PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2020-D15

PROVIDER –
Innovis Hospital d/b/a Essentia Health Fargo

Provider No.: 35-0070

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions, LLC

HEARING DATE –
December 13, 2017

Cost Reporting Period Ended –
December 31, 2004

CASE NO. – 12-0269

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor's adjustment to reconcile outlier payments was proper and, since the Contractor waited 5 years after discovering the error before notifying the Provider, whether the law bars recovery of the overpayment.[1]

DECISION

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

1. The Medicare Contractor properly adjusted the Provider's cost report for the fiscal year ending December 31, 2004 ("FY 2004") to reconcile outlier payments and properly applied the "time value" of money as part of this adjustment pursuant to 42 C.F.R. § 412.84(m) (2003); and

2. The law does not bar recovery of the overpayment resulting from this adjustment.

INTRODUCTION

Innovis Health, LLC d/b/a Essentia Health Fargo[2] ("Innovis" or "Provider") is an acute care hospital located in Fargo, North Dakota. Innovis' assigned Medicare contractor[3] is Noridian Healthcare Solutions, LLC ("Medicare Contractor").

Innovis disputes the Medicare Contractor's Audit Adjustment No. 16 in the final settled cost report for FY 2004.[4] This adjustment reduced the operating outlier payments by $4,485,181, reduced the capital outlier payments by $182,767, and assessed a "time value of money"[5] in the amount of $377,960.[6] As a result, the total amount at issue is $5,045,908.

Innovis timely appealed the issue to the Board and met the jurisdictional requirements for a hearing. The Board conducted a telephonic hearing on December 13, 2017. Innovis was represented by David M. Glaser, Esq. of Fredrikson & Byron, P.A. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

---

[1] Transcript ("Tr") at 5-6.
[2] Amended Stipulation of Undisputed Facts (hereinafter "Stipulations") at ¶ 1.
[3] 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.
[4] Provider's Final Position Paper, 5-6 (Aug. 31, 2017).
[5] The Provider and Medicare Contractor frequently refer to the "time value" of money 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").
[6] Provider's Final Position Paper at 6.

STATEMENT OF FACTS

A. REGULATORY BACKGROUND

42 U.S.C. § 1395ww(d) established an inpatient prospective payment system ("IPPS") for *operating* costs of acute care hospital stays under Medicare Part A. Under IPPS, each case is categorized into a diagnostic-related group ("DRG"). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG. In addition to the DRG payment, hospitals can receive several other adjustments or add-on payments, one of which is an operating outlier payment for particular cases that are unusually costly.[7]

Additionally, 42 U.S.C. § 1395ww(g) requires the Secretary to pay for the *capital* related costs of inpatient hospital 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, hospitals also receive, under Capital PPS, a capital outlier payment for those cases that qualify.[8]

To receive an outlier payment the combined operating and capital cost of a case must exceed the fixed–loss outlier threshold amount (a dollar amount by which the cost of a case must exceed payments in order to qualify for outliers).[9] The operating cost and capital cost of a case are computed separately by multiplying the total covered charges by the operating and capital cost-to-charge ratios ("CCRs").

The regulations at 42 C.F.R. § 412.84(h) provide the rules for applying CCRs in outlier 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).[10]

On June 9, 2003, the Secretary published a final rule solely addressing cost outliers and, to that end, was entitled "Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems" (the "June 2003 Final Rule").[11] In the

---

[7] 42 C.F.R. §§ 412.80 - 412.86.
[8] 42 C.F.R. § 412.312(c).
[9] 68 Fed. Reg. 34494, 34495 (June 9, 2003).
[10] (Emphasis added.)
[11] 68 Fed. Reg. at 34494.

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 and that hospitals are "on notice" of this change:[12]

> [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). . . .
>
> [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.[13]

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:

> (h) For discharges occurring ***before*** October 1, 2003, the operating and capital cost-to-charge ratios 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. For discharges occurring before August 8, 2003, statewide cost-to-

[12] *Id.* at 34501 (implementing the regulations at issue).
[13] *Id.* at 34502 (emphasis added).

> 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 the reasonable parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payments published in the Federal Register in accordance with §412.8(b).
>
> (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-charge ratio based on substantial evidence presented by the hospital. Such a request must be approved by the CMS Regional Office.
>
> (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. . . .*
>
> (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.[14]

Significantly, the new § 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 regulatory revisions, the Secretary implemented a "time value of money" adjustment because a hospital that receives *excess* outlier payments would have access to those funds until the amount was repaid to the Medicare trust funds (or in the case of an underpayment would not have had access to the appropriate amount of funds during the same period).[15] The Secretary gave the following explanation of why the "time value of money" adjustment is necessary:

> [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

[14] *See id.* at 34515 (emphasis added).
[15] *Id.* at 34504.

> 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.[16]

Further, in the preamble to the June 2003 Final Rule, the Secretary gave the following response to a comment questioning the authority of the Secretary to make the "time value of money" adjustment:

> [T]his adjustment is consistent with the statutory requirement at [42 U.S.C. § 1395ww(d)(5)(A)(iii)] that outlier payments approximate the marginal cost of care beyond the threshold. That is, because hospitals are uniquely able to manipulate outlier payments by increasing charges, it is necessary to establish a mechanism whereby an adjustment can be made to ensure payments appropriately reflect the true marginal costs of care for outlier cases. As a result, the outlier adjustment can be distinguished from other IPPS payment adjustments where interest is applied, such as IME or DSH, because changes to these adjustments are subject to review by the fiscal intermediary before additional payments are made.[17]

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)[18] 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.[19]

---

[16] *Id.* (emphasis added).
[17] *Id*. at 34504.
[18] The regulation originally cross referenced paragraph (h)(3), but was amended to reference paragraph (i)(4) in 2006. *See id.*; 74 Fed. Reg. 47870, 48098, 48138 (Aug. 18, 2006).
[19] 68 Fed. Reg. at 34514 (emphasis added).

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 also 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 cost-to-charge ratios 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.
>
> ***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 cost-to-charge ratio 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*.[20]

Consistent with the above preamble discussion, CMS issued Program Memorandum Intermediaries ("PMI") Transmittal A-03-058 on July 3, 2003[21] to provide guidance to Medicare

---

[20] *Id.* at 34503 (emphasis added).

[21] DHHS, CMS, Program Memorandum Intermediaries, Transmittal A-03-058, Change Req. 2875 (July 3, 2003) (copy at Exhibit I-6) (also *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/a03058.pdf (last visited August 6, 2020). The instructions in this memorandum were later incorporated into MCPM, Ch. 3, § 20.2 (Rev. 707, Oct. 12, 2005).

contractors on the reconciliation process and, in particular, finalizing the 10 percent threshold discussed in the June 9, 2003 Final Rule. In this this regard, PMI Transmittal A-03-058 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:
>
> 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
>
> 2) Total outlier payments in that cost reporting period exceed $500,000.
>
> Consistent with the June 9, 2003 Federal Register (68 FR 34504) in which we indicated that we intended to issue program instructions that would provide specific criteria for identifying those hospitals subject to reconciliation for the remainder of FY 2003 and for FY 2004, these criteria allow fiscal intermediaries to focus their limited resources on only those hospitals that appear to have disproportionately benefited from the time lag in updating their CCRs. . . .
>
> These criteria for IPPS . . . will be reevaluated periodically to assess whether they should be revised.
>
> In the event that the criteria in this section III for IPPS hospitals . . . do not identify additional hospitals that are being similarly overpaid (or underpaid) significantly for outliers, then, based on an analysis of the hospital's most recent cost and charge data that indicates that CCRs for those hospitals are significantly inaccurate, fiscal intermediaries also have the administrative discretion to reconcile cost reports of those additional IPPS hospitals . . . . However, fiscal intermediaries must seek approval from their CMS Regional Office in the event they intend to reconcile outlier payments for an IPPS hospital . . . that does not meet the above-specified criteria.
>
> CMS will be issuing separate instructions detailing procedures to follow regarding this reconciliation process and the application of the adjustment for the time value of money.[22]

[22] *Id.* at 4-5.

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" under 42 C.F.R. § 412.84(h)(3).[23] CMS essentially incorporated PMI Transmittal A-03-58 into the MCPM and added the following provisions at MCPM, Ch. 3, § 20.1.2.6 to address the adjustment for the time value of money:

> 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 Medicare contractor, or the date an email was received from the Medicare contractor by the CMS Central Office, whichever date is earlier.[24]

[23] MCPM, Transmittal 707, Change Req. 3966 at 1 (Oct. 12, 2005) (copy at Exhibit I-7).
[24] *See id.* at 8; MCPM, Ch. 3, § 20.1.2.6 (Rev. 2242, June 17, 2011) (copies at Exhibits I-12 & P-18) (emphasis added).

B. FACTS PERTINENT TO INNOVIS' APPEAL

On November 14, 2000, Innovis became Medicare certified to participate in the Medicare program as an acute care hospital.[25] Prior to August 14, 2003, Innovis' operating CCR was 0.622 based on the statewide average CCR for North Dakota.[26] On August 14, 2003, the Medicare Contractor settled Innovis' FY 2000 cost report (*i.e.*, cost report for the fiscal year ending December 31, 2000) and, based on this settled cost report, updated Innovis' operating CCR to 1.187, effective September 1, 2003.[27]

On June 6, 2003, the Medicare Contractor tentatively settled Innovis' FY 2002 cost report with an operating CCR of 0.418. However, the Medicare Contractor did not update Innovis' operating CCR to 0.418 *on October 1, 2003* consistent with the instructions in the new regulation at 42 C.F.R. § 412.84(i)(2) which was effective October 1, 2003. As a result, for discharges occurring in the 8+ month period between October 1, 2003 and June 14, 2004, the Medicare Contractor processed Innovis' claims for outlier payments using an operating CCR of 1.187 (the CCR from Innovis' FY 2000 *settled* cost report) rather than 0.418 (the CCR from Innovis' FY 2002 *tentative* settled cost report).[28]

On June 15, 2004 the Medicare Contractor tentatively settled Innovis' FY 2003 cost report and on the same day updated Innovis' operating CCR to 0.369 based on this tentative settled cost report.[29] As a result, Innovis' *weighted average* operating CCR for its FY 2004 cost reporting period was 0.740.[30]

In March of 2006, the Medicare Contractor conducted a review of Innovis' FY 2004 cost report and determined that the *actual* operating CCR for the FY 2004 cost reporting period was 0.380. In addition, the Medicare Contractor determined that Innovis' FY 2004 cost report should be subject to reconciliation because: (1) the weighted average operating CCR of 0.740 that was used to make Innovis' outlier payments during the FY 2004 cost reporting period was more than 10 percentage points above Innovis' actual FY 2004 operating CCR of 0.380; and (2) Innovis' total outlier payments exceeded $500,000. Accordingly, on March 29, 2006, the Medicare Contractor notified CMS that Innovis' outlier payments for FY 2004 would be reconciled.[31]

On May 24, 2011, CMS approved the reconciliation and, on August 25, 2011, the Medicare Contractor notified Innovis that its outlier payments for FY 2004 would be reconciled.[32] On October 21, 2011, the Medicare Contractor issued the Notice of Program Reimbursement

---

[25] Stipulations at ¶ 1.
[26] Provider's Final Position Paper at 2; *see also* Exhibit P-5.
[27] Stipulations at ¶¶ 2-3.
[28] *See id.* at ¶¶ 3-6
[29] Stipulations at ¶ 6. The Board notes that the Stipulations at ¶ 5 indicates that the CCR of 1.187 was used for the period between January 1 and June 15, 2004 and Stipulations at ¶ 6 state that the Medicare Contractor updated Innovis' CCR on June 15, 2004 to 0.369. As such, the Board will use June 14, 2004 as the last day 1.187 was used as Innovis' CCR.
[30] Stipulations at ¶ 7. The 0.740 annual weighted average reflected 166 days paid at a CCR of 1.187 and 200 days paid at a CCR of 0.369.
[31] Stipulations at ¶¶ 10-11; Exhibit I-21. *See also* Exhibit I-6 (copy of PMI Transmittal A-03-058).
[32] Stipulations at ¶ 13.

("NPR") for Innovis' FY 2004 cost reporting period. This NPR reduced Innovis' operating outlier payments by $4,485,181, and the capital outlier payments by $182,767. In addition, the Medicare Contractor assessed a "time value of money" adjustment in the amount of $377,960. The time value of money adjustment was assessed from the midpoint of the cost reporting (*i.e.*, from the midpoint of FY 2004) to the March 29, 2006 notification to CMS.[33]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Innovis maintains that the Medicare Contractor mistakenly used a CCR of 1.187 from Innovis' FY 2000 cost report when it processed its claims for payment for discharges during the period January 1, 2004 through June 14, 2004 (*i.e*, discharges during the first 2 quarters of FY 2004).[34] Innovis points out that, effective October 1, 2003, the regulations at 42 C.F.R. § 412.84 were revised to require that the Medicare Contractors process claims for payment using a CCR based on the *most recently* settled cost report ***or*** tentative settled cost report, whichever is from the later cost reporting period. Since Innovis' FY 2002 cost report was tentatively settled on June 6, 2003 and, since this cost report is from the later cost reporting period, Innovis maintains that, beginning October 1, 2003, the Medicare Contractor should have been using the operating CCR of 0.418 from this FY 2002 cost report when processing the claims for the outlier payments at issue.[35]

According to Innovis, "but for" the Medicare Contractor's application of this incorrect CCR, Innovis' outlier payments for FY 2004 would not have been subject to reconciliation because the actual operating CCR of 0.380 would not have been "plus or minus 10 percentage points" from its operating CCR of 0.418 from its FY 2002 tentative settled cost report.[36] Innovis argues that the "without fault" statutory protections at 42 U.S.C. § 1395gg are applicable in this case and that, as a result, the Medicare Contractor cannot recoup the overpayment related to the outlier payments because Innovis is "without fault" based on those protections. In other words, Innovis believes that § 1395gg(b) "makes non-fault a defense" for providers and "sets up a presumption of non-fault three years after payment is made.[37] Innovis points out the Medicare Contractor did not notify Innovis of the outlier reconciliation until August 2011 and did not issue the NPR *until October 2011*, more than six years after the outlier payments were made in 2004.[38]

Innovis argues that there is no evidence to rebut the presumption that it was "without fault" with regard to the application of the incorrect CCR. Innovis further maintains that it did not take any action that caused or made it responsible for the Medicare Contractor's application of the incorrect CCR. The relevant Medicare regulations and manuals are clear that, while the provider is responsible for providing accurate claims and cost report information, the calculation of the CCR is the responsibility of CMS, not the provider.[39] Innovis goes on to contend that 42 U.S.C. § 1395gg(c) provides that an incorrect payment will not be recouped if the provider is without

[33] Stipulations at ¶¶ 13-14; Exhibit I-21.
[34] *See* Provider's Final Position Paper at 3-4.
[35] *Id.* at 3.
[36] Provider's Final Position Paper at 5.
[37] Provider's Final Position Paper at 6 (citations omitted).
[38] Provider's Written Closing Argument at 12.
[39] Provider's Final Position Paper at 7 (citing 68 Fed. Reg. 34494, 34495 (June 9, 2003)).

fault and the recovery would be against equity and good conscience. Here, Innovis maintains that the alleged overpayment was caused when the Medicare Contractor, by its own admission, failed to update Innovis' CCR in accordance with the regulations.[40] More specifically, Innovis maintains that the Medicare Contractor's failure to notify Innovis when it first discovered its error in 2006, rather than waiting for five years, "means that it would violate equity and good conscience, and both the spirit and letter of 42 U.S.C. § 1395gg(c) for the funds to be recouped."[41]

Alternatively, Innovis argues that, at a minimum, the Board should put Innovis in the position it would have been in, but for the Medicare Contractor's error.[42] If the Medicare Contractor had correctly calculated the outlier payments during FY 2004, no reconciliation would have been required under the rules and guidance. In other words, if Innovis' outlier payments must be recalculated in the settlement of its FY 2004 cost report, they should be recalculated as the Medicare Contractor was originally required to calculate them under 42 C.F.R. § 412.84(i)(2), namely using the CCR ratios from the FY 2002 tentative settled cost report for the period January 1, 2004 through June 14, 2004.[43]

Lastly, Innovis argues that the Medicare Contractor may not assess a "time value of money" adjustment under 42 C.F.R. § 412.84(m) because, without question, it is the Medicare Contractor's error that caused the alleged overpayment in the first instance. If the Medicare Contractor had not applied an incorrect CCR at the time it initially calculated Innovis' outlier payments, Innovis would not have been subject to reconciliation and the "time value of money" regulation would not apply. Thus, Innovis concludes that it is without fault in this regard and that the Medicare Contractor cannot assess a "time value of money" adjustment when the need for that adjustment arose from its own calculation error.[44]

The Medicare Contractor maintains that it completed an outlier reconciliation and assessed the "time value of money" adjustment in accordance with CMS regulations. While the Medicare Contractor acknowledges that it should have used a different CCR ratio for a portion of FY 2004, it maintains that this error does not preclude it from reconciling Innovis' outlier payments and assessing a "time value of money" adjustment.[45] The Medicare Contractor points out that the regulations allow for outlier reconciliations and the manuals state that "a hospital's outlier claims ***will be*** reconciled at the time of cost report settlement"[46] if the specified criteria are met. The Medicare Contractor asserts that the goal of the outlier regulations and instructions is to ensure outlier payments are accurate and, therefore, outliers must be reconciled if the initial payment is materially different from the CCR reflected in the cost report for that year.[47]

---

[40] *Id.*; Medicare Contractor's Final Position Paper at 14.
[41] Provider's Final Position Paper at 9.
[42] *Id.* at 10.
[43] *Id.*; Provider's Written Closing Argument at 2, 17.
[44] Provider's Final Position Paper at 10-11; Provider's Written Closing Argument at 19-20.
[45] Medicare Contractor's Final Position Paper at 14-15.
[46] *Id.* (citing MCPM, Ch. 3, § 20.1.2.5) (emphasis added).
[47] *Id.* at 15.

Finally, the Medicare Contractor disagrees with Innovis' interpretation of 42 U.S.C. § 1395gg(b) and maintains that the "without fault" provision does not apply to the outlier determinations at issue in this appeal. In this regard, the Medicare Contractor points out that §1395gg(b) applies to *claim* determinations and asserts that it did not alter the underlying *claim* determinations when it reconciled Innovis' outlier payments because it did not modify either the covered charges, the DRG weight, or the federal payment amount. Rather the contractor simply made a cost report adjustment using the information from the claim and the actual CCR in accordance with 42 C.F.R. § 412.84(i)(4).[48]

At the outset, it is important to first understand the Medicare regulations and rules for payment of outliers that were in effect during the time at issue—FY 2004. The preamble to the June 2003 Final Rule, specifies that outlier payments made for discharges on or after October 1, 2003 are "subject to possible reconciliation" when hospitals' cost reports are settled and that hospitals are "on notice" of this change.[49] The Secretary's discretionary authority to make such reconciliations is specified at 42 C.F.R. § 412.84(i)(4) (2003) which states "any reconciliation of outlier payments will be based on operating and capital cost-to-charge ratios calculated based on a ratio of cost to charges computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled" (*i.e.*, any reconciliation of outlier payments will be based on the actual CCR from the relevant settled cost report). Further, as part of this "reconciliation process," the June 2003 Final Rule includes an adjustment for the time value of money which, as previously discussed, was implemented at MCPM, Ch. 3, § 20.1.2.6.

Beginning on October 1, 2003, the Medicare Contractor did not process the cost outlier claims using Innovis' latest CCR (*i.e.*, using Innovis' latest final settled ***or*** tentative settled cost report, whichever was from the latest cost reporting period, as instructed in 42 C.F.R. §412.84(i)(2)). Because of this error, Innovis has requested that the Board apply principles of equity to exempt Innovis from the "time value of money" adjustment under 42 C.F.R. 412.84(m) even though this adjustment stems from the fact that the Medicare Contractor applied reconciliation pursuant to 42 C.F.R. § 412.84(i)(4) and as directed by MCPM, Ch. 3, § 20.1.2.5.[50]

However, it is not surprising, neither 42 C.F.R. § 412.84(m), the June 9, 2003 Final Rule promulgating the relevant portions of § 412.84(m), nor the manuals implementing § 412.84(m) include *any* exemption to the "time value of money" adjustment, much less an exemption based on principles of equity which Innovis is requesting. Indeed it is clear that the Medicare Contractor correctly followed the following instructions in MCPM, Ch. 3, § 20.1.2.6 when it applied the adjustment for the time value of money in March 2006:

> Effective for discharges occurring on or after August 8, 2003, at the time of any reconciliation under §20.1.2.5, outlier payment

---

[48] *Id.* at 20.

[49] 68 Fed. Reg. 34494, 34501 (June 9, 2003) (implementing the regulations at issue).

[50] MCPM, Ch. 3, § 20.1.2.5 (Rev. 2111, Dec. 3, 2010) (copy at Exhibit I-12) (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: 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 2. Total outlier payments in that cost reporting period exceed $500,000.").

> 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 Medicare Contractor 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 . . . .[51]

As Innovis' outlier payments met the criteria for reconciliation, the Board finds the Medicare Contractor was correct in reconciling Innovis' outlier payments and applying a "time value of money" adjustment as part of this reconciliation and, in particular, the calculation of the overpayment at issue.[52] Indeed, pursuant to 42 C.F.R. § 405.1867, the Board "must comply" with all Medicare program regulations and "afford great weight" to Medicare program manuals, including MCPM, Ch. 3, § 20.1.2.6.

Even if there were an exemption as alleged by Innovis, the Board does not agree with Innovis that it was without fault (*i.e.*, had clean hands) as to full assessment of the "time value of money" adjustment. In this regard, the Board agrees with the Medicare Contractor that Innovis, at some point, should have been aware that the CCR used to process its claims was materially different from their actual CCR.[53] Specifically, Innovis should have recognized it was receiving outlier payments based on a significantly inflated operating CCR of 1.187.[54] The Board finds that the regulation at 42 C.F.R. § 412.84(i)(1) addresses just such a situation in stating that:

> 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-charge ratio based on substantial evidence presented by the hospital.* Such a request must be approved by the CMS Regional Office.[55]

---

[51] (Emphasis added.)

[52] In this regard, the Board notes that 31 C.F.R. § 901.1 require agencies to "aggressively collect" debts arising out of agency activities. *See also* 31 U.SC. § 3711.

[53] Medicare Contractor's Final Position Paper at 16.

[54] Innovis was receiving operating outlier payments based on an inflated CCR of 1.187 for the period January 1, 2004 through June 14, 2004. These payments were significantly higher than if its operating CCR was 0.418 based on Innovis' FY 2002 tentative settled cost report or 0.380 which was Innovis' actual operating CCR for 2004. *See* Stipulations at ¶¶ 3-7.

[55] The Board recognizes that, during the Provider's FY 2004, MCPM, Ch. 3, § 20 related to Outlier payments and had not yet been updated to reflect the regulatory changes made in 2003. However, the regulations at 42 C.F.R. § 412.84(i)(1) and the guidance published in the Federal Register at 68 Fed. Reg. at 34497-34499 are clear that a hospital could request a different CCR. Further, the MCMP provisions were based on PMI Transmittal A-03-058

Innovis could have requested a correction to its CCRs, but failed to do so.[56] Moreover, the record reflects that CMS approved the reconciliation in advance of it occurring[57] and a plain reading of the regulation itself provides CMS with discretion on whether to conduct a reconciliation and does not itself impose any threshold (rather the 10 percent threshold is specified in the MCPM).[58]

Similarly, the Board is not persuaded by Innovis' alternative equity argument that the Medicare Contractor may not recover the outlier overpayment because Innovis is "without fault" and recovering would be against equity and good conscience.[59] Specifically, Innovis claims that, pursuant to 42 U.S.C. § 1395gg, a provider is deemed to be "without fault" if the Secretary determines that more than the correct amount was paid subsequent to the third year following the year of payment.[60] In this case, Innovis claims the plain language of this statute applies because it was the Medicare Contractor's error that caused the FY 2004 overpayment and the Medicare Contractor delayed correcting this error until 2011.[61] However, the Board notes that this statutory waiver provision pertains only to an "overpayment *on behalf of individuals*…"[62] and not to aggregate payments such as the *cost report* payments involved in this case.[63] The Administrator in *Athens-Limestone Hosp. v. BC/BS of Alabama*[64] included the following quote from a 1998 proposed rule to explain the statutory basis for CMS' policy of not applying the "without fault" provisions to aggregate overpayment issues:

---

which was issued on July 3, 2003 (less than a month after the June 9, 2003 Final Rule). PMI Transmittal A-03-058 was issued, in part, to "provide[] instructions for applying CCRs for IPPS hospitals and LTCHs, including: the use of alternative CCRs when directed by CMS or ***at the request of the hospital*** . . . ." and, in this regard, reaffirmed that: "A hospital ***may*** also ***request*** that its fiscal intermediary use a different (higher or lower) CCR based on substantial evidence presented by the hospital. Before a change based on a hospital's request can become effective, the CMS Regional Office must approve the change." *See* Exhibit I-6 at 1 (emphasis added).

[56] *See also* MCPM 100-4, 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 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 (Jan. 25, 2002) (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" pursuant to 42 U.S.C. 1320a-7k(a)(3)).

[57] *See* Exhibit P-9.

[58] Moreover, the *supra* regulatory discussion on the preamble to the June 2003 Final Rule, PMI Transmittal A-03-058, and the MCPM make clear that the Agency has consistently maintained that the Medicare Contactor still has certain discretion to conduct reconciliation when the 10 percent threshold has not been met.

[59] Provider's Final Position Paper at 9.

[60] *Id.* at 6 (referencing 42 U.S.C. § 1395gg(b)).

[61] Provider's Written Closing Statement at 10-11.

[62] (Emphasis added.)

[63] *See* 68 Fed. Reg. 34494, 34500-34504 (June 9, 2003) (providing for a cost report reconciliation process for outlier payments beginning with discharges occurring on or after August 8, 2003).

[64] CMS Adm'r Dec. (Aug. 16, 1999), *modifying*, PRRB Dec. No. 1999-D51 (June 16, 1999).

> Under [42 U.S.C. § 1395gg], if the provider is found to be without fault for an overpayment, the individual who received the service for which payment was made is liable for the overpayment. Therefore application of the without fault provision in [42 U.S.C. § 1395gg] is limited to overpayments for individual claims for which liability can ultimately be shifted to a specific individual.
>
> Consequently, the without fault provisions under [§ 1395gg] do not extend to aggregate overpayment issues, such as Medicare cost report errors, because liability for an individual claim cannot be shifted to a specific individual. For certain providers, aggregate overpayments resulted from payment under a reasonable cost payment methodology in which payment is made on an interim basis throughout the year, with appropriate adjustments made upon settlement of the annual cost reports. Because Medicare cost report errors are not directly associated with specific services, liability cannot be shifted from a specific provider to a specific individual.
>
> Thus, the without fault provisions in this proposed rule would not apply to overpayments resulting from aggregate payment issues, such as cost report errors.[65]

The overpayments at issue do not involve individual claims, and instead pertains to aggregate payments related to outlier adjustments. Consequently, the Board finds that the waiver provision under 42 U.S.C. § 1395gg does not apply in this case,[66] and hereby denies the Providers request for relief under this statutory provision. The Board notes that this finding is consistent with prior decisions of the Board[67] and federal courts.[68]

Finally, the Board disagrees with Innovis' argument that, if reconciliation is required, its outlier payments should be recalculated using an operating CCR of 0.418 from its FY 2002 tentative settled cost report based on 42 C.F.R. 412.84(i)(2).[69] The Board finds the regulations are clear that "any reconciliation of outlier payments will be . . . computed from the relevant cost report and charge data determined at the time the cost report coinciding with the discharge is settled."[70]

---

[65] *Id.* at 4-5 (quoting 63 Fed. Reg. 14506, 14510 (Mar. 25, 1998)).
[66] *See, e.g., Maine Type 6 Medicaid Dual Eligible Days DSH Grps. v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2013-D9 (Mar. 29, 2013), *modified by,* Adm'r Dec. (May 30, 2013) (upholding Board's determination that 42 U.S.C. § 1395gg did not apply to aggregate payments); *Canon Health Care Hospice v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2012-D15 (Apr. 13, 2012), *modified in part and aff'd in part,* Adm'r Dec. (June 6, 2012) (upholding Board's determination that 42 U.S.C. 1395gg did not apply to aggregate payments).
[67] *See supra* note 66.
[68] *See, e.g., Maine Med. Ctr. v. Burwell*, 841 F.3d 10, 23-24 (1st Cir. 2016); *Visiting Nurses Ass'n of Southwestern Ind., Inc. v. Shalala*, 213 F.3d 352, 356-57 (7th Cir. 2000), *reh'g en banc denied* (Aug. 9, 2000); *MacKenzie Med. Supply, Inc. v. Leavitt*, 506 F.3d 341, 348-349 (4th Cir. 2007); *Las Mercedes Home Care Corp. v. Burwell*, 2014WL 12857877 at *10-11 (S.D. Fla. 2014).
[69] Provider's Written Closing Argument at 2.
[70] 42 C.F.R. § 412.84(i)(4).

There is simply no basis (in equity or otherwise) for reconciling outlier payments using a CCR other than the actual CCR from the cost report being settled. Accordingly, because the Medicare Contractor determined that Innovis' 2004 operating outlier payments were initially paid based on an annual weighted average CCR of 0.740 which is more than 10 percentage points different than Innovis' actual 2004 CCR of .0380 (based off Innovis' 2004 cost report) and that Innovis' total outlier payments exceeded $500,000, the Medicare Contractor correctly determined that reconciliation was appropriate.[71]

DECISION AND ORDER:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that:

1. The Medicare Contractor properly adjusted the Provider's cost report for the fiscal year ending December 31, 2004 ("FY 2004") to reconcile outlier payments and properly applied the "time value" of money as part of this adjustment pursuant to 42 C.F.R. § 412.84(m) (2003); and

2. The law does not bar recovery of the overpayment resulting from this adjustment.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

8/14/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

[71] 68 Fed. Reg. at 34503. *See also* MCPM 100-4, Ch. 3, § 20.1.2.5(A) (stating that "a hospital's outlier claims will be reconciled at the time of the cost report final settlement if they meet the following criteria: 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 the outlier payments . . . .") (copy at Exhibit I-12).