PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D42

PROVIDER -
Oakwood Healthcare System 1992-2001
Capital Prospective Payment System
Hospital Specific Rate Determination Grp.
Dearborn, Michigan

Provider Nos.: 23-0142, 23-0270 and 23-0176

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, LLC - WI

DATE OF HEARING -
August 31, 2007

Cost Reporting Periods Ended -
December 31, 1992; December 31, 1994 through December 31, 2001

CASE NO.: 04-0393G

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ISSUE:

Whether as a result of underpayment of Medicare reimbursement during the ten-year transition period of the Capital Prospective Payment System (CPPS), the Providers are entitled to a payment of interest under the Medicare statute, 42 U.S.C. §1395g(d), the applicable Medicare regulation, 42 C.F.R. §405.378, and the Medicare Intermediary Manual (CMS Pub. 13-2) §2219.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Medicare reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred but excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. §413.9 provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services.

Initially, hospitals were reimbursed on the basis of reasonable costs as defined in 42 U.S.C. §1395x(v). However, in 1983 Congress created the Medicare prospective payment system (PPS). Under this system hospital inpatient operating costs are no longer reimbursed on the basis of reasonable cost but are paid based upon a prospectively determined rate per discharge. All discharges are classified according to a list of diagnostics related groups.

Under PPS, operating costs are defined as including all routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services. Capital-related costs, which include such items as depreciation, interest, taxes and insurance on plant, fixed and movable equipment were excluded from this definition.

In 1991, in accordance with 42 U.S.C. § 1395ww(g), CMS finalized a prospective payment system for hospital inpatient capital-related costs which had previously been subject to cost-based reimbursement. The Secretary promulgated regulations that established a phase-in period intended to ease the transition of hospitals from cost reimbursement to the inclusion of capital payments under the PPS (Fed. Reg. Vol. 52, No. 96, May 19, 1987). 42 C.F.R. §412.304 established a ten-year transition of the PPS capital payment system with cost reporting periods beginning on or after October 1, 1991. During this period, hospitals were paid based on a blend of their own capital costs and the Federal prospective rate. At the end of the period, hospitals would be paid solely on the Federal prospective rate. 42 C.F.R. §412.324 sets out the general rule that during the ten-year transition period hospitals with a hospital-specific capital rate below the Federal rate would be paid based on the fully prospective payment methodology, while hospitals with a hospital-specific capital rate above the Federal rate would be paid under the hold-harmless methodology.

In addition, hospitals paid under the fully prospective methodology could request that their hospital-specific capital rate be redetermined subsequent to the base period to reflect the addition of certain capital expenses and other specific changes in their capital-related costs. The hospital-specific capital rate could be redetermined using a hospital's cost reporting period beginning in fiscal year 1994 or later, pursuant to certain conditions.

Pertinent to this case is the Medicare program's obligation to pay interest to a provider when it is determined that the provider was underpaid for services furnished to beneficiaries, and such underpayment is not paid on a timely basis. The statutory authority regarding interest, 42 U.S.C. §1395g(d) states:

> [w]henever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

Implementing regulations at 42 C.F.R. §405.376[1] state in pertinent part:

> (b) *Basic rules*. (1) HCFA will charge interest on overpayments, and pay interest on underpayments, to providers and suppliers of services (including physicians and other practitioners), except as specified in paragraphs (f) and (h) of this section.

[1] Redesignated as 42 C.F.R. §405.378. (61 FR 63745, Dec 2, 1996)

> (2) Interest will accrue from the date of the final determination as defined in paragraph (c) of this section, and will either be charged on the overpayment balance or paid on the underpayment balance for each 30-day period that payment is delayed.
>
> (c) *Definition of final determination*. (1) For purposes of this section, any of the following constitutes a final determination:
>
> (i) A Notice of Amount of Program Reimbursement (NPR) is issued, as discussed in §§405.1803, 417.576, and 417.810, and either ─
>
> (A) A written demand for payment is made; or
>
> (B) A written determination of an underpayment is made by the intermediary after a cost report is filed.
>
> (ii) In cases in which an NPR is not used as a notice of determination (that is, primarily under part B), one of the following determinations is issued ─
>
> (A) A written determination that an overpayment exists and a written demand for payment;
>
> (B) A written determination of an underpayment; or
>
> (C) An Administrative Law Judge (ALJ) decision that reduces the amount of an overpayment below the amount that HCFA has already collected.
>
> iii) Other examples of cases in which an NPR is not used are carrier reasonable charge determinations under subpart E of this part, interim cost settlements made for HMOs, CMPs, and HCPPs under §§417.574 and 417.810(e) of this chapter, and. . .

Program instructions found in the Medicare Intermediary Manual (CMS Pub. 13-2) §2219 state in part:

> 2219.1 Final Determination. – The definition of final determination used in conjunction with 42 CFR 405.376ff. is not synonymous with the term final determination used in settling provider cost reports when you issue a Notice of

Program Reimbursement (NPR) under 42 CFR 405.1803. For purposes of this chapter:

A. A final determination is deemed to occur upon final settlement of a cost report when both an NPR and a written demand for payment of an overpayment or a written determination of an underpayment is transmitted to a provider based upon:
    1. An audited final settlement;
    2. Final settlement without audit; or
    3. Reopening for any reason.

B. When an NPR is not utilized, a final determination is deemed to occur upon the issuance of a written determination and a written demand for payment of an overpayment or the issuance of a notice of underpayment to a provider based upon:
    1. Initial retroactive adjustment, with or without desk review; or
    2. Revised initial retroactive adjustment.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Oakwood Annapolis Hospital, Oakwood Heritage Hospital and Oakwood Seaway Hospital (Providers) are short-term, acute care facilities that are part of the Oakwood Healthcare System located in Dearborn, Michigan. As acute care hospitals, the Providers are reimbursed under Medicare's PPS for inpatient hospital services and became subject to Medicare's CPPS effective with their cost reporting period ended December 31, 1992. During the CPPS transition, the Providers requested that their CPPS hospital-specific rate (HSR) be redetermined pursuant to 42 C.F.R. §412.328(f). Health Care Service Corporation (HCSC), the Providers' intermediary at that time, reviewed their requests and notified each of the individual facilities that their request had been approved. The notifications advised the Providers that their HSRs were increased as a result of the redeterminations, and that their new rates were effective for Medicare discharges occurring on or after January 1, 1992.[2]

HCSC issued NPRs for the Providers' 1993 cost reports and included CPPS payments based upon the redetermined HSRs. However, HCSC did not reopen the Providers' 1992 cost reports to correct CPPS payments for the new rates. In addition, United Government Services (UGS) replaced Health Care Service Corporation as the Providers' intermediary. Through the efforts of

[2] To the best of the parties' knowledge, the Intermediary's notifications were issued in 1996, and a notification was issued to each of the individual facilities in the group. See, Stipulation No. 3 below.

the Providers and UGS (Intermediary), it was confirmed that the redetermined HSRs had not been used to reimburse the Providers for any of the other CPPS transition period cost reports, i.e., fiscal years 1992 and 1994 through 2000. Ultimately, the Intermediary issued revised NPRs reflecting the appropriate amount of CPPS payments for the cost reporting periods under appeal. However, the Providers requested that the Intermediary pay interest on the corrected CPPS payments because they were not made on a timely basis. The Intermediary denied the Providers' requests.

The Providers appealed the Intermediary's denial of their request to be paid interest to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations.[3] The amount in controversy is approximately $4,000,000.

The Providers are represented by Kenneth R. Marcus, Esquire, of Honigman Miller Schwartz and Cohn, LLC. The Intermediary is represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

STIPULATIONS OF THE PARTIES:

1. During the CPPS transition period, each of the Providers submitted to the then fiscal intermediary, Blue Cross Blue Shield of Michigan ("BCBSMI"), a timely request for Capital Prospective Payment System Hospital Specific Rate Redetermination, as provided by 42 C.F.R. § 412.328(f) ("Capital PPS HSR Redetermination Request"). After the submittal, Health Care Service Corporation ("HCSC") replaced BCBSMI as the Providers' Fiscal Intermediary.

2. HCSC reviewed the CPPS HSR Redetermination Request submitted by each of the Providers.

3. HCSC notified each of the Providers that HCSC approved their CPPS HSR Redetermination Requests. For example, as stated in an undated letter to the Oakwood Healthcare System Assistant Administrator Lynn Torossian, HCSC issued a notification that HCSC had redetermined the HSR for Annapolis Hospital, and stated that the redetermined HSR was $375.17. (Exhibit 1.) To the best of the Parties' knowledge, the undated letter was issued during 1996 after the CPPS Audit was conducted by Auditor Melanie Kelly. To the best of the Parties' knowledge, HCSC issued similar notification letters to each of the other Providers. The letter advised, inter alia:

> Because your HSR is lower than the adjusted Federal rate, Annapolis Hospital will be paid based upon the fully prospective method of payment provision of the final rule. As such, the payments for Medicare inpatient capital related costs that you will receive for discharge (sic)

[3] This case is before the Board on remand from the United States District Court for the Eastern District of Michigan. Initially, the Providers requested a hearing before the Board within 180 days of the Intermediary's issuance of revised NPRs. The Board denied jurisdiction and dismissed the appeal. By order dated February 8, 2007, the Board's decision was reversed by the court and the case remanded.

> occuring on or after 01-01-92, will be based on the fully prospective of payment method." (Exhibit 1.)

4. When the Intermediary issued the Medicare Notice of Program Reimbursement for FYE December 31, 1993 on or about August 23, 1996, for Provider 23-0014; on or about August 18, 1996 for Provider 23-0270; and on or about January 15, 1996 for Provider 23-0176, CPPS payments were based on the corrected HSR as described in paragraph 4 above.

5. However, the Intermediary did not, at the same time, reopen the Group's Cost Reports for FYE December 31, 1992 to correct CPPS payment to reflect the updated HSR. The Intermediary also did not enter the updated HSRs into its payment system for future payments for the remainder of the ten year CPPS Transition Period. The Providers' estimate of the CPPS underpayment and applicable interest is summarized on [Provider] Exhibit 2.

6. Neither the Medicare Notice of Program Reimbursement nor the filed or finalized Medicare Cost Report specifically identifies the HSR used in the CPPS payments.

7. The Remittance Advices ("RA") sent to Providers during the periods in controversy identified on a claim-by-claim basis the Diagnostic Related Group coding ("DRG"), and the total PPS Capital payment included on each Medicare claim**.** The DRG weights associated with each coding are routinely published in the Federal Register (see [Provider] Exhibit 3).

8. On an annual basis shortly after the beginning of each Federal Fiscal Year, intermediaries routinely notify providers of information in its (sic) records of payment information including but not limited to the applicable Federal Capital Payment Rate and the HSR (see [Provider] Exhibit 4).

9. On August 1, 2001, the Providers notified the then fiscal Intermediary, United Government Services ("UGS") that the correct HSR may not have been used in preceding years (sic) Medicare Payments and requested confirmation and correction (see [Provider] Exhibit 5). The Providers enclosed a copy of the letter from HCSC to one of the Providers, attached as Exhibit 1, originally notifying the Providers that the HSR redetermination request had been granted. The letter advised, inter alia:

> When the Medicare Intermediary was changed to UGS, the revised rates were not reflected in Medicare's payment system or included in any other year-end cost report audits as a lump sum adjustment. The Oakwood Healthcare System is requesting that the Hospital Specific Capital Rates that are currently being used by Medicare for capital payments be verified against the final audit completed by HCSC. If it is determined that there was an error in the rates, we are requesting that the appropriate lump sum adjustment be included in the final settled cost reports.

10. Through the joint efforts of the Providers and UGS staff, commencing in the spring of 2003 the Intermediary compiled the necessary documentation to reprocess the Providers' CPPS HSR redetermination request that previously had been conducted and completed by HCSC. (See HCSC's 1996 correspondence attached as Exhibit 1). In fact, UGS confirmed that the redetermination made by HCSC was accurate with respect to the Providers' entitlement to a redetermined HSR and with respect to the specific dollar amount of the redetermined HSR. Finally, UGS determined that the correct HSR for the three hospitals should have been but had not been utilized in all the applicable fiscal years except for FYE December 31, 1993.

11. By letter dated September 29, 2003 from the Providers to the Intermediary, the Providers claimed entitlement to interest, based on the provisions of Intermediary Manual § 2219, relating to the late payment of the appropriate amount of the Capital PPS ([Provider] Exhibit 6).

12. By letter dated November 19, 2003 to the Providers, the Intermediary stated that the Intermediary was not required to pay interest to the Providers ([Provider] Exhibit 7). The letter advised inter alia:

> As you know, the predecessor intermediary, Health Care Service Corporation (HCSC) determined that the above referenced providers were entitled to an increased HSR. However, before HCSC could issue a Notice of Reopening and NPR pursuant to that determination, United Government Services was directed by CMS (formerly HCFA) to replace HCSC as the fiscal intermediary. As a result, certain of HCSC original documentation underlying their determination was misplaced and it has taken some time to find and resolve that matter.

13. The Intermediary subsequently issued revised NPR's (sic), reflecting the appropriate principal amount of the Capital PPS but did not include interest. ([Provider] Exhibit 8.) The Intermediary paid to the Providers the amount due in late December 2003.

PROVIDERS' CONTENTIONS:

The Providers contend they are entitled to be paid interest on the revised CPPS payments made by the Intermediary in 2003 because the payments were not made within 30 days of the date (1996) they were notified of their redetermined HSRs, as required by 42 U.S.C. §1395g(d).

The Providers contend that, pursuant to 42 C.F.R. §405.376,[4] Health Care Service Corporation's notices are "final determinations." The regulation's definition of a "final determination" that is not an NPR includes: "[a] written determination that an overpayment exists and a written demand for payment" or "[a] written determination of an underpayment."

[4] Redesignated as 42 C.F.R. §405.378.

The Providers add that CMS Pub. 13-2 §2219.1 explicitly states that a final determination for purposes of the interest provisions (under 42 C.F.R. §415.376ff) differs from the use of the term "final determination" for purposes of cost report settlement and issuance of an NPR.[5]

The Providers also contend that should the Board find that the 1996 redetermination letters are not final determinations, in the alternative, the Board should find that they are entitled to payment of interest from August 1, 2001. The Providers assert that their letter to the Intermediary dated August 1, 2001 was notice of its determination of underpayment. Stipulation No. 9.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that a correction to an existing cost report to reflect an additional amount due a provider can only be accomplished by the issuance of an NPR. While the existence of a discrepancy between an original HSR determination and a redetermined HSR is evidence of an error that requires adjustment, it does not equate to a "written determination of an underpayment" as defined in 42 C.F.R. §405.378. Also, a favorable re-determination under 42 C.F.R. §412.328(g), titled, Review and revision of the hospital-specific rate, does not establish and quantify the existence of an underpayment under §405.378. Essentially, the redetermined HSR is an element used in determining an underpayment but does not, in and of itself, create an underpayment. The Intermediary cites to Library of Congress v. Shaw (478 U.S.C. 310, 317) for the proposition that the government is generally not liable for interest unless expressed in contract or statute.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes that the Providers are not entitled to be paid interest based upon the redetermination of their CPPS HSRs. Contrary to the Providers' arguments, neither the notices issued by Health Care Service Corporation in 1996 advising the Providers of their redetermined HSRs, nor the Providers' letter dated August 1, 2001 notifying the Intermediary that the redetermined HSRs may not have been applied in the applicable payment years, meet the statutory and regulatory requirements for the payment of interest.

Both the interest statute, 42 U.S.C. §1395g(d), and the implementing regulation, 42 C.F.R. §405.376 (redesignated as 405.378), are clear. In order for a provider to be entitled to interest on a program underpayment, the amount of the underpayment must be determined by the intermediary, and the intermediary must issue the provider a written determination of that amount.[6]

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[5] Exhibit I-6.

[6] The parties agree that the Intermediary issued revised NPRs reflecting the appropriate principal amount of the CPPS payments and paid the Providers the amounts due beginning in late December 2003. In it undisputed that these amounts were paid timely.

With respect to the instant case, the notices issued by Health Care Service Corporation in 1996 did not convey an underpayment amount but, as previously noted, advised the Providers of their redetermined HSRs. While the redetermined HSRs are factors needed to determine an underpayment amount, they alone do not represent an amount due and payable by the program. Similarly, the Providers' August 1, 2001 letter did not reflect an underpayment amount, nor was it an intermediary determination.

The Board acknowledges that the CPPS regulation at 42 C.F.R. §412.328(g)(2)(iii) characterizes an intermediary's notice of an HSR as a final determination. However, this regulatory provision establishes a provider's right to administrative and judicial review in accordance with 42 C.F.R. §405.1801ff governing provider reimbursement determinations and appeals. In addition, a notice of a provider's CPPS HSR or redetermined HSR does not meet the second prong of the interest rules. That is, it does not convey an overpayment or underpayment amount to a provider but, rather, conveys a payment rate or a change in a previously established payment rate.

The Board also acknowledges the Providers' reliance upon CMS Pub. 13-2 §2219.1, which explains that a final determination used in conjunction with 42 C.F.R. §405.376ff, the interest regulation, is not synonymous with the term "final determination" used in settling provider cost reports when a NPR is issued under 42 C.F.R. §405.1803. However, the manual is consistent with the interest statute and regulation and does not support the Providers' position. In the case of program underpayments, the manual requires the use of: (1) an NPR and a written determination of an underpayment issued by an intermediary, or (2) when an NPR is not used, the manual requires an intermediary to issue a written determination and a written notice of the underpayment to a provider.

The Board notes that after the Intermediary issued the NPR for FY 1993 based on the revised HSR, it should have reopened the cost reports for 1992, and also used the revised HSR to compute payments to the Provider's in subsequent years. The Intermediary's failure to promptly utilize the Providers' redetermined CPPS HSRs delayed significantly the amount of program payments due the Providers. Nevertheless, based on the Medicare statute and the Secretary's regulations, the Board finds that the Providers are not entitled to payment of interest.

DECISION AND ORDER:

The Providers are not entitled to a payment of interest under the Medicare statute 42 U.S.C. §1395g(d) and the applicable Medicare regulation 42 C.F.R. §405.378 as a result of the underpayment of Medicare reimbursement during the ten-year transition period of the CPPS. The Intermediary's denial of the request to pay the Providers interest is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Elaine Crews Powell, C.P.A
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A. (inactive)

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: September 29, 2008