CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:	Claim for:
Saint Mary's Hospital	**Medicare Reimbursement for Cost Year Ending: 12/31/94**
Provider	
vs.	
Blue Cross and Blue Shield Assn.	**Review of: PRRB Dec. No. 2006-D1 Dated: November 8, 2005**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. Comments were received from the Center for Medicare Management (CMM) and the Provider. Accordingly, the Board decision is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue was whether the Intermediary's denial of the Provider's request for an adjustment to its TEFRA[1] target amount due to untimely filing of the request was proper.

The Board found that the controlling regulation in this case, at 42 CFR 413.40(e)(1), invokes two different standards. The Intermediary relied upon the language of the regulation in effect at the time the Provider filed its request for a TEFRA adjustment in December 1997. Based upon that wording, the Intermediary determined that the Provider's request was untimely filed, as it was not "received" by the Intermediary within 180 days of the notice of program reimbursement (NPR) at issue. However, the Provider had argued that the wording of the regulation in place during the cost period at issue, i.e.,

[1] Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub.L.No. 97-248.

FYE 12/21/94, applies. The regulation at that time required TEFRA requests to be "made" no later than 180 days after the NPR date. The Provider asserted that its request was timely filed since it was "mailed" on the 181st day after the NPR, observing that the 180th day fell on a Sunday.

The Board found that the regulation in effect during the Provider's cost reporting period governed the timing of the Provider's TEFRA request. The Board maintained that the TEFRA request process is based upon the issuance of an NPR and, thus, can span several years during which regulatory changes may occur. The Board concluded that providers should be able to rely upon the rules in effect during the cost reporting period at issue. The Board opined that new regulations and modifications are generally applicable at the beginning of cost reporting periods.

Moreover, the Board found that the Provider correctly concluded that the mail date equaled the date the request was "made." The Board also found that §3004.2 of the Program Reimbursement Manual (PRM), which was authorized by the version of §413.40(e)(1) in effect during FYE 12/31/94, equated the date a request was "made" to the date a request was "submitted." The regulations at §405.1801(a) state that the "[d]ate of filing and date of submission of materials mean the day of the mailing (as evidenced by the postmark) or hand-delivery of materials, unless otherwise defined in this subpart." Last, the Board did not dispute the Provider's contention that the request was timely filed on the 181st day after the NPR because the 180th day was a Sunday. Accordingly, the Board reversed the Intermediary's denial of the Provider's request and remanded the request to the Intermediary for a determination on the merits.

SUMMARY OF COMMENTS

CMM requested reversal of the Board's decision. CMM maintained that currently, §413.40(e)(1) states that the TEFRA request must be "received" by the intermediary no later than 180 days after the date on the initial NPR. Prior to October 1, 1995, that regulation stated that the request must be "made" within 180 days of the NPR. In the proposed rule for FY 1996, CMM discussed clarifying that section of the regulation in the interest of policy uniformity. In that document, CMM stated that, while CMS had consistently interpreted "'made'" to equal "'received by'" the intermediary, there had been different interpretations by providers and intermediaries. Thus, in the final rule (published on September 1, 1995), CMM revised the language. CMM emphasized that, "[i]n making that change, we did not change our policy."

CMM disagreed with the Board's determination that the regulations in effect during the provider's cost year at issue are applicable to the timing of TEFRA requests. The issue is not a cost reporting issue. CMM also stated that new regulations or modifications are not generally effective with the beginning of provider cost reporting periods. CMM stated that the regulation is applicable as of October 1, 1995 for actions occurring subsequently.

Moreover, CMM disputed the Board's conclusion that the mail date is the equivalent of the request date. The regulation at §405.1801(a) and the definition for date of filing and date of submission are not applicable in this case as that regulation relates to filing appeals to the Board.

Further, CMM stated that a TEFRA request is a legal process and, therefore, legal definitions should prevail. CMM noted that the TEFRA section of the Act does not specify time requirements. However, CMM observed that Black's Law Dictionary defines to "file" as "'[t]o deposit in the custody or among the records of a court. To deliver an instrument or other paper to the proper officer or official.'" "Made" is defined in Black's Law Dictionary as "filed." On that point, CMM explained that, in the final rule published August 30, 1991, it stated that §413.40(e) " 'requires that the hospital file its request with its FI no later than 180 days from the date on the NPR.' " Moreover, in an American Hospital Association publication entitled, "TEFRA Provider's Guide to Adjustments and Appeals," dated June 1992, it is stated that " 'A hospital must file for an adjustment no later than 180 days from the NPR.' " Thus, CMM concluded, in the legal sense, "'file'" means that something must be received by another party. Therefore, even if the regulation as written prior to October 1, 1995 was the standard, the meaning of that language, i.e., "'request must be made,'" has the same meaning as the language used thereafter, i.e.., "'must be received.'"

Moreover, CMM continued, " 'submit' " requires one party submitting something to another, and "'request'" involves one party asking something of another. If the TEFRA adjustment request is not received by the intermediary within 180 days from the date of the NPR, the timing requirement at §413.40(e)(1) has not been met. In conclusion, CMM stated that, regardless of whether the pre-October 1, 1995 or the post-October 1, 1995 language is used, the meaning is the same, and CMS' interpretation has remained consistent to that meaning, i.e., the intermediary must <u>receive</u> (CMM's emphasis) the TEFRA request within 180 days of the NPR. Accordingly, CMM recommended that the Board's decision be reversed.

The Provider submitted comments supporting the Board's decision that its TEFRA request was timely filed. The Provider argued that the dispute derives from the change in the governing regulation. Prior to October 1, 1995, TEFRA regulations required that exception requests be "'made'" to the intermediary no later than 180 days after the date on the NPR. After October 1, 1995, the regulation required the request be "'received'" within 180 days of the date on the NPR. The Provider agreed with the Board's conclusion that a request for an appeal for FY 1994 should be governed by the regulations as they existed in 1994, and that a request is "'made'" when it is filed.

In addition, the Provider argued that §3004.2 of the PRM informs providers that exception requests must be "submitted" within 180 days and receipt within 180 days is not required.

Although the Intermediary has argued that the PRM language is inapplicable because it was written before the regulation was clarified, the Provider maintained that the PRM section has not changed since the regulations were amended, although the Agency could have changed the PRM to mirror the regulations. Providers should not be penalized for relying on published information. The Provider pointed out that the forward to the PRM states that it "'accurately reflect[s]'" law and regulations, but also noted that it states it "'does not have the effect of regulation.'" Further, the Provider noted that the U.S. Supreme Court has ruled that when an agency has established a deadline, the agency has the discretion to waive the deadline.[2]

Moreover, the Provider argued that, while the PRM does not define "submitted," the regulations at §405.1801(a) state that the date of submission means the date of mailing. The Provider noted that a federal court considered §405.1801(a) to be relevant to TEFRA requests because §413.40(e) was originally promulgated within the same chapter of regulations and because most steps of reimbursement reference §405.1801(a) definitions.[3] Further, the Provider argued that the regulatory definition of "submitted" was also consistent with the conventional use of the word, meaning "completion."

Finally, the Provider pointed out that the 180 day deadline for TEFRA requests begins to run on the date of the NPR, which is presumably also the date it is mailed. Thus, it is logical and consistent to use the same method to determine when the appeal is due. The Provider noted that the CMS Administrator has rejected provider arguments that the date the providers receive materials from the intermediaries should be the first day for purposes of determining deadlines.[4] In closing, the Provider urged the affirmance of the Board's decision on the basis of due process and basic fairness.

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 considered and included in the record.

In 1982, Congress enacted provisions in the TEFRA legislation to address containment of Medicare costs. TEFRA added §1886(a) to the Act, which established broader routine cost limits than those authorized under the reasonable cost provisions at §1861(v)(1)(A). Specifically, the §1886(a) cost limits covered ancillary service operating costs and special

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[2] American Farm Lines v. Black Ball Freight Service, 397 US 532, 539 (1970).
[3] Empire Health Services d/b/a Deaconess Medical Center v. Shalala, Case No. CS-98-341 (E.D. Wa. 1999).
[4] University Medical Center of Southern Nevada, Admr. Dec. May 20, 1999.

care unit operating costs in addition to routine operating costs, and applied to cost reporting periods beginning after October 1, 1982.[5]

While TEFRA left the basic retrospective, cost-based structure of Part A reimbursement undisturbed and expanded pre-existing routine cost limits, it also imposed a limit on the rate of increase of hospital operating costs reimbursed under Part A, adding §1886(b) to the Act. That section established that payment for inpatient operating costs would be based on the relationship between the provider's actual costs and a ceiling, or target amount, determined by a target rate of increase in operating costs per case. Section 1886(b) established that an annual target amount would be set for each provider based on the provider's own cost experience in an assigned base year. In the first year subject to the ceiling, the target amount would be established for each provider equal to the hospital's allowable operating costs per case for the preceding 12-month period, increased by a target rate percentage. After the first year, a hospital's target amount would be calculated by increasing the previous year's target amount by the current year's target rate percentage increase.

The regulations, at 42 CFR 413.40, *et. seq.*, implement the TEFRA provisions. Section 413.40(e) sets forth a procedure under which providers may request adjustments to the payment allowed under the rate-of-increase ceiling. Prior to October 1, 1995, §413.40(e)(1) stated that a provider's adjustment request "must be made to its fiscal intermediary no later than 180 days after the date on the intermediary's notice of amount of program reimbursement."

In the September 1, 1995 Federal Register,[6] the regulations were amended with an effective date of October 1, 1995, to clarify CMS' policy that an adjustment request is "made" when received by the intermediary. Section 413.40(e)(1), as amended, states that:

> A hospital may request an adjustment to the rate-of-increase ceiling imposed under this section. The hospital's request must be received by the hospital's fiscal intermediary no later than 180 days after the date on the intermediary's initial notice of program reimbursement (NPR) for the cost reporting period for which the hospital requests an adjustment. [Emphasis added.]

The preamble to the September 1, 1995 final regulation confirmed that CMS has always interpreted its policy to be that an adjustment request must be received by the intermediary by the end of the 180-day period:

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[5] See §1886(a)(4) of the Act, 42 USC 1395ww(a)(4).
[6] 60 Fed. Reg. 45777 (Sep. 1, 1995).

> We have consistently interpreted the word "made" to mean "received by the fiscal intermediary" since the original regulation was promulgated (47 Fed. Reg. 43282, September 30, 1982).[7]

In this case, the Provider's TEFRA cost year at issue was FYE 12/31/94. The NPR for that fiscal year was dated June 24, 1997. The TEFRA adjustment request was mailed to the Intermediary on December 22, 1997. The Intermediary received the TEFRA adjustment request on December 24, 1997, 183 days after the date of the NPR.[8]

Applying the above law to the facts of this case, the Administrator disagrees with the Board's finding, and the Provider's contention, that the meaning of the governing regulation in this case changed between the cost years at issue, i.e., FYE 12/31/94 and the year in which the request was made, i.e., 1997. Rather, CMS clarified in the above preamble language that its regulation had consistently been interpreted to mean that "made" equaled "received by the intermediary" within 180 days of the NPR date. Thus, the Administrator finds that there is no demarcation in the timeline of the facts of this case which is determinative. Rather, as the agency stated, it changed the language of the regulation to more clearly reflect its longstanding interpretation. The U.S. Supreme Court has held that an agency's interpretation must be given controlling weight unless it is plainly erroneous or inconsistent with the regulation.[9] In that regard, the Administrator finds that the agency's interpretation of the 180-day period for requesting a TEFRA adjustment is not plainly erroneous or inconsistent with the language of the governing regulation.

Thus, the Administrator finds that the Board incorrectly reversed the Intermediary's determination that the Provider's TEFRA adjustment request was untimely. It is undisputed that the Intermediary did not receive the Provider's request for an exception within the 180-day period provided in the regulations governing TEFRA adjustment requests. In this case, the TEFRA adjustment request was required to have been received by the Intermediary by December 22, 1997.[10] However, the Intermediary did not receive the request until December 24, 1997. Based on these facts, therefore, the Provider did not comply with the procedures set forth in the regulations at §413.40(e)(1) for requesting a TEFRA exception. Moreover, the Provider's reliance on §3004.2 of the PRM is unwarranted, as, in contrast to the regulations, that section does not define "submitted."

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[7] 60 Fed. Reg. at 45840.
[8] See Provider's Position Paper at 13.
[9] Thomas Jefferson University v. Shalala, 114 S. Ct. 2381, 2386 (1994).
[10] The 180th day fell on a Sunday; therefore, the due date advanced to the next business day, i.e., Monday, December 22, 1997.

Accordingly, for the reasons set forth above, the Board incorrectly held that the Provider complied with the 180-day requirement for requesting a TEFRA adjustment by mailing its TEFRA adjustment request within the 180-day period.

DECISION

The Administrator reverses the decision of the Provider Reimbursement Review Board.

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

Date: 1/3/06

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services