CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Hospital Corporation of America Providers with Late Notices of Program Reimbursement **Providers** **vs.** **Blue Cross Blue Shield Association/ Various Intermediaries** **Intermediary**	**Provider Reimbursement for Cost Reporting Periods Ending: Various** **Review of: PRRB Dec. No. 2005-D16 Dated: December 27, 2004**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). Comments were received from the Intermediary requesting reversal of the Board's decision. The parties were then notified of the Administrator's intention to review the Board's decision. Comments were received from CMS' Office of Financial Management (OFM) requesting reversal. Comments were received from the Providers requesting affirmation of the Board's decision. All comments were timely received.[1] Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue as stated by the Board was what relief is available through appeal to the Provider Reimbursement Review Board for failure of the Intermediary to timely

[1] The Provider responded to OFM's comments, by letter dated February 15, 2005. As these comments were submitted after the 15-day period, they cannot be considered, but have been made a part of the administrative record.

settle the Providers' cost reports, especially where prejudice will result from the failure to settle such cost report.

The Board found that the Intermediary's determinations were late and that the late determinations are not the fault of the Providers. The Board noted that, under 42 CFR 405.1835(c), the Providers are entitled to a hearing when Notices of Program Reimbursement (NPRs) have not been timely issued through no fault of the Providers. The Board also found that the Providers may be disadvantaged, as a result of late determinations, in their abilities to claim graduate medical education costs pursuant to section 713 of the Medicare Modernization Act (MMA) of 2003 (Pub. Law 108-173.)

The Board stated that, other than the regulations, there is no guidance or prior cases concerning hearings on late determinations. The Board noted the Providers argument that the Intermediary should be ordered to deem the cost reports settled for purposes of the MMA, but found that it was premature to specify what, if any, type of payment should be permitted. Further, the Board considered the Intermediary's contention that the only remedy is for the Board is to decide that the determinations are late and not the fault of the Provider in order to permit the Providers to claim accelerated interest if the case proceeds to court. However, the Board found that interest applied to a debt owed by Medicare, and since there is no determination, there is nothing on which interest may be determined.

Thus, the Board concluded that the matter should be remanded to the Intermediary and directed the Intermediary to issue determinations before the end of the 2004 calendar year so that the Providers would not be prejudiced under the MMA.

SUMMARY OF COMMENTS

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary noted that, while an appeal based on non-issuance of an NPR is a regulatory right, this appeal presented a challenge as to what remedy may be available. Neither party could produce any regulatory, legislative, or other guidance as to what should be done. The Intermediary further pointed out that when this case was heard there were 57 separate cost years which were consolidated, and that by the time the Board decision was issue, 40 NPRs were issued leaving 17 remaining cost years. With regard to the 17 remaining cost years, the Intermediary argued that the Board's order was not reasonable. The Board's decision bears a date of December 27, 2004 and was not received until January 3, 2005 (after the December 31 compliance deadline.)

In addition, the Intermediary noted that, under the controlling regulation, Administrator's review is an integral part of the administrative decision process. The Board's decision in this case eliminates the Administrator and CMS' opportunity to evaluate the decision and the complex issues the underlying problem raises. Thus, the Intermediary maintained that the appropriate solution is to vacate the decision of the Board and remand it for a decision that can be reasonably implemented, if not changed, or challenged by the affected provider on judicial review.

The Providers commented, requesting that the Board's decision remain intact, with certain modifications. The Providers argued that some of the Providers involved in the appeal were prejudiced by the untimely issuance of an NPR due to the language of CMS' One Time Notification (OTN), which implements section 713 of the MMA. The Providers urged that the Administrator modify the Board's decision and instruct the Intermediary to count the Providers' residents in accordance with the GME Moratorium. This result would have occurred if the Intermediary had followed the regulation regarding the timely issuance of NPRs. The Providers contended that the Board had the authority, under the statute, to order the Intermediary to apply the GME Moratorium to the cost reports at issue. The Providers claimed that if the decision is not revised, the Providers may be denied Medicare payments to which they were lawfully entitled. Referring to a prior Board decision for support, the Providers maintained that because they will suffer harm as a direct result of the Intermediary's failure to timely issue NPRs, the needed standard for remedy for an appeal under the statute is satisfied in this case.

Further, the Providers maintained that the Intermediary failed to demonstrate any of the five bases set forth in the regulation for Administrator's review to support vacating the Board's decision because of the timing of that decision and the compliance deadlines. The Providers noted that the Intermediary's difficulties in implementing the decision could have been eliminated if the Intermediary had settled the cost reports prior to the close of 2004 and subsequently reopened for further consideration. The Providers pointed out such options were discussed on two occasions in May and July 2004. However, those options were rejected by the Intermediary. Thus, the Intermediary cannot now suggest that when the Board ruled consistent with earlier discussed options, it did not have time to implement such a remedy. Instead, the Provider argued, the Intermediary summarily determined that it could not comply and prepared a request for review which is improper and greatly prejudiced the Providers.

OFM commented, requesting reversal of the Board's decision. OFM argued that the Administrator should instruct the Intermediary to issue the NPRs for the remaining 17 Providers as soon as practicable. Relevant to this case, OFM noted that under the statute and implementing regulations, if a provider has not received an NPR, it has the right to appeal the amount of it Medicare payment by requesting a hearing within a specified time period. However, neither the statute nor regulations specify a remedy, other than appeal to the Board, for the untimely issuance of an NPR. OFM also noted that the Board's authority to grant relief is limited by the powers articulated in the statute, regulations, manuals, and CMS rulings. OFM, citing several prior Board cases in support, argued that the Board does not have general powers in equity to grant relief. Rather, the Board's authority is limited to deciding matters related to the total amount of reimbursement due a provider for a period covered by a cost report.

Similarly, OFM stated that the statutory and regulatory provisions providing for appeal of an NPR that is not issued timely is couched in terms of entitling a provider the right to a hearing with respect to its payments, and does not explicitly grant the Board equitable power to order the issuance of an NPR. OFM noted that in this case, no payment disputes regarding final payment amounts due the providers have arisen as yet, and may, indeed, never arise because the Providers may be satisfied with their reimbursement. OFM argued that, nonetheless, the Providers want their NPRs immediately and the Board appears to have granted the Providers equitable relief by ordering the issuance of NPRS by a date certain.

Further, OFM asserted that it was inappropriate for the Board to wade into the audit process in light of the facts presented by the Providers in this case. OFM maintained that the Providers have not demonstrated any extraordinary need for the immediate issuance of NPRs. OFM noted that some Providers want NPRs issued in 2004 in an effort to capitalize on an MMA provision. However, it is not clear whether that provision even applies to all the Providers. The Providers in this instance have not demonstrated a pressing need for their NPRs. The Providers have not suggested that their businesses are threatened by the failure to receive NPRs, or even that they believe any additional monies are due as a result of the NPRs. OFM also noted that the Intermediaries are working diligently to fulfill their Medicare responsibilities and have endeavored to issue NPRs in a timely manner; a fact which the Providers appear not to dispute.

Moreover, OFM argued that the Providers' request for expedited issuance of their NPRs is analogous to cases arising from the Freedom of Information Act (FOIA). FOIA imposes statutory timetables for agencies to process and release requested information. Often agencies are burdened by extensive backlogs of requests and

cannot meet the statutory timetables for release of information. Citing to several cases in support, OFM stated that the courts have held that as long as an agency is acting in good faith and exercising due diligence in processing FOIA request, the courts should not intervene. This premise is particularly true where there is no demonstration of "urgency" or "exceptional need" for the information. The courts have narrowly construed a showing of exceptional need, applying such where the requester's life or personal safety, or substantial due process rights would be jeopardized by failure to process a request immediately.

Further, OFM argued that the courts have recognized that by allowing requesters to file suit in an effort to jump to the front of the processing line, or placing one requester ahead of all others has an adverse effect and sets a bad precedent. These concerns are equally true in the context of Medicare. In this instance, the Providers have made no showing that the Intermediaries have failed to act with due diligence or demonstrated bad faith in processing open cost reports. Thus, OFM concluded that there is no reason to require the extraordinary relief granted by the Board.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been included in the record and considered.

Section 1878 of the Social Security Act [42 USC 1395 oo] establishes the Provider Reimbursement Review Board and affords providers of services the right to obtain a hearing before Board with respect to its cost report. Specifically, subsection (a) provides that:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board…. and (except as provide in subsection (g)(2)) any hospital which receives payments in the amounts computed under subsection (b) or (d) of section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—
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> (1) such provider—
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> (A)(i) is dissatisfied with a final determination of the … intermediary … as to the amount of total program reimbursement due the provider

> for the items and services furnished to individual for which payment may be made under this title for the period covered by such report, … or
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> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886,
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> (B) has not received such final determination from such intermediary on a timely basis after filing such report, which such report complied with the rules and regulations of the Secretary relating to such report, or….
> (C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,
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> (2) the amount in controversy is $10,000 or more, and
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> (3) such provider files a request for a hearing within 180 days after the notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after the notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C) within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

In addition, Section 1878(b) of the Act provides that:

> A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence which the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report….

In implementing the provisions of the statute, the regulation at 42 CFR 405.1801(a) defines certain terms including that an "intermediary determination" means:

> (1) With respect to a provider of services that has filed a cost report under 413.20 and 413.24(f) of this chapter, the terms means a determination of the total amount of reimbursement due the provider,

> pursuant to 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement maybe made on a reasonable costs basis under Medicare for the period covered by the cost report,
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> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter) the term means a determination of the total amount due the hospital, pursuant to 405.1803 following the close of the hospital cost reporting period, under that system for the period covered by the determination.
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> (3) For purposes of appeal of the Provider Reimbursement Review Board the term is synonymous with the phrases "intermediary's final determination" and "final determination of the Secretary" as those phrases are used in section 1878(a) of the Act.

The regulation at 42 CFR 405.1835 sets forth the criteria for a right to a hearing before the Board, stating that:

> (a) *Criteria*. The provider (but no other entity or party) has a right to a hearing before the Board about any matter designated in 405.1801(a)(1), if:
> (1) An intermediary determination has been made with respect to the provider; and
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in 405.1841(a)(1); and
> (3) The amount in controversy (as described in 405.1839(a)) is $10,000 or more.
> (b) *Prospective Payment Exceptions*. Except with respect to matters for which administrative or judicial review is not permitted as specified in 405.1804, <u>hospitals that are paid under the prospective payment system are entitled to hearings before the Board under this section if they otherwise meet the criteria described in paragraph (a) of this section.</u> (Emphasis added.)

Moreover, consistent with the paragraphs (B) and (C) of section 1878(a)(1) of the Act, the regulation at 42 CFR 405.1835 affords a provider a right to a Board hearing when the intermediary does not issue a reasonable cost determination as reflected by the NPR, within a certain timeframe. Subsection (c) states:

> *Right to hearing based on late intermediary determination about reasonable cost*. Notwithstanding the provisions of paragraph (a)(1) of this section, the provider also has a right to a hearing before the Board if an intermediary's determination concerning the amount of reasonable cost reimbursement due a provider is not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report or amended cost report … provided such delay was not occasioned by the fault of the provider.[2] (Emphasis added.)

In 1974, the Secretary implemented the provisions of section 1878 of the Act and in particular paragraphs (B) and (C) by regulation. In doing so, the Secretary rejected commenters' proposals for a shorter timeframe in 42 CFR 405.1835(c) noting, inter alia, the complexity of issues presented by the cost reports that must be addressed by intermediaries.[3] In addition, the Secretary noted that:

> The intermediary's review may include such time consuming procedural steps as extensive desk examination of the cost report, further communication with the provider requesting clarification of particular entries and/or supporting documentation arranging for and completing an audit…. Such review by the intermediary is conducted at a time when work demands are at a peak, since most providers file their cost reports at the same time…..[4]

Consequently, over 30 years ago, well before the implementation of the numerous payment systems that now further complicate the settlement process, the Secretary determined that: "Thus it is apparent that in view of the procedural steps set forth above and the limitations of intermediaries' audit capabilities, a period less than 12 months would not be adequate in the majority of cases."[5]

While a provider may seek a hearing if an NPR is not issued within the prescribed one year period set forth in 405.1835(c), regarding the intermediary's responsibilities, 42 CFR 405.1803(a) states that:

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[2] With respect to Board jurisdiction, the regulation at 42 CFR 405.1873(a) provides, in part, that: "The Board decides questions relating to its jurisdiction to grant a hearing, including (1) the timeliness of an intermediary determination …"
[3] 39 Fed. Reg. 34514 (September 26, 1974).
[4] 39 Fed. Reg. 34515.
[5] Id.

> Upon receipt of a provider's cost report, or amended cost report, where permitted or required, the intermediary must within a reasonable period of time (see 405.1835[c]) furnish the provider…. written notice reflecting the intermediary determination of the total amount of reimbursement due the provider.

Other than the timeframe which allows certain providers to seek a Board hearing, the regulation does not otherwise specify any regulatory timeframe for the audit of a cost report and issuance of the intermediary determination of the total amount of reimbursement due the provider. The specific expectations are left to the CMS Manuals and Program Memorandums and Instructions. For example, Chapter 8, Section 90 of the Medicare Management Manual, which gives guidance to intermediaries, states that:

> CMS expects that you settle (i.e., issue the Notice of Amount of Program Reimbursement (NPR)) all cost reports that are not scheduled for audit within 12 months of acceptance of a cost report. If you audit a cost report, issue the NPR to the provider within 60 days of the exit conference or within 60 days after the audit adjustments are finalized … if an exit conference is waived.[6]

In contrast, the provider's responsibilities for filing a timely cost report are set forth in the regulation at 42 CFR 413.24(f) which explains that:

> For cost reporting purposes, the Medicare program requires each provider of services to submit periodic reports of its operations that generally cover a consecutive 12-month period of the provider's operation.

Paragraph (f)(2)(i) explains the due dates for cost reports, stating that:

> Cost Reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period.

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[6] See also PM Transmittal A-01-82 (July 3, 2001) ("CMS Audit and Cost Report Settlement Expectations").

However, due to the implementation of outpatient prospective payment system certain due dates for cost reports ending in 2000 were extended.[7] Later, programming difficulties with the Provider Statistical and Reimbursement (PS&R) Report resulted in the delay in the release of the PS&R for use in filing cost reports causing the additional extensions for cost report due dates.[8]

Consistent with the regulation, Section 104.A.1 of the Provider Reimbursement Manual (Part II) sets forth the cost report due dates stating that "Cost reports are due on or before the last day of the fifth month following the close of the cost reporting period." However, paragraph A.3 states that:

> The Provider must receive the … (PS&R) on or before the 120\th/ day. If the intermediary is late mailing the PS&R, the provider will have 30 days from the date of receipt of the PS&R to file its cost report, even if it extends beyond the 5 month due date. No interest will be assessed against the provider for filing the cost report beyond the 5 month period if the cost report is late due to late receipt of the PS&R.

The Administrator notes that this case presents one of first impression. The Providers[9] appealed to the Board challenging the failure of the Intermediary to issue NPRs within one year of its receipt of the respective Providers' cost reports. The

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[7] See e.g. Program Memorandum (PM) Transmittal No A-01-22 (February 6, 2001) Change Request 1501, "Extension of Due Dates for Filing Provider Cost Reports."

[8] See e.g. (PM) Transmittal A-01-62 (May 9, 2001) Change Request 1673 "Extension of Due Dates for Filing Provider Cost Reports." ("All hospitals … with fiscal years ending on or after August 31, 2000, through February 28, 2001, will be due August 31, 2001." In addition, the PM stated that: "should the PS&R continue to experience programming difficulties beyond the August 31, 2001, extension date, the Provider Reimbursement Manual (PRM), Part II … Chapter 100 addresses due dates of cost reports when the PS&R is not mailed timely to the provider. Cost reports are due 5 months from the end of the fiscal year or 30 days from the date of receipt by the provider of the PS&R…."); See PM Transmittal A-02-095 (October 4, 2002 Change Request 2389, "Production Dates for the … PS&R report and extension of Due Date for Filing Provider Cost Reports for Providers Having Their Claims Processed by the Arkansas Part A Standard System (APASS)")

[9] The record shows that a consolidated hearing was held for 57 cost years for commonly-owned providers, for which no NPRs had been received within one year of the Intermediary's receipt of a perfected cost report or amended cost report. At the time of the Board's decision, NPRs had not yet been issued for 17 cost years. See Board's decision, p. 3 and Board attachment; See also Intermediary's Comments, dated January 14, 2005.

Administrator notes that the parties agreed that the NPRs were not issued, inter alia, due to outpatient PPS audit pressures on the fiscal intermediaries and through no fault of the providers.[10] However, the question remains as to whether the Board may grant the relief requested under the facts in this case.

The Providers asserted that they will be seriously prejudiced in the amount of reimbursement they are entitled to receive if the NPRs are not issued by December 31, 2004, because of the provisions of the recently enacted MMA and because it will inhibit their ability to file commonly owned group appeals because of restrictive Board group instructions. The Board agreed on the first allegation regarding the MMA, finding that the Providers may be disadvantaged as a result of a late NPRs in their ability to claim GME costs. Thus, the Board remanded the case and ordered the Intermediary to issue NPRs by December 31, 2004.

After a review of the law and facts of this case, the Administrator disagrees with the Board's findings and order. The Administrator notes that a review of the statute and regulation suggests that the Board jurisdiction, under the circumstances where a final intermediary determination has not been issued within the one year timeframe, was intended for reasonable cost determinations. In particular, the statute distinguishes between final determinations of the intermediary under reasonable cost reimbursement[11] and final determinations of the Secretary under Section 1886 (b) and (d).[12] The language at section 1878(a)(1)(B) and (C) appears to allow a Board hearing pursuant to an intermediary's untimely reasonable cost determinations.[13]

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[10] The record shows that of the 17 remaining cost years, 15 involved cost reports submitted more than five months after the close of the cost reporting period. Whether these cost reports were still considered timely submitted was not at issue before the Board and based on the limited facts cannot be determined in light of provisions of section 104.A.3 of the Provider Reimbursement Manual (Part II) Medicare Management Manual regarding the release of the PS&R.

[11] Section 1878(a)(1)(A)(i) of the Act.

[12] Section 1878(a)(1)(A)(ii) of the Act.

[13] Congress arguably drafted section 1878 of the Act to recognized two distinct payments systems and appeal avenues and to thus foreclose providers from arguing that the level of its payment which it receives under PPS is inadequate to cover its reasonable costs. See H. R. Rep. 98-25(I), 98th Cong., 1st Sess. 1983, 1983 U.S.C.C.A.N 210 ("Your Committee's bill would provide for the same procedures for administrative and judicial review of payment under the prospective payment system as is currently provide for cost-based payments. In general the same conditions, which now apply for review by the PRRB and the courts, would continue to apply….. It is the purposes of your committee's bill to establish a prospective payment system for Medicare. The prospective payment will no longer have any

In addition, consistent with the statute, the regulation at 42 CFR 405.1835 also distinguishes between reasonable cost determinations at paragraph (a) and prospective payment determinations at paragraph (b). Hospitals that are paid under inpatient PPS are entitled to a hearing before the Board if they meet the criteria of paragraph (a). Notably, similar to the statute, paragraph (c) at issue in this case only addresses the right to request a Board hearing if "an intermediary's determination concerning the amount of reasonable cost reimbursement due a provider is not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report…."[14] (Emphasis added.)

The underlying issue raised in this case does not involve the amount of reasonable cost reimbursement due the providers, but rather is injunctive in nature and related to the implementation of section 713 of the MMA which involves payments under section 1886(h) of the Act.[15] Accordingly, the language of the statute and regulation allowing a Board hearing prior to a "final determination" would appear not to have been intended for other than reasonable cost payments issues, which is not the issue raised in this case.[16] Consequently, a strict reading of the regulation and law requires a finding that the Board had no jurisdiction, at this time, over the matter in dispute.

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relationship to a hospitals actual costs. Thus it is your Committee's intent that a hospital would not be permitted to argue that the level of the payment which it receives under the system is inadequate to cover its costs.")

[14] Payments under section 1886(h) are not specifically referenced in section 1878 of the Act or 42 CFR 405.1801, et seq. regarding Board appeals. However, these types of GME payments are not considered paid under reasonable costs. The regulation at 42 CFR 413.1(b) defines reasonable costs by stating that: "Medicare is generally required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2)of the Act (for services paid under Part B) to pay for services furnished by providers on the basis of reasonable costs as defined in section 1861(v) of the Act, or the provider's customary charges for those services if lower." See also 42 CFR 413.1 (a)(1)(B). Compare 42 CFR 413.1(a)(1)(K).

[15] The record indicates that, at most, only three of the providers remaining even allege to have GME programs: Memorial Hospital of Jacksonville, Rapides Regional Medical Center, and Alleghany Regional Hospital. See Providers' Supplemental Position Paper (providers with *) pp 2-3; Providers' Post-Hearing Brief Attachment (shadow boxed providers) and listing of remaining providers set forth in Board Decision Attachment.

[16] Congresses' rationale for allowing providers to seek a hearing before receiving a determination is not shown in the legislative history. However, CMS has attempted to mitigate any harm a provider might experience by instructing intermediaries to issue prompt initial/tentative retroactive adjustments as "essential to ensure proper

However, regardless, of whether Congress intended to limit appeals, under these circumstances, to reasonable cost reimbursement issues, the Providers' request for relief is also problematic as it is injunctive in nature. Under the law, the Board does not have the explicit authority to order the Intermediary to issue NPRs, or to otherwise order a final intermediary action by a date certain. Yet the Providers have in effect requested injunctive relief in requesting that the Board order the Intermediary to issue NPRs by a certain date.[17] Established law recognizes that injunctive relief is based in equity.[18] The Administrator notes that, unlike courts, administrative agencies and boards do not have any inherent equitable powers unless expressly provided by statute.[19] As noted above, the Medicare statute does not

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cash flow to providers. Reducing or delaying tentative settlements until a final determination could jeopardize the financial viability of some providers." PM A-01-82 at 3. As shown by CMS' instructions describing the circumstances under which tentative settlements should be made, CMS has attempted to ensure proper cash flow to providers, while not exposing the Medicare Trust funds to excessive risk. In this case, 11 of the 17 cost reports were tentatively settled at the time of the Board's decision.

[17] Black's Law Dictionary (7th Edition) (1999)("*Injunctive*, adj. That has the quality of directing or ordering; of or relating to an injunction. Injunction … n, A court order commanding or preventing an action—To get an injunction, the complainant must show that there is no plain, adequate, and complete remedy at law, and that an irreparable injury will result unless the relief is granted." Also quoting 1 Howard C. Joyce. *A Treatise on the Law Relating to Injunctions* Section 1, at 2-3 (1909): "In a general sense, every order of a court which commands or forbids is an injunction, but in its accepted legal sense, an injunction is a judicial process … by which, upon certain established principles of equity, a party is required to do or refrain from doing a particular thing.") at 788.

[18] See e.g. City of Houston v. Department of House and Urban Development, 24 F. 3d 1421, 1428 (D.C. Cir. 1994)(''[T]he instant Complaint … seeks injunctive relief under the APA and therefore sounds in equity….)

[19] See, e.g., Ramos v. District of Columbia Department of Consumer and Regulatory Affairs, 601 A.2d 1069 1073 (1992) ("In contrast with judicial tribunals, however, administrative law tribunals—created by the legislature to serve dispute resolution and rulemaking-by-order functions within agencies of the executive branch—by definition and design do not have the inherent equitable authority that courts in the judicial branch have derived from common law traditions and powers … 'The sanctioning authority of an agency may include a specific sanction, or may be stated in general terms. In either case, the agency may exceed neither the specific nor general grant of power authorized by [the legislature].' J.STEIN, G. MITCHELL & B. MEZINES, 4 Administrative Law at 41A.01. (1991 ed.) (footnotes omitted)….")

confer general equitable authority to the Board. A review of the applicable Medicare law reflects that the Board's decision grants the Providers relief beyond that provided by law. Accordingly, the Board acted outside the scope of its authority in ordering the intermediary to issue the NPRs by a date certain for the 17 cost years involved in this case.[20]

Notably, the Secretary addressed, in rulemaking, similar concerns as those expressed by these Providers' argument that they will be disadvantaged as a result of issuance of NPRs after December 31, 2004 in their abilities to claim GME costs pursuant to section 713 of the MMA. In 1987, Section 1886(h) of the Act was amended to allow the time residents spent in nonprovider settings to be counted for GME payment purposes if certain conditions were met. The Secretary has required that hospitals meet specified criteria, including criteria regarding the financial arrangement for supervisory teaching costs, in order to count residents in non-hospital settings The MMA statute provides, inter alia, that, during the one-year period beginning on January 1, 2004 and ending December 31, 2004, Medicare is to allow all hospitals to count residents in allopathic and osteopathic family practice programs training in nonhospital settings, without regard to the financial arrangement between the hospital and the teaching physician practicing in the nonhospital setting to which the resident has been assigned.

In implementing the above MMA provision, CMS first issued a One-Time Notification (OTN), dated March 12, 2004.[21] Among other things, the OTN noted:

Stark v. Wickland, 321 288, 309 (1944) (1944) ("The Board as a statutory creation has only those powers given to it by statute.")

[20] The Administrator notes that the Board's decision is also problematic as it required the Intermediary to act in a timeframe that would have mooted the Secretary's right of final review. Furthermore, even assuming that such relief could be granted, the three Providers that may have GME programs, have not, for example, submitted their cost reports to show that they have GME programs or other evidence that they would benefit by the moratorium provisions or the level of harm they will experience if denied that relief. The other remaining Providers argument, that they are injured because the delay in issuing the NPRs may affects their ability to file group appeals because of Board instructions, is a non-issue. As noted by the Intermediary, the Board has certain discretionary flexibility on the management of group appeals.

[21] Pub. 100-20, Transmittal 61, CR 3071.

> [T]hat the moratorium does not apply to cost reporting periods that are not settled during January 1 through December 31, 2004, or which do not coincide with, or overlap the January 1—December 31, 2004 period. For example, if the cost report for fiscal year ended December 31, 2003 (June 30, 2003, etc.) is not settled during the January 1—December 31, 2004 period, the moratorium does not apply.

CMS further stressed in the OTN that the scheduling of cost report audit or settlement activities during CY 2004 should be done in accordance with normal procedures.

Importantly, the Secretary discussed the affects of the MMA moratorium in the preambles to the proposed and the final rule on the Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates.[22] The Secretary explained that:

> [W]hen settling prior cost reports during this one-year period, or for family practice residents actually training in nonhospital settings during this one-year period, the fiscal intermediaries should allow the hospitals to count allopathic and osteopathic family practice residents training in the nonhospital setting for direct GME and IME payment purposes without regard to the financial arrangement between the hospital and the nonhospital site pertaining to the teaching physicians' costs associated with the residency program.[23]

The Secretary continued, citing the following example of settling a 2001 cost report:

> For example, when a fiscal intermediary is settling a cost report during CY 2004 that has a fiscal year end of June 30, 2001, the fiscal intermediary will allow the hospital to count family practice FTE residents that trained in a nonhospital setting during the period covered by the June 30, 2001 cost report, regardless of the financial arrangement in place between the hospital and the teaching physician at the nonhospital site during the period covered by the June 30, 2001 cost report.[24]

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[22] 69 Fed. Reg. 28196 (May 18, 20040); 69 Fed. Reg. 48916, 49176-49177 (August 11, 2004).
[23] 69 Fed. Reg. 49177.
[24] Id.

The Secretary recognized that, because it interpreted the moratorium to apply to cost reporting periods that are settled during the calendar year (CY) 2004 and to cost reports that are settled after the CY 2004 that cover training that occurred during the moratorium period, a gap in the applicability of the moratorium may result for family practice residents training in nonhospital settings. Citing to an example of the gap, the Secretary stated in the preamble to the Proposed PPS rule, that:

> For example, a hospital might be permitted to count certain FTE family practice residents that are included in its FY 2001 cost report in accordance with the moratorium because that cost report is settled during CY 2004. However, the hospital might not be permitted to count certain FTE family practice residents in its FY 2002 and 2003 cost reports because these cost reports would not be settled during CY 2004 and the moratorium would not apply. The hospital then could be permitted to count certain FTE family practice residents in its FY 2004 cost report in accordance with the moratorium, because the FY 2004 cost report would contain family practice residents who actually trained in a nonhospital setting during CY 2004.[25]

Finally, in response to providers explicit concerns that fiscal intermediaries may purposely delay audits or the issuance of settled cost reports to avoid the impact of the moratorium, the Secretary reiterated its policy as described in the OTN with respect to those settlement activities and added that:

> [S]cheduling of audit or settlement activities should be done using the normal procedures. Given the above instruction, fiscal intermediaries should not take the moratorium into consideration or delay settlement and audit activities. Because we have instructed fiscal intermediaries to follow normal procedures, we request that hospitals respect our instructions and refrain from pressuring fiscal intermediaries to settle more cost reports than they would during the normal course of business in an attempt to take advantage of this moratorium.[26]

Thus, as noted above, the Secretary was aware of the desire of hospitals to benefit from this limited moratorium period and also of the burden the MMA may place on intermediaries in settling cost reports. The Secretary instructed intermediaries not to delay settlements because of the moratorium and, likewise, requested that hospitals not request expedited treatment in order to take advantage of the moratorium. The Secretary recognized that some providers maybe advantaged in

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[25] 69 Fed. Reg. 28315 (May 18, 2004).
[26] 69 Fed. Reg. 49177.

the normal course of auditing cost reports and other providers, and even the same provider for a different cost year, may be disadvantaged by the normal course of auditing cost reports. However, the aforementioned policy, in light of the competing demands of providers and the realities of the auditing process, guaranteed that no one provider would be singled out to receive favored, or disparate, treatment. In implementing the MMA moratorium, the Secretary reasonably balanced providers' concerns, similar to those raised here, with the practical realities of administering the Medicare program.[27]

In sum, the Administrator finds that the Board's instruction to the intermediary to issue NPRs by December 31, 2004, was outside the scope of its authority. Based on the foregoing reasonable policy and the limitations on granting relief beyond that allowed under the law, the Administrator also denies the Providers' request that Administrator order the intermediary to apply the moratorium in these cost years.

[27] To the extent the Providers may be challenging the Secretary and CMS' instructions to intermediaries to follow normal auditing procedures, the Administrator finds such an instructions were reasonable. The Administrator notes, however, that the Providers have not characterized the issue under appeal as a challenge to the Secretary's policy reflected in the final FFY 2005 inpatient prospective payment rule and/or the OTN implementing the MMA provisions.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: 3/3/05 /s/

Leslie V. Norwalk, Esq.
Deputy Administrator
Centers For Medicare & Medicaid Services