PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2023-D28

PROVIDER –
Bergen Regional Medical Center

RECORD HEARING HELD –
September 14, 2022

PROVIDER NO. –
31-0058

FISCAL YEAR END– 12/31/2014

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

CASE NO. – 19-0405

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly excluded a lump sum payment of $4,991,315 from the interim payments included on the Provider's notice of program reimbursement ("NPR") for fiscal year ("FY") 2014 and, if so, whether the Provider is entitled to have that lump sum payment returned?[1]

DECISION

The Board finds that the Medicare Contractor improperly excluded a tentative lump sum payment of $4,991,315 from the payments included on the FY 2014 NPR for Bergen Regional Medical Center ("BRMC" or "Provider") and that BRMC is entitled to recoup the payment. Accordingly, the Board remands this case to the Medicare Contractor and directs it to modify BRMC's NPR for FY 2014 to reflect $4,991,315 as a tentative payment so that it may be returned to BRMC.

INTRODUCTION

BRMC is an acute care hospital located in Paramus, New Jersey.[2] The Medicare contractor[3] assigned to BRMC for this appeal is Novitas Solutions, Inc. ("Medicare Contractor").[4]

For the cost reporting period at issue, *i.e.*, January 1, 2014 to December 31, 2014, BRMC was eligible for a disproportionate share hospital ("DSH") payment.[5] This cost reporting period straddles 2 federal fiscal years ("FFY"), namely FFYs 2014 and 2015.[6] The DSH payments to a hospital for a particular FFY are based, in part, on a "Factor 3" calculation, namely the amount of uncompensated care ("UCC") provided by the hospital relative to the aggregate amount of UCC provided by all hospitals receiving DSH payments.[7] The Centers for Medicare and Medicaid Services ("CMS") published the Factor 3 ratios for hospitals for FFYs 2014 and 2015 on August 19, 2013[8] and August 22, 2014,[9] respectively, as Medicare DSH Supplemental Data Files associated with the Final Rules, published concurrently on CMS' website. CMS used FY 2011

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[1] Issue Statement for Issue 1, Provider's Appeal Request (Nov. 7, 2018); Provider's Final Position Paper at 1 (June 21, 2022) (hereinafter "Provider's FPP"). The Medicare Contractor recognizes that the Provider's appeal pertains to lump-sum payments related to Medicare uncompensated care payments made to BRMC for FY 2014 and that the Provider is seeking to have a payment of $4,991,315, that it made in connection with FY 2014, considered as a lump sum payment and returned to it. *See* Medicare Contractor's Final Position Paper at 3, 6 (July 22, 2022). However, as part of the stipulations, it did not agree with the Provider on an issue statement for this appeal.

[2] Stipulations of Undisputed Facts and Principles of Law, ¶ 1 (Sept. 9, 2022) (hereinafter "Stip.").

[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 and relevant.

[4] *See* Stip. at ¶ 7.

[5] *Id.* at ¶ 3.

[6] The federal fiscal year ("FFY") runs from October 1st through September 30th. Thus, FFY 2014 covered the period from October 1, 2013 to September 30, 2014 and FFY 2015 covered the period from October 1, 2014 to September 30, 2015. Therefore, Sunnyside's cost reporting period encompasses 9 months of FFY 2014 and 3 months of FFY 2015.

[7] *See* 42 U.S.C. § 1395ww(r)(2)(C).

[8] 78 Fed. Reg. 50496 (Aug. 19, 2013).

[9] 79 Fed. Reg. 49854 (Aug. 22, 2014).

data as the base year in calculating the Factor 3 for FFY 2014[10] and used FY 2012 data as the base year in calculating the Factor 3 for FFY 2015.[11]

On August 14, 2013, BRMC notified the Medicare Contractor that "BRMC's FY 2011 filed cost report included inpatient psychiatric days in calculating its total patient days on Worksheet S-2, Part I, line 24."[12] The Parties agree that, between the time that BRMC's FY 2014 cost report was filed in 2015 and the date that the Medicare Contractor issued the NPR for FY 2014, BRMC corresponded with the Medicare Contractor regarding certain errors that CMS had not corrected in the Factor 3 ratios used in the interim UCC payments made during BRMC's FY 2014 (as well as for BRMC's FYs 2013, 2015 and 2016).[13]

As a result of this cost reporting error, prior to the issuance of the FY 2014 NPR, BRMC proactively refunded $4,991,315 ("the FY 2014 refunded amount") on November 1, 2016 to address an impending overpayment for FY 2014 DSH UCC, due to a "statistical overstatement"[14] that it was anticipating the Medicare Contractor would assess on the FY 2014 NPR.[15] On September 12, 2017, the Medicare Contractor informed BRMC that CMS instructed it not to recalculate the Factor 3 ratio and that it would have to (*i.e.*, was obligated to) send back the $12 million that was previously sent by BRMC, including $4,991,315 that was attributed to FY 2014.[16] The Medicare Contractor further stated "[p]lease do not submit voluntary refunds due to incorrectly calculated factor 3 amounts previously established by CMS. *These amounts are considered **final***."[17] On April 17, 2018 the Medicare Contractor reaffirmed that CMS would *not* recalculate the Factor 3 ratios to correct the error (by removing the overstated days) and would not be issuing a Notice of Intent to Reopen.[18] However, in an apparent change in position, the Medicare Contractor stated that the FY 2014 refunded amount would *not* be returned.[19] Accordingly, the Medicare Contractor did not return the FY 2014 refunded amount and, in particular, the NPR issued on May 9, 2018 for FY 2014 did *not* return or otherwise incorporate or reference the refunded amount.[20] Nor did it assess any overpayment on BRMC for DSH UCC related to the overstated FY 2011 total days in the determination of Factor 3. BRMC timely appealed the FY 2014 NPR and met all jurisdictional requirements for a hearing before the Board.[21]

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[10] 78 Fed. Reg. at 50641-50642 ("For purposes of this final rule, the most recent SSI fraction is the FY 2011 SSI fraction . . . . For this final rule, we are using the March 2013 update of HCRIS and we are identifying a hospital's Medicaid days based on the Medicaid days reported on the [FY] 2011, or if not available, the [FY] 2010 Medicare Hospital Cost Report.").

[11] 79 Fed. Reg. at 50018 ("We are finalizing our proposal to use the most recently available full year cost report for the Medicaid days...the [FY] 2012 cost report, unless that cost report is unavailable or reflects less than a full 12-month year...In addition, we are using the FY 2012 SSI ratios published on the CMS Web site to calculate Factor 3.").

[12] Stip. at ¶ 7. *See also* Exhibit (hereinafter "Ex.") P-1 (copies of emails between BRMC and the Medicare Contractor).

[13] Stip. at ¶ 8.

[14] Ex. P-2.

[15] Stip. at ¶ 9.

[16] Ex. P-3.

[17] *Id.* (emphasis added).

[18] Stip. at ¶ 12; Ex. P-4.

[19] Ex. P-4.

[20] Stip. at ¶ 14; Ex. P-5.

[21] The Board issued a Jurisdictional Decision on March 17, 2021, finding that it does, in fact, have jurisdiction over the appealed issue in this case ("[T]he Board finds that it has jurisdiction over whether Provider's interim payments [for FY 2014] were properly reported.").

The Board approved a record hearing on September 14, 2022. BRMC was represented Robert Wanerman, Esq. of Epstein Becker & Green, P.C. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most Medicare participating hospitals for the operating costs of inpatient hospital services under the operating Inpatient Prospective Payment System ("IPPS").[22] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[23]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[24] One of the adjustments is the hospital-specific DSH adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.[25]

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[26] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[27] The DPP is defined as the sum of two fractions expressed as percentages.[28] Those two fractions are referred to as the "Medicare/SSI fraction"[29] and the "Medicaid fraction."[30]

Alternatively, providers can qualify for a flat rate DPP that is not affected by their specific Medicare and Medicaid fractions. Using this alternative reimbursement DSH reimbursement calculation is known as the "pickle method" and is available for providers that are located in an

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[22] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[23] *Id.*
[24] *See* 42 U.S.C. § 1395ww(d)(5).
[25] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[26] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[27] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[28] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[29] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment. 42 C.F.R. § 412.106(b)(2)-(3). The Medicare Contractor determines the number of the hospital's patient days of service for which patients were entitled to both Medicare Part A and SSI benefits, and divides that number by the total number of patient days furnished to patients entitled to benefits under Medicare Part A. *Id.*
[30] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. 42 C.F.R. § 412.106(b)(4).

urban area, have 100 or more beds, and can demonstrate that more than 30 percent of their net inpatient care revenues are derived from low income patients.[31]

However, *beginning in 2014*, § 3133 of the Patient Protection and Affordable Care Act[32] (as amended by § 10316 of the Affordable Care Act[33] and § 1104 of the Health Care and Education Reconciliation Act of 2010[34]) changed the methodology for calculating DSH payments by adding 42 U.S.C. § 1395ww(r). Under the new methodology, a hospital's DPP is responsible for the calculation of only an empirically justified amount/portion of its DSH payment(based upon 25 percent of its historical DSH calculation), regardless of which method is used.[35] The remainder of the hospital's "new" DSH payment is known as the Uncompensated Care ("UCC") Payment,[36] and is equal to the product of three factors.[37] At issue in this case is the third factor ("Factor 3"), which "is a hospital-specific value that expresses the proportion of the *estimated* uncompensated care amount for each subsection (d) hospital and subsection (d) Puerto Rico hospital with the potential to receive DSH payments ***relative to*** the *estimated* uncompensated care amount for ***all*** hospitals *estimated* to receive DSH payments in the [federal] fiscal year for which the uncompensated care payment is to be made."[38] Specifically, 42 U.S.C. § 1395ww(r)(2)(C) states:

> (C) **Factor three**
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> A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—
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> (i) the amount of uncompensated care for such hospital *for a period selected by the Secretary* (*as estimated by the Secretary*, based on appropriate data (including, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and
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> (ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).[39]

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[31] 42 U.S.C. § 1395ww(d)(5)(F)(i)(II). *See also* 78 Fed. Reg. at 50614.
[32] Pub. L. 111-148, 124 Stat. 119, 432 (2010).
[33] *Id.* at 947.
[34] Pub. L. 111-152, 124 Stat. 1029, 1047 (2010).
[35] 42 U.S.C. § 1395ww(r)(1).
[36] *See* 78 Fed. Reg. at 50621.
[37] The Uncompensated Care payment is made up of three factors: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percent change in the percent of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the aggregate amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. at 50496, 50627, 50631 and 50634.
[38] 78 Fed. Reg. at 50634 (emphasis added).
[39] (Bold emphasis in original and italics and underline emphasis added.)

In the FFY 2014 IPPS Final Rule, CMS declined to use the Worksheet S-10 data to calculate the Factor 3 ratios and instead exercised its discretion to use "alternative data," namely certain data used in the empirically justified DSH payment calculations. CMS gave the following explanation for using "alternative data" as the basis for the FY 2014 Factor 3 ratios in 78 Fed. Reg. at 50636:

> While the statute instructs the Secretary to estimate the amounts of uncompensated care for a period "based on appropriate data," section 1886(r)(2)(C)(i) of the Act permits the Secretary to use alternative data "in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured" for the numerator of Factor 3. For the denominator of that quotient, section 1886(r)(2)(C)(ii) of the Act requires the Secretary to use "the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (*as so estimated, based on such data*).[*sic* "] (Emphasis added.) The phrase "as so estimated, based on such data" in the latter section can be reasonably interpreted to require the calculation to similarly be based on the same data as is used to estimate the numerator of the quotient in Factor 3, including any alternative data which is determined to be a better proxy for the costs of treating the uninsured.
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> As a result of our concerns regarding variations in the data reported on the Worksheet S–10, we stated in the proposed rule that we believe it is appropriate to consider the use of alternative data, at least in [F]FY 2014, the first year that this provision is effective, and possibly additional years until hospitals have adequate experience reporting all of the data elements on Worksheet S–10. We noted that this is consistent with input we received from some stakeholders in response to the CMS National Provider Call in January 2013, who stated their belief that existing FY 2010 and FY 2011 data from the Worksheet S–10 cannot be used for implementation of section 1886(r) and who requested the opportunity to resubmit the data once more specific instructions were issued by CMS. Accordingly, we examined alternative data sources that could be used to allow time for hospitals to gain experience with and to improve the accuracy of their S–10 reporting.
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> We stated in the [F]FY 2014 IPPS/LTCH PPS proposed rule that we believe that data on utilization for insured low-income patients can be a reasonable proxy for the treatment costs of uninsured patients. Moreover, due to the concerns regarding the accuracy and consistency of the data reported on the Worksheet S–10, we believe that this alternative data, which is currently reported on the

> Medicare cost report, would be a better proxy for the amount of uncompensated care provided by hospitals. Accordingly, in the [F]FY 2014 IPPS/LTCH PPS proposed rule (78 FR 27587 through 27588), we proposed to use the utilization of insured low-income patients defined as inpatient days of Medicaid patients plus inpatient days of Medicare SSI patients as defined in 42 CFR 412.106(b)(4) and 412.106(b)(2)(i), respectively to determine Factor 3. We describe our proposal and rationale, on which we sought public comment, more fully below.

For FFY 2014 (the ***first*** year for UCC payments), CMS published the Factor 3 ratios for hospitals as Medicare DSH Supplemental Data files, which were posted on the CMS website concurrently with the FFY 2014 IPPS Final Rule and selected FY 2011 as the period on which to base the FFY 2014 Factor 3 ratios.[40] Specifically, each hospital's Factor 3 ratio is based on the following FY 2011 data: (1) the Medicaid fraction listed in the March 2013 update of the FY 2011 Provider-Specific File in the Medicare Hospital Cost Report Information System ("HICRIS") database; and (2) the FFY 2011 SSI ratios published on the CMS website in June, 2013.[41] In particular, for FFY 2014 UCC payments, CMS used Medicaid days reported on Worksheet S-2 of the FY 2011 as-filed cost report, which are used in the computation of the Medicaid fraction.[42] While these figures may not represent the "true" patient days of a provider,[43] the Secretary maintains that they are consistent with the statutory directive to the Secretary "to *estimate*" these figures to determine the factors used in calculating UCC payments.[44] By statute and regulation, these ***estimates***, as well as the underlying data and methodologies used to create them, are *not* subject to administrative or judicial review.[45]

CMS noted in the FFY 2014 IPPS Final Rule that, for each upcoming federal fiscal year, CMS "publish[es] a table or tables listing Factor 3 for all hospitals that we estimate would receive empirically justified Medicare payments in a fiscal year (that is, hospitals that would receive interim uncompensated care payments during the fiscal year)."[46] As part of the cost reporting process for the hospital's fiscal year, the Medicare contractor would then complete a "reconciliation of the ***interim*** payments made [to the hospital] during the year to the total [UCC]

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[40] 78 Fed. Reg. at 50641.
[41] *Id*.
[42] *Id.* at 50642.
[43] *See id.* ("Several hospitals submitted public comments regarding the accuracy of the data used in the calculation of the hospital's Factor 3 amount . . . . [and] indicated that their Medicaid days were understated and had not been updated in the . . . database used to calculate the Medicaid days for Factor 3 . . . . Many hospitals submitted supporting documentation of the additional Medicaid days.").
[44] 42 U.S.C. § 1395ww(r)(2)(C) (stating that Factor 3 is based on the amount of uncompensated care a hospital provided for a period "as estimated by the Secretary, based on appropriate data . . . .").
[45] 42 U.S.C. § 1395ww(r)(3); 42 C.F.R. § 412.106(g)(2). *See also Ascension Borgess Hospital v. Becerra*, 61 F. 4th 999 (D.C. Cir. 2023); *Scranton Quincy Hosp. Co. v. Azar,* 514 F. Supp. 249 (D.D.C. 2021); *DCH Regional Med. Ctr. v. Azar*, 925 F.3d 503 (D.C. Cir. 2019); *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*, 830 F.3d 515 (D.C. Cir. 2016).
[46] 78 Fed. Reg. at 50640. *See also id.* at 50642 (stating: "For the final rule, we have published an updated list of the hospitals we have identified to be subsection (d) hospitals and subsection (d) Puerto Rico hospitals eligible to receive empirically justified Medicare DSH payment adjustments and uncompensated care payments for FY 2014.").

payment derived as the product of Factors 1, 2, and 3."[47] As part of the FFY 2014 IPPS Final Rule, CMS recognized that it might publish a revised Factor 3 table for FFY 2014: "If we identify changes to the list of hospitals, we will publish a ***revised*** list of hospitals and updated Factor 3 values on the CMS Medicare DSH Web site after August 31, 2013."[48] Finally, it is possible that the hospital may not ultimately qualify for the payments at the time of cost report settlement and, in that situation, the payments received would be deemed overpayments that would have to be returned to CMS.[49]

For FFY 2015, CMS continued to used "alternative data" in the form of DSH data. However, CMS used FY 2012 hospital cost report data for each hospital unless that cost report was not available:

> *Comment:* **Several commenters questioned the data used to calculate the hospitals' Factor 3**. **Several commenters stated that their Medicaid days were understated**. **Furthermore, commenters stated that they submitted their updated cost report to be included in the March 2014 update of the Medicare cost report data but the contractor had not yet uploaded the information in the HCRIS database. In addition, some commenters indicated that they had updated Medicaid days and had submitted their cost report to their contractors after the March 2014 update of the Medicare hospital cost report data and wanted their updated data included. Some commenters requested use of the June update of cost report data to obtain Medicaid days to calculate Factor 3**. Some commenters sought clarification of why some hospitals have their Medicaid days based on Worksheet S–2 and some hospitals have their Medicaid days based on Worksheet S–3. Some commenters stated that their Medicaid days were based on a 6-month cost report and they should be based on a 12-month cost report either by combining cost reports or annualizing the data. . . . Finally, several commenters requested additional time after the publication of the final rule to review the data used to calculate Factor 3 and submit corrections.
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> *Response:* **We are finalizing our proposal to use the most recently available full year cost report for the Medicaid days (that is, our proposal to use the [FY] 2012 cost report, unless that cost report is unavailable or reflects less than a full 12-month year**; in the event the [FY] 2012 cost report is for less than 12 months, we will use the cost report from [FY] 2012 or [FY] 2011 that is closest to being a full 12-month cost report) and the

[47] *Id.* at 50643 (emphasis added).
[48] *Id.* at 50642.
[49] *Id*. at 50640 (stating: "In the case of hospitals…that received interim empirically justified Medicare DSH payments and uncompensated care payments, but are found to be ineligible for DSH payments at cost report settlement, we would recover the overpayment.")

most recently available SSI ratios. **For this FY 2015 final rule, we are using the March 2014 update of the hospital cost report data in the HCRIS database and cost report data submitted to CMS by IHS hospitals as of March 2014 to obtain the Medicaid days to calculate Factor 3**. In addition, we are using the FY 2012 SSI ratios published on the CMS Web site to calculate Factor 3 (*http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html*).

We note that we are unable to use a later update of the cost report data, like the June update, and still calculate the final Factor 3 in time for publication of the IPPS final rule. Any delay in the publication of the final rule would prevent changes and updates to payments under the IPPS from taking effect on October 1, the first day of the fiscal year. **We are not able to accept supplemental data for hospitals, as we are not able to validate the information included in that supplemental data**. We note that hospitals have ample time after the close of their fiscal year to submit the data that are used in this calculation. Specifically, Chapter I, section 104 of the Provider Reimbursement Manual, Part 2, generally allows a hospital 5 months after the close of its cost reporting period to file its cost report. In addition, CMS allows hospitals to request amendments of their cost report submissions before CMS issues a Notice of Program Reimbursement. **In response to the commenters that indicated they had submitted their updated cost reports, but that the MAC had not yet uploaded the information, we note that MACs follow guidelines to upload revised cost report information. In accordance with Medicare Financial Management Manual, Chapter 8, Section 10.4—Submission of Cost Report Data to CMS, the MACs are required to submit an extract of the following Medicare cost reports to CMS in accordance with the HCRIS specifications within 210 days of the cost reporting period ending date or 60 days after receipt of the cost report, whichever is later**.

With respect to the comments requesting clarification on whether Worksheet S–2 or Worksheet S–3 is used to obtain Medicaid days, we addressed this concern in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50642) and reiterate that we use the Medicaid days reported on Worksheet S–2 of the Medicare Hospital Cost Report version 2552–10 for hospitals projected to receive Medicare DSH because the Medicaid days reported on Worksheet S–2 are used in the computation of the Medicaid fraction for Medicare DSH payments. Therefore, because they are used for payment of Medicare DSH, we believe that these data are more reliable than data not used for payment purposes. Hospitals that were not eligible

> to receive Medicare DSH payments on that cost report were unable to report Medicaid days on Worksheet S–2, but could report their Medicaid days on Worksheet S–3. Therefore, for hospitals that we project to not be eligible for Medicare DSH payments, we are using the Medicaid days reported on Worksheet S–3 to calculate their Factor 3. A transmittal has been issued to allow for hospitals that are not receiving DSH to report their Medicaid days on Worksheet S–2, and we hope to rely only on the data reported on that Worksheet S–2 in the future, if we continue to use this data on low-income insured days in the future.
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> With regard to the comments from hospitals that found that their Factor 3 was calculated using a cost report that was less than 12 months, we are finalizing our proposal to use the [FY] 2012 cost report, unless that cost report is unavailable or reflects less than a full 12-month year. In the event the [FY] 2012 cost report is for less than 12 months, we would use the cost report from [FY] 2012 or [FY] 2011 that is closest to being a full 12-month cost report. In the case where a less than 12-month cost report was used to calculate a hospital's Factor 3, this would indicate that both the [FY] 2012 and [FY] 2011 cost reports were less than 12 months. In such a case, we would use the longer of the two cost reports to calculate a hospital's Factor 3. We did not make a proposal to annualize or combine cost reports to calculate Factor 3. We note that section 1886(r)(2)(c) of the Act specifies that Factor 3 is equal to the percent that represents ''the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on appropriate data . . .'' divided by ''the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated . . .'' In implementing this provision, as we did through rulemaking in FY 2014, we believe it is appropriate to first select the period—in this case, the period for which we have the most recently available data—and then to select the data from a cost report that aligns best with that period. However, we acknowledge that the situations presented by commenters, where a hospital remains in operation in both Federal fiscal years for which we analyze cost report data but submits cost reports for both Federal fiscal years that reflect substantially less than a full year of data, pose unique challenges in the context of estimating Factor 3. As a result, this is an issue that we intend to consider further and may address in future rulemaking.[50]

In summary, in determining the interim UCC payment for FFYs 2014 and 2015, CMS used "alternative data" as its proxy for the Factor 3 "insured low-income patients." The "alternative data" for Factor 3 was inpatient days of Medicaid patients plus inpatient days of Medicare SSI

[50] 79 Fed. Reg. at 50018-19 (emphasis added).

patients as defined in 42 C.F.R. §§ 412.106(b)(4) and 412.106(b)(2)(i). For FFY 2014, the "alternative data" was based on FY 2011 hospital DSH data and, for FFY 2015, the "alternative data" was based on FY 2012 hospital DSH data (unless FY 2012 data was not available for a hospital in which case that hospital's FY 2011 data was used).

B. Requirement to Refund Overpayments

As previously noted, a hospital that received *interim* UCC payments, but was found ineligible for DSH payments at the time of the cost report, would need to repay those *interim* UCC payments.[51] Similarly, reconciliation of the *interim* UCC payments to the final total UCC payment derived from the product of Factors 1, 2, and 3 may result in an overpayment assessment if the net *interim* UCC payments are more than the Factor-1-2-3 product. Regardless of the reason for receiving an overpayment, providers are required to return any self-identified overpayments from the Medicare program at the time the applicable cost report is due, or within sixty (60) days of discovering the overpayment.[52]

Here, CMS' adoption of the "alternative data" for FFYs 2014 and 2015 impacted BRMC's UCC payment for FY 2014 as follows:

1. As the first 3 quarters of Bergen's FY 2014 (*i.e.*, January through September 2014) fell within FFY 2014, Bergen's interim UCC payments during this period were based on flawed FY 2011 "alternative data."

2. As the last quarter of Bergen's FY 2014 (*i.e.*, October through December 2014) fell within FFY 2014, Bergen's UCC interim payments during this period were based on flawed FY 2012 "alternative data."

Thus, relevant to this case is the fact that "total patient days" and/or "total Medicaid days" in the DSH Medicare and Medicaid fractions from the FY 2011 and FY 2012 as-filed cost reports as used in Bergen's Factor 3 ratios for FFY 2014 and FFY 2015 respectively should *not* include patient days related to furnishing inpatient psychiatric care in an excluded unit. Neither party disputes this point.[53] Indeed, DSH payments are provided for "subsection (d)" hospitals.[54] Stand-alone inpatient psychiatric facilities, as well as excluded inpatient psychiatric units within a subsection (d) hospital, are paid under a separate PPS that is distinct from the IPPS, which is referred to as the inpatient psychiatric facility PPS ("IPF PPS").[55]

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[51] *Id.* at 50640.
[52] 42 U.S.C. § 1320a-7k(d); 42 C.F.R. § 401.305(b)(1). *See also* 81 Fed. Reg. 7654, 7683-84 (Feb. 12, 2016).
[53] Provider's FPP at 3; Medicare Contractor's Final Position Paper at 5 (July 22, 2022) ("Medicare Contractor's FPP").
[54] 42 U.S.C. § 1395ww(d)(5)(F).
[55] *See* 42 U.S.C. § 1395ww(d)(1)(B)(i). *See also* 42 U.S.C. § 1395ww(s); 42 C.F.R. Part 412, Subpart N. Congress mandated the creation of a separate Inpatient Psychiatric Facility PPS via § 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999. Pub. L. 106-113, 113 Stat. 1501A-322, 332 (1999).

C. Medicare Contractor Policies on Overpayments, etc.

The Medicare Program Integrity Manual specifically prohibits Medicare contractors from immediately returning voluntary refund checks and directs them to "refer to the Financial Management Manual for instructions on processing and reporting unsolicited/voluntary refunds received from providers/physicians/suppliers."[56] Chapter 5, § 410 of the Medicare Financial Management Manual, CMS Pub. 100-06 ("MFMM"), governs unsolicited voluntary refunds received by a Medicare Contractor. In particular, § 410.4 establishes the procedures to be followed when an unsolicited voluntary refund is received:

> The following instructions shall not supersede the present Program Integrity Manual (PIM) that references procedures for handling unsolicited refunds where there is a voluntary repayment and referral to law enforcement. The following procedures shall be followed when unsolicited/voluntary refund checks are received:
>
> 1) Do not return any check submitted by a provider/physician/ supplier and other entities that is made payable to the Medicare program.
>
> 2) **To ensure that repayment of Medicare funds is handled <u>properly</u>**, Medicare contractors shall deposit such a check within 24 hours of receipt in accordance with Chapter 5, Financial Reporting Manual, section 100.3 and record the check in the account entitled "Other Liabilities – Unapplied Receipts" per Form CMS-750 instructions *found in Chapter 5, Financial Reporting, Section 210*.
>
> ****
>
> 5) If the provider/physician/supplier, or other entity is not participating in the Self-Disclosure Protocol, contractors shall ensure that any MSN, or Remittance Advice, generated as the result of the claims adjustment contains appeals language, where appropriate. *If necessary,* ***contractors should determine the proper handling of unsolicited/voluntary refunds <u>on any open</u>*** *or re-openable* ***<u>cost report</u>***.
>
> 6) No appeal rights shall be afforded, as stated in Exhibit 1, if the provider/physician/supplier, or other entity 1) does not submit the specific Patient/HIC/Claim Number information, or 2) is participating in a Self-Disclosure Protocol agreement.

[56] CMS Pub. 100-08, Ch. 4, § 4.16 (Rev. 259, Issued: 06-13-08, Effective: 07-01-08) (stating "Voluntary refund checks payable to the Medicare program shall not be returned, regardless of the amount of the refund. . . . The ACs and MACs shall refer to the Financial Management Manual for instructions on processing and reporting unsolicited/voluntary refunds received from providers/physicians/suppliers."). *See also* 81 Fed. Reg. at 7675.

> 7) The Medicare contractor shall establish an accounts receivable in the Medicare system that shall be recognized on line 2a, New Accounts Receivable on Form CMS-751 report within 60 days after the deposit of the voluntary refund *for Non-MSP, or 100 days from initial ECRS inquiry for MSP*. In addition, the Medicare contractor shall reduce the "Other Liabilities" account for the same amount, and shall apply the refund to the established accounts receivable and recognize the collection on line 4a, Cash/Check Collections on Form CMS-751 report.
>
> 8) The accounts receivable shall be established using the last name of the debtor that issued the check or on whose behalf the check was issued, as well as the debtor's employer/tax identification number and/or provider or beneficiary number. If the debtor's employer/tax identification number or provider or beneficiary number is unavailable, then the first four letters of the debtor's name and last four digits of the bank account number on the check shall be used as identifying information for setting up the accounts receivable. All Medicare systems shall have the ability to manually complete this procedure.
>
> 9) **If the amount of the unsolicited/voluntary refund check exceeds the amount of the original claim**, Medicare contractors shall check all categories of open account(s) receivable for that provider/physician/supplier or other entity including those established as a result of medical review, benefit integrity (BI) review, cost reports, other overpayment demands, and MSP demands. **If an outstanding receivable is identified**, the contractor shall apply the *remaining* amount of the unsolicited/voluntary refund to the outstanding receivable balance. **If there are multiple outstanding accounts receivables**, then the excess funds should be applied to the oldest accounts receivable first – interest then principal.
>
> 10) Medicare contractors shall not **automatically** refund excess recoupments to the provider/physician/supplier, or other entity. **Contractors shall** only **refund excess recoupments when no other outstanding accounts receivable exists, or written documentation/evidence clearly supports that Medicare is not entitled to the money** or was not the intended recipient of the refund check. . . .[57]

The Medicare Contractor also concedes that, *when a refund/payment is received from a provider after a cost report is filed* and is "properly recorded in the [Medicare Contractor's] accounting

[57] MFMM, Ch. 5, § 410.4 (as modified by Rev. 50 (July 30, 2004)) (bold and underline emphasis added).

system," then "[a]s a matter of practice during the audit, ***all*** lump sums are reconciled to the cost report, and adjustments [*sic* are] made as appropriate."[58]

Significantly, after BRMC filed its FY 2014 cost report (presumably on or about the May 31, 2015 filing deadline) but prior to the NPR being issued on May 9, 2018, CMS published the final rule addressing the reporting and returning of overpayments. Specifically, on February 12, 2016, CMS issued regulations at 42 C.F.R. § 401.305 specifying that a provider that has received an overpayment must report and return the overpayment within the later of: (a) 60 days of identifying the overpayment; or (b) the date any corresponding cost report is due.[59] Further, if a provider identifies an overpayment after a cost report has been filed, CMS explained that the provider must return the overpayment within 60 days of identifying it:

> *Comment*: Given that cost reports can remain under audit review for 3 to 4 years and are not finalized until the Notice of Program Reimbursement ("NPR") date, commenters requested that CMS provide guidance on providers' responsibilities when an overpayment is discovered by the provider or the MAC auditor **after the cost report is due/filed but prior to the NPR date**. Commenters questioned whether the provider would be required to report and repay the overpayment within 60 days of identification rather than allowing for completion of the audit process, which includes netting out of underpayments and overpayments, while the cost report is still open. Commenters stated that requiring reporting and returning within 60 days of identification, as opposed to allowing completion of the audit process, would force providers to send in numerous overpayments for minor errors while the cost report is open and disrupt the normal MAC audit process.
>
> Commenters also questioned a number of other cost report issues that they believed to be not entirely known to the provider at the time of initially filing the as-filed cost report, but which are reconciled through the audit process, and finalized with the issuance of the NPR, including–
>
> • Home office cost statements (HOCS), providers usually file an estimate of home office costs on the hospital cost report, which is subsequently reconciled to the HOCS when the MAC audits the HOCS;
>
> • Any interim payments such as Medicare bad debt or graduate medical education (GME), including resident "overlap" reports from the MAC; . . .
>
> • Tentative settlement payments;

[58] Medicare Contractor's Jurisdictional Challenge at 2 (Feb. 26, 2019) (emphasis added).
[59] 81 Fed. Reg. at 7683.

> • Updated Provider Statistical & Reimbursement Report (PS&R) for claims processed after cost report submission;
>
> • Prior-year audit adjustments, CMS rulings, and PRRB appeals; . . . .
>
> *Response*: If the provider self-identifies an overpayment after the submission and applicable reconciliation of the Medicare cost report, it is their responsibility to follow the procedures in this rule, and report and return the overpayment within 60 days of identification. The provider must use the applicable reporting process for cost report overpayments (submit an amended cost report) along with the overpayment refund. The amended cost report must include sufficient documentation and data to identify the issue in order for the MAC to adjust the cost report.[60]

CMS confirmed that Medicare contractors must follow the Medicare Program Integrity Manual, CMS Pub. 100-08 ("MPIM"), Ch. 4, § 4.16 in processing refunds received:

> *Comment*: **Several commenters questioned how providers and suppliers should handle delays by the Medicare contractor in <u>processing the refund</u>**, whether submitted through the electronic claims adjustment system, filing of the CMS-838, or by submitting a check or requesting an offset through the self-reported refund process. Commenters reported that there is great variability in how the contractors handle voluntary refunds. . . . Commenters requested that the rule should be modified to expressly state that a provider or supplier satisfies its repayment obligation under the statute and the rule by making good faith efforts to submit a valid form of payment to the contractor or government entity that the provider or supplier reasonably believes to be the appropriate recipient of a particular repayment. Other commenters suggested that the contractor inform the provider or supplier when it has preliminarily determined that the overpayment report complied with the rule. **Commenters also suggested a processing deadline for the contractors**.
>
> *Response*: We agree with commenters that the obligations of this final rule are satisfied when the provider or supplier follows the appropriate process for the overpayment issue in good faith to report and return the overpayment, including calculating the amount of the overpayment. Publication 100-08, Chapter 4, Section 4.16 of the Medicare Program Integrity Manual requires contractors to process all voluntary refunds. The Program Integrity Manual specifically prohibits contractors from returning voluntary refund checks. We see no basis for a contractor to refuse a

[60] *Id.* at 7670 (bold and underline emphasis added).

> refund because a different company was the contractor during the period covered by the refund. **Finally, we may consider a processing deadline for contractors in the future**.
>
> **Regarding obtaining a preliminary determination**, we believe contractors may not be able to conclude whether the overpayment refund complied with this rule on the face of the report. The provider or supplier is ultimately responsible for complying with this rule. Contractors are instructed to refer suspected fraud to law enforcement. Any overpayment refund does not negate any potential liability the provider or supplier may have for the overpayment issue.[61]

The Board notes that MPIM, Ch. 4, § 4.16 directs Medicare Contractors to follow the MFMM process cited above:

> Voluntary refund checks payable to the Medicare program shall not be returned *to the provider/supplier*, regardless of the amount of the refund. . . . *The MAC shall refer to Pub. 100-06, Financial Management Manual, for instructions* ***on processing and reporting unsolicited/voluntary refunds*** *received from providers/physicians/suppliers*.
>
> . . . . *The* ZPIC or MAC shall send one letter annually (calendar year) to any provider/*supplier* that submits a voluntary refund during that calendar year, advising the provider/*supplier* of the following:
>
> > "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating these or any other claims."
>
> . . . . The MACs may send the language above on a voluntary refund acknowledgement letter or on a Remittance Advice, if this capability exists.

Finally, CMS confirmed that providers would be afforded appeal rights relative to voluntary refunds *with respect to specific claims*:

> *Comment*: A number of commenters questioned whether providers and suppliers have appeal rights to self-identified overpayments. Commenters stated that the potential penalties for not reporting

[61] *Id.* at 7675 (bold and underline emphasis added and italics in original).

> and returning an overpayment, coupled with the short 60-day time period for doing so, **likely will result in providers and suppliers erring on the side of caution and returning an overpayment prematurely**. Commenters suggested expanding the list of actions in 42 CFR 405.924 that constitute an initial determination to provide for an appeal right related to a "contractor's acceptance of a refund of an overpayment made in accordance with§ 401.305." Other commenters stated that the acceptance of the overpayment and the related adjustment should be considered a reopening and revised determination of the initial determination of payment under the current regulations and CMS manual instructions. **Other commenters stated that the concept of reconciliation should incorporate the existing appeals process**.
>
> *Response*: Section 1128J(d) of the Act clearly requires providers and suppliers to report and return identified overpayments they have received. **To the extent that the return of any self-identified overpayment results in a revised initial determination of <u>any specific claim or claims</u>, a person would be <u>afforded any appeal rights that currently exist</u>, as some commenters stated**. Revised initial determinations, which trigger appeal rights under the existing rules, are issued when specific claims are adjusted. . . . As such, we decline the commenters' suggestion to create an explicit appeal right by classifying "contractor's acceptance of a refund of an overpayment made in accordance with§ 401.305" as an initial determination in§ 405.924.[62]

The discussion of appeal rights is relevant since the FY 2014 refund at issue *relates to **specific claims***. Here, the "specific claims" at issue are the interim FY 2014 UCC payments made to BRMC which are adjustments (add-on payments) to the DRG payments made to BRMC for discharges occurring during FY 2014. These payments are made on a per-claim basis at the time of claim payment and then adjusted, in total, to the final UCC total payment amount as a part of the cost report calculations on Worksheet E Part A of the cost report.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

The material facts in this case are not in dispute. On or about May 31, 2015, BRMC filed its cost report for FY 2014.[63] On November 4, 2016 (after filing its cost report, but prior to the issuance of the FY 2014 NPR), BRMC made an additional lump-sum payment to the Medicare program, and identified that payment as a voluntary or self-identified refund of a "perceived," "estimated" overpayment in the amount of $12,125,098.77 covering FYs 2013 through 2016.[64] As further explained below, BRMC made this refund "to address a statistical overstatement that resulted in

[62] *Id.* at 7667-68 (bold and underline emphasis added and italics emphasis in original).
[63] BRMC's Response to Novitas Solutions' Jurisdictional Challenge at 3 (Mar. 27, 2019).
[64] Initial Appeal Request, Tab 4.

Medicare [DSH] reimbursement that has been paid to [BRMC]" for FYs 2013 – 2016.[65] BRMC further explained that the portion of the perceived/estimated overpayment refund applicable to FY 2014 (the year under appeal) is $4,991,315.[66]

BRMC made the lump sum payment because, in August 2013, it discovered that patient days attributable to its inpatient psychiatric admissions ("inpatient psychiatric days") in its excluded Psych unit (Sub-Provider Number 35-S058) were factored into the statutory formula[67] for its DSH payments. This caused the total inpatient days to be overstated, which, in turn, affected the Factor 3 ratios published by CMS for BRMC's FFY 2014 and FFY 2015 UCC pool DSH reimbursement (causing it to increase).[68] Initially, BRMC informed the Medicare Contractor that the inpatient psychiatric days were incorrectly included on the cost report it had already filed for FY 2011. The Medicare Contractor removed the days from the FY 2011 cost report before the FY 2011 NPR was issued.[69] However, this removal occurred ***after*** CMS had already used the FY 2011 data to calculate BRMC's Factor 3 for FY 2014.[70] In fact, in their email informing the Medicare Contractor of the error, BRMC asked if "[t]o correct this and prevent being overpaid, should we resubmit the [FY] 2011 Medicare cost report with only the IPPS Medicaid days on line 24?"[71] However, the Medicare Contractor responded by asking BRMC to provide a list of the days to be removed, and stated "If you can[,] we can make an adjustment to remove the IPF days."[72] While the Medicare Contractor did, eventually, remove the erroneous IPF days from the FY 2011 cost report, the adjustment was not finalized until the cost report was settled. At that time, CMS had already used the as filed (not settled) BRMC FY 2011 cost report to calculate the FFY 2014 Factor 3 used in the calculation of the uncompensated care payment. The Board notes that, had the Medicare Contractor directed BRMC to amend its cost report for FY 2011 (as BRMC had asked[73]), then the DSH data used by CMS would have been correct. Thus, *as a direct result of the Medicare contractor's instructions to provide a listing so that the correction could be made as a cost report adjustment*, the correction was not made until ***after*** CMS had made the Factor 3 calculations for FFY 2014.

Finally, BRMC indicates that it "appropriately informed [the Medicare Contractor] of a similar issue for the [FY] 2012 cost reporting year."[74] However, again, CMS used the as-filed (not settled) BRMC FY 2012 cost report to calculate the FFY 2015 Factor 3 used in the calculation of the uncompensated care payment.

Even though the Medicare Contractor revised BRMC's FY 2011 IPPS Medicaid days, CMS did not use that new data when calculating subsequent Factor 3 ratios for FFY 2014 which used FY

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[65] Ex. P-2 at 1.
[66] Provider's FPP at 4; Stip. at ¶¶ 8-10.
[67] *See supra* notes 25-28 and accompanying text.
[68] Provider's FPP at 3.
[69] *Id.*
[70] *See* Medicare Contractor's FPP at 5. The data was finalized for purposes of calculating FY 2014 Factor 3 values in 2013. *See supra* n. 30 and accompanying text.
[71] Ex. P-1 at 4 (email dated 8/14/2013).
[72] *Id.*
[73] The Board further notes that a Medicare contractor has discretion whether to accept an amended cost report. As a result, the Medicare Contractor's response to Bergen suggests that it would not have accepted an amended cost report because it preferred to make the correction through the cost report audit process. *See* PRM 15-1 § 2931.
[74] Provider's FPP at 3; Ex. P-1 at 1 (email dated 8/20/2014).

2011 data as the base year and impacted the interim payments that BRMC received during the first 3 quarters of its FY 2014.[75] Similarly, BRMC knew a similar error existed in its FY 2012 data used for the Factor 3 ratios published for FFY 2015 which impacted the interim payments that BRMC received during the last quarter of its FY 2014. As such, BRMC believed it was "statistically" overpaid in its FY 2014 interim UCC payments (which are specific identifiable claims). On November 1, 2016, prior to the issuance of its FY 2014 NPR, BRMC sent the Medicare Contractor a $12,125,098.77 voluntary refund to the Medicare program, paid via four (4) checks, one for each fiscal year from FY 2013 to FY 2016 for "perceived," "estimated" "statistical overpayments."[76] The cover letter enclosed with the checks explained the basis for the perceived/estimated "statistical overpayments" and the extent that it impacted each of the four different fiscal years. The amount of the refund attributable to FY 2014 was $4,991,315 under check number 159531[77] and the Medicare Contractor has confirmed that it "accepted the hospital's check number 159531, which was negotiated and cleared on November 4, 2016."[78]

On September 12, 2017, the Medicare Contractor informed BRMC that, based on instructions from CMS, its Factor 3 calculations for FY 2014 (which affect BRMC's FY 2014 cost report and the cost reports for the three other years not at issue here, FYs 2013, 2015, and 2016) would *not* be adjusted to reflect BRMC's adjusted FY 2011 data, nor would corrections be made to any of CMS' "previously established" Factor 3 amounts, which included those using BRMC's incorrect FY 2012 data.[79] The Medicare Contractor further stated that "[w]e will have to send back to you the 12 million you've previously sent" for FYs 2013 to 2016 and then instructed BRMC to "not submit voluntary refunds due to incorrectly calculated factor 3 amounts previously established by CMS" because "[t]hese amounts are considered ***final***."[80] Seven months later, on April 17, 2018, the Medicare Contractor reaffirmed that "the factor 3 ratios as calculated are final and will not be recalculated based on the updated data decrease in Medicaid days submitted by the provider."[81] However, the Medicare Contractor appeared to retract its earlier statement that it would return the $12 million refund by stating that "we have been notified by CMS that per the Overpayment regulation Pub 100,06, Chapter 5, Section 110 and Chapter 4, Section 110.14, the MAC does not return the money and it is applied as a self-identified refund."[82]

Accordingly, on May 9, 2018, the Medicare Contractor issued the NPR for FY 2014 and the original UCC payments remained "final." Since the Medicare Contractor did not update BRMC's FFY 2014 and 2015 Factor 3 ratios, the interim UCC payments included in the NPR, and finalized therein, for FY 2014 were based on the original Factor 3 ratios published in the FFY 2014 and 2015 IPPS Final Rules which, in turn, included BRMC's FY 2011 and FY 2012 data, respectively, and that data improperly included inpatient psychiatric days. However, the

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[75] *See* Provider's FPP at 3*,* Ex. P-2 at 2.
[76] *See* Initial Appeal Request. *See also* Ex. P-2.
[77] Provider's FPP at 4. *See also* Ex. P-2 (November 1, 2016 cover letter for refund attributing Check No. 159531 to FY 2014); Provider's Calculation Support for the Amount in Controversy (stating that "[t]he Medicare Contractor accepted the hospital's check number 159531, which was negotiated and cleared on November 4, 2016" for FY 2014 in the amount of $4,991,315).
[78] Stip. at ¶ 10.
[79] Ex. P-3.
[80] *Id.* (emphasis added).
[81] Ex. P-4.
[82] *Id.*

NPR did not reflect any portion of the voluntary refund that was submitted by BRMC in anticipation of the removal of the inpatient psych days from the ratio. Nor did the Medicare Contractor return the voluntary refund independently of the NPR.[83]

On November 7, 2018, BRMC filed an Individual Appeal Request from this NPR, arguing that the Medicare Contractor failed to take into consideration the voluntary refund of the perceived/estimated overpayment when issuing the NPR.

The Board notes that the payment returned by BRMC was based on an "*estimate*[]"[84] of "perceived"[85] "statistical overpayments" (*i.e.*, the BRMC data that CMS plugged into the larger Factor 3 calculation used to split a UCC national "pie" as discussed *infra*). BRMC alerted the Medicare Contractor that its FY 2011 days were overstated, and the Medicare Contractor removed those IPF days from the FY 2011 cost report.[86] Based on this, even though the incorrect FY 2011 and FY 2012 IPPS days had already been used as part of CMS' calculation of the Factor 3 ratios used for FFY 2014 and FFY 2015 UCC payments respectively, BRMC believed that the Factor 3 ratios could and would be updated with the corrected days, resulting in a reduction to BRMC's calculated UCC payments, and payable when the cost reports were finalized. BRMC, therefore, ***estimated*** the ultimate net impact of its overstated days but, as discussed above, the DSH formula is dependent on the aggregate number of days for *all* DSH hospitals in a fiscal year.[87] Each UCC-eligible hospital is entitled to a percentage of the whole UCC payment pool.[88] If the pool, or even one hospital's UCC payment, is made larger or smaller, ***every*** Factor 3 percentage and payment would be affected since they are all calculated as a relative portion of the whole. The *interrelatedness* of every hospital's UCC payments would presumably be one of the reasons administrative and judicial review of the underlying data (*i.e.*, the number of "days") is strictly prohibited.[89]

Here, BRMC's final determination does not indicate that there was any *actual* overpayment assessed for its FY 2014 DSH or uncompensated care payments. In particular, CMS did not otherwise revise BRMC's Factor 3 "estimates" that were used to calculate the DSH payment reflected in the NPR[90] (again, presumably because any revisions to BRMC's Factor 3 ratio would require revisions to all other hospitals' Factor 3 ratios[91]). Indeed, the following email sent on

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[83] Provider's FPP at 3-4.

[84] Ex. P-2 at 1 (stating "[a]s we are already in the midst of Cost Report Settlements for the affected years, and there has been no proffered resolution to date, attached to this letter are four checks representing the respective *estimated* overpayments pertinent to each of the Cost Reporting periods along with a spreadsheet explaining the accounting for the enclosed checks for the Calendar Years affected by years 2013-2016" (emphasis added).)

[85] *Id.* at 2 (stating "[t]his overstatement, effecting [*sic* affecting] discharges occurring within CY 2014 resulted in the *perceived* overpayment addressed in CHECK# 15931" (emphasis added).

[86] Provider's FPP at 3.

[87] 42 U.S.C. § 1395ww(r)(2)(C).

[88] *Id.*

[89] *See supra* n.33 and accompanying text.

[90] Provider's FPP at 4; Ex. P-3 & P-4.

[91] In this regard, the Board notes that the Factor 3 ratios are based on data available in HCRIS as a particular point in time (*e.g.*, FFY 2014 was based on the March 2013 HCRIS file). If updated data is used for one hospital, then presumably CMS would need to use updated data from all hospitals in order to comply with the best data available obligations. NOTE—in making this observation, the Board is making no rulings regarding UCC payments but merely explaining why it would make sense for CMS ***not*** to revise BRMC's published Factor 3 ratios for FFYs 2014 and 2015.

September 12, 2017 from the Medicare Contractor to BRMC after it had made the voluntary refund confirms that the original published Factor 3 amounts (that resulted in perceived/estimated overpayments) were final and would ***not*** be revised:

> We finally received a response from CMS. *We are **not** to recalculate the uncompensated care factor 3 ratio.* ***We will have to send back to you the 12 million you've previously sent***. You can reopen cost reports to properly state MA days. Please do not submit voluntary refunds due to incorrectly calculated factor 3 amounts previously established by CMS. ***These amounts are considered final***. If you have revisions to the MA days for each fiscal year, please submit reopening requests or submit revised listings for any cost reports not already NPR'd.[92]

Significantly, the email suggests CMS directed the Medicare Contractor to return the 12 million which BRMC had voluntarily submitted as a perceived/estimated overpayment. However, seven months later, on April 17, 2018, the Medicare Contractor and CMS retracted this promise to return the 12 million, while again confirming that the original Factor 3 ratios for FFY 2014 and FFY 2015 were final and would ***not*** be revised:

> We have gotten resolution to the recalculation of the Factor 3 ratio and the subsequent self-identified refunds submitted by [BRMC].
>
> ln discussion with CMS, *the factor 3 ratios as calculated are **final** and will **not** be recalculated* based upon the updated data decrease in Medicaid days submitted by the provider. We will *not* be issuing a Notice of Intent to Reopen.
>
> In regards to the self-identified payments submitted by [BRMC] based upon the potential revision of the Factor 3 ratios, *we have been notified by CMS* that per the Overpayment regulation Pub 100,06, Chapter 5, Section 110 and Chapter 4, Section 110.14, the MAC does not return the money and it is applied as a self-identified refund.[93]

Further, since the underlying data is shielded from administrative review,[94] the Board is prohibited from attempting to estimate what changes might occur if the data used in BRMC's Factor 3 ratios (both the numerator ***and*** denominator) for FFYs 2014 and 2015 were corrected. Thus, the Board must accept the DSH and UCC payments determined by CMS and the Medicare Contractor, even if potentially flawed data was used. Indeed, as discussed above, the accuracy of the data used for BRMC's published Factor 3 ratios is relative to the accuracy of the whole dataset used for the Factor 3 ratios applicable to all eligible hospitals and, accordingly, CMS

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[92] Ex. P-3 (emphasis added).
[93] Ex. P-4 (emphasis added).
[94] *See supra* n.33 and accompanying text.

presumably made the determination not to revisit or revise the datasets used for the FFY 2014 and FFY 2015 Factor 3 ratios.

As a result, the Board finds that BRMC submitted an ***estimated*** overpayment, *i.e.*, returned a portion of its interim payments already received, in anticipation of an overpayment being assessed by the Medicare Contractor as part of the then-ongoing FY 2014 cost report audit. The Medicare Contractor, however, never assessed any overpayment. Even though the Medicare Contractor concedes that, *when a refund/payment is received from a provider after a cost report is filed*, it is "properly recorded in the [Medicare Contractor's] accounting system" and that "[a]s a matter of practice during audit, ***all*** lump sums are reconciled to the cost report, and adjustments [*sic* are] made as appropriate,"[95] the perceived/estimated overpayment was not reflected on the NPR for FY 2014.

The Board has the power to modify the Medicare Contractor's NPR for FY 2014 with respect to the underlying cost report and adjustments thereto[96] and, pursuant to this authority modifies Worksheet E-1, Part 1, Line 5.52 (tentative to program payments), Column 1 to reflect 11/04/2016[97] and Column 2 to reflect $4,991,315, representing the refunded amount which was tendered to the Medicare Contractor for purposes of the then-ongoing audit of BRMC's FY 2014 as-filed cost report and in connection with specific and identifiable claims/payments (*i.e.*, the FY 2014 interim UCC payments).[98] The Board notes that, as the payment was made after the cost reporting period had ended, it requires treatment as a tentative payment on the cost report, rather than as an interim lump sum payment, which would be reported on line 3.xx. This will allow all payments related to the UCC calculation (those made as interim payments on specific claims, those made as lump sum payments during the cost reporting period, and those made as tentative payments made after the cost reporting period had ended) to be compared to the final UCC payment calculation.

MFMM, Ch. 5, § 410.4 buttresses the Board's decision. This section directs the Medicare Contractor to apply voluntary refunds to outstanding receivables and to otherwise hold the refund *until it is verified that no open receivables remain*. Accordingly, § 410.4(10) directs the Medicare Contractor *to return refunds* ***once no outstanding accounts receivable exist***.[99] Here, the Medicare Contractor has not identified any open accounts receivable for BRMC or provided any other authority for it to retain the payment received *in connection with specific claims* (*i.e.*, the payment received in connection with the interim UCC payments associated with BRMC's FY 2014). Rather, the record confirms that CMS and the Medicare Contractor specifically refused to otherwise revise the payment determination(s) for which the perceived/estimated refund at issue was submitted. As a result, consistent with MFMM, Ch. 5, § 410.4, the Board finds that the $4,991,315 payment must be reflected in the FY 2014 NPR as a tentative payment so that it may be returned to BRMC.

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[95] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (emphasis added).
[96] 42 U.S.C. § 1395oo(d) ("The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report . . .").
[97] *See* Provider's FPP at 4.
[98] *See* Ex. P-5 at P0029 (Adjustment No. 33/Ref. 11 adjusts Worksheet E-1, lines 5.50 and 5.51 to reflect other tentative payments made to the Program, therefore, the Board chooses to use line 5.52, which has not been used on the NPR, per the adjustment report.)
[99] "Contractors shall only refund excess recoupments when no other outstanding accounts receivable exists . . ."

DECISION AND ORDER

The Board finds that the Medicare Contractor improperly excluded a tentative lump sum payment of $4,991,315 from the payments included on the FY 2014 NPR for BRMC and that BRMC is entitled to recoup the payment. Accordingly, the Board remands this case to the Medicare Contractor and directs it to modify BRMC's NPR for FY 2014 to reflect $4,991,315 as a tentative payment so that it may be returned to BRMC.

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FOR THE BOARD

8/16/2023

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Chair
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