CCRs for FY 2007 reflected on the FY 2007 NPR.

> THE WITNESS: *This was prior to our solidifying our procedures*. And so, at that time there was -- Currently it's automatic. We automatically review all settlements for that criteria. But *at that time, there -- we had not solidified our procedures*. And so, there were certain audit – certain auditors had confusion over the word "settlement" versus "reviews." And so that we discovered that there were instances where the -- that comparison had not been completed on all settlements. So, we had different types of settlements internally, whether it was a limited desk review, straight to settlement desk review audit. And so, *there was confusion on whether it needed to be completed on 100 percent of cost reports*.
>
> MR. PERKINS: So, at that point in time, was anything done at all with regard to noting that or was it just passed over or was notice given to CMS? What happened?
>
> THE WITNESS: I could not find any indication that CMS was notified.[144]

The Medicare Contractor details its delay in conducting an outlier reconciliation by stating, "In 2010 and 2011 change requests were issued on instructions addressed in [MCPIM], Chapter 3, § 20, which directed the MAC's attention to review Outlier Reconciliations further."[145] However, from the Board's perspective, there was no plausible explanation from the Medicare Contractor regarding its delay in pursuing the outlier reconciliation process on or about its issuance of the June 4, 2009 NPR. At that time, the Medicare Contractor knew the outlier payments needed to be reconciled, but failed to begin the process to do so.

Based on the foregoing, the Board finds that, while the Medicare Contractor properly reconciled the UI Medical Center's outlier payments for FY 2007, the Medicare Contractor did not properly exercise its discretion under 42 C.F.R. § 412.84(m) to assess a TMV adjustment because: (1) that adjustment was not made to the date of reconciliation *as directed by that regulation*; and (2) due to the 5+ year delay in conducting an outlier reconciliation, it would be inconsistent with the intent and purpose of the TMV adjustment to assess a TMV adjustment to the actual date of reconciliation (which, based on the record before the Board, has not been precisely established). Accordingly, the Board reverses the Medicare Contractor's assessment of the TVM adjustment and determines that UI Medical Center should *not* be assessed an operating *or* capital TVM adjustment.

* * * * *

In summary, the Board finds the Medicare Contractor's adjustment of the UI Medical Center's outlier claims were proper, following its re-run with 98 percent of the outlier claims universe available for FY 2007. Therefore, as a result of the outlier reconciliation, the Board estimates that the operating outlier amount due by the UI Medical Center for FY 2007 will total approximately

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[144] Tr. at 191-192.

[145] Medicare Contractor's FPP at 4. *See also* MCPM, Transmittal 2111, Change Req. 7192 (Dec. 3, 2010); MCPM, Transmittal 2242, Change Req. 7464 (June 17, 2011).

$6,786,976 and that the capital outlier amount due by the UI Medical Center for FY 2007 will total approximately $8,464.[146]

Additionally, the Board finds that the Medicare Contractor's inclusion of a TVM for FY 2007 was not in compliance with 42 C.F.R. § 412.84(m), and therefore, the operating and capital TVM adjustments for the UI Medical Center total $0.

DECISION AND ORDER:

After considering Medicare law, regulations, and program guidance, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds:

1. The Medicare Contractor properly selected the Provider's FY 2007 cost report for the outlier reconciliation process and properly reopened the Provider's cost report on March 22, 2012 to reconcile outlier payments without regard to CMS' delay in publication of the revised 2006 SSI ratios;

2. The Medicare Contractor has validated the overpayment assessment of $6,531,151 in connection with the Provider's FY 2007 outlier claims by establishing that this assessment, which was based on 47 percent of the FY 2007 outlier claims, is lower than the overpayment amount associated with 98 percent of the FY 2007 cost outlier claims; and

3. In exercising its discretion under 42 C.F.R. § 412.84(m), the Medicare Contractor failed to assess a TMV adjustment that complied with that regulation and assessing a compliant TMV adjustment in the unique circumstance of this case would be improper.

Accordingly, the Board: (A) reverses the TMV adjustment and orders the Medicare Contractor to refund this amount; and (B) pursuant to its authority under 42 U.S.C. § 1395oo(d) and 42 C.F.R. §§ 405.1845(h) and 405.1869(a), remands this appeal to the Medicare Contractor and directs the Medicare Contractor to 1) run the 98 percent of the outlier claims (as identified by the Medicare Contractor) through the FISS Lump Sum Utility, 2) reconcile the claims through the applicable IPPS Pricer software to formally arrive at the overpayment assessment based solely on that 98 percent (which is estimated to total $6,795,440 per the Medicare Contractor Workpapers at Exhibit C-2), and then 3) issue the new overpayment assessment to the UI Medical Center.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

9/6/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[146] Ex. C-2 at 2.