IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

MEMORIAL HERMANN HOSPITAL SYSTEM 1635 North Loop West Houston, Texas 77008	§ § § §	
Plaintiff,	§	
v.	§	Civil Action No. 4:18-cv-1368
ALEX M. AZAR II in his official capacity as Secretary, United States Department of Health and Human Services,	§ § § §	
Defendant.	§	

COMPLAINT

1) This is an action for judicial review of an arbitrary and capricious decision of the Secretary of the United States Department of Health and Human Services that deprived the plaintiff hospital, Memorial Hermann Hospital System ("Hospital"), of reimbursement for interest, paid by the Hospital on an incorrectly calculated Medicare overpayment, in violation of an agreement between the Hospital and the Medicare Administrative Contractor ("MAC"). [1]

2) In short, the MAC failed to comply with an agreement, which was consistent with case law and agency practice, between the MAC and the Hospital in which the parties agreed to calculate interest after the issuance of a ***revised*** notice of program reimbursement ("NPR") for the cost reporting period ending June 30, 1995. The MAC charged interest expense to the Hospital in error before issuing this revised NPR. Under Medicare rules, the Hospital should not

[1] The Secretary contracts its Medicare payment and audit functions to insurance companies (each known as a MAC) that determine payment amounts due to participating hospital providers under Medicare laws and guidelines.

have been held liable for any interest until the issuance of the revised NPR.

3) After the Hospital received an NPR dated September 20, 1999, the MAC and the Hospital entered into an agreement on September 24, 1999, memorialized in a letter from the Hospital's attorney, Dan Peterson, to David Korn, Regional Director of Provider Audit, TrailBlazer Health Enterprises, LLC. The agreement stated that the Hospital would request that the cost reporting period be reopened by October 15, 1999 (less than one month from the NPR date). The MAC then agreed to issue a revised NPR by October 31, 1999.

4) Consistent with Medicare rules and precedent, the parties agreed that interest would be calculated on the basis of overpayments to the Hospital, determined from the ***revised*** October NPR, rather than the erroneous September NPR. The MAC, however, did not issue its revised NPR until June 5, 2000—eight months after the agreed upon deadline. Moreover, the MAC assessed interest to the Hospital for the additional eight months that the original, erroneous overpayment assessment was outstanding.

5) Consistent with the parties' agreement, the Hospital requested a refund of the additional eight months of interest charges, which the MAC has not refunded.

6) Because the ***revised*** NPR constitutes the final determination, no interest should have been due until the MAC issued its revised NPR in June 2000. The fact that the parties agreed that an audit had not been completed further supports that the debt was not established or certain—and interest was not due—until the MAC issued the revised NPR in June 2000.

7) Accordingly, no interest should have been due for the period of September 1999 through June 2000, and interest was charged in error. The Hospital should receive a full refund for the improper charge of interest for the eight months preceding the issuance of this revised NPR.

8) The Hospital timely appealed the revised NPR, including this interest expense issue by filing an administrative appeal with the Provider Reimbursement Review Board (the "Board").[2]

9) The MAC challenged the Board's jurisdiction over this issue on the grounds that there was no adjustment to the cost report for the overpayment of interest expense and therefore no appealable issue. In addition, the MAC claimed that interest assessed on an overpayment is not part of the reimbursement due a provider as determined on a cost report and therefore beyond the jurisdiction of the Board. As discussed below, federal courts have disagreed with this conclusion and this issue is, in fact, appropriate for Board review.

10) In its October 24, 2017 decision, the Board agreed with the MAC and found that it did not have jurisdiction over the interest expense issue.

11) In denying jurisdiction over this issue, the Board essentially allowed the MAC to delay final settlement of the cost report, all while racking up interest charges on the overpayment that the Hospital would be unable to pay until final settlement.

12) The MAC does not deny that it entered into an agreement with the Hospital, that it assessed interest in error, or that this sum is owing and due to the Hospital. Instead, with the Board's tacit blessing, the MAC seeks to avoid its liability on a technicality.

THE PARTIES

13) This action is brought by Memorial Hermann Hospital System, formerly known as Memorial Hospital System.

14) Defendant Alex M. Azar II is named in his official capacity as Secretary of the

[2] The Provider Reimbursement Review Board is a five person board within the Centers for Medicare & Medicaid Services ("CMS") that decides Medicare reimbursement disputes between healthcare providers and the Medicare program.

Department of Health and Human Services. The Provider Reimbursement Review Board, which rendered the final decision in this case, acts under authority delegated by the Secretary. 42 U.S.C. § 1395oo(a).

JURISDICTION AND VENUE

15) This action for judicial review is filed within sixty days of the date of a final Board decision (PRRB Case No. 00-2690), as required by 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1877(b). The Board notified the Hospital that it was closing the appeal on February 27, 2018, as all issues in the appeal had been settled and withdrawn by the Hospital or ruled upon by the Board. The Board's decision is final for the purposes of judicial review because the Administrator has not reversed, affirmed, or modified the Board's decision within 60 days. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1877. Thus, this ruling is the Secretary's final decision for the purposes of appeal.

16) The Court has jurisdiction over this action under 28 U.S.C. § 1331 and 42 U.S.C. § 1395oo(f)(1). This complaint properly seeks judicial review of a final administrative decision of the Secretary, for which the amount in controversy exceeds $50,000 in the aggregate. Plaintiff is also entitled to judicial review under the Administrative Procedure Act ("APA"), 5 U.S.C. § 551 *et seq.*, including 5 U.S.C. §§ 703, 704 and 706; and the Declaratory Judgments Act, 28 U.S.C. §§ 2201, 2202.

17) Venue in the Southern District of Texas is proper because this is the district in which the Hospital is located. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1877(e).

LEGAL BACKGROUND

Background on Medicare Reimbursement and Final Determinations

18) The Medicare program, established under Title XVIII of the Social Security Act,

provides health insurance to the aged and disabled. 42 U.S.C. § 1395 *et seq.*

19) The Secretary contracts its payment and audit functions to insurance companies—each known as a MAC—that determine payment amounts due to participating hospital providers under Medicare laws and guidelines.

20) Generally, the MAC determines payment amounts owed to providers under Medicare law and interpretive guidelines published by CMS. *See, e.g.*, 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20(b) and 413.24(b). The Medicare Intermediary Manual ("MIM") requires that the MAC ensure that the Hospital's cost report is "in conformity with the Medicare principles of payment," that it "reflects the current Medicare principles of payment," that it is "in accordance with Medicare laws, regulations, and instructions," that it determines the "appropriate amount of payment due," the "proper payment is made for services provided to Medicare beneficiaries," and that a determination is made of any "overpayment made or underpayment due." MIM §§ 4112.1.A, 4112.1.B, 4112.4.A, 4112.4.B.1, and 4112.4.C.1. Accordingly, the MAC has a responsibility to ensure that the Hospital received appropriate and accurate reimbursement

21) At the end of its fiscal year, a provider must submit a cost report to the MAC showing its costs and allocating certain costs to Medicare. 42 C.F.R. § 413.20. The MAC audits each cost report, finds the total amount of Medicare reimbursement due to the provider, and issues a notice of program reimbursement ("NPR"). 42 C.F.R. § 405.1803. The NPR sets forth the individual expenses allowed and disallowed by the MAC. *Id.* A provider dissatisfied with the MAC's determination may appeal to the Board within 180 days of receiving the NPR. 42 U.S.C. § 1395oo; 42 C.F.R. § 405.1835.

22) A final determination for purposes of interest does not occur until the revised NPR is issued. Generally, a "final determination" under 42 C.F.R. § 405.378(c)(1) is defined as

an NPR ***and*** either (i) a written demand for payment or (ii) a written determination of an underpayment. Decisions from federal courts, the CMS Administrator, and the Provider Reimbursement Review Board support that the revised NPR constitutes this final determination.

23) Federal appellate court decisions show that the "final determination" refers to the correct determination, not an earlier determination found to have errors. For example, in *National Medical Enterprises, Inc. v. Sullivan*, 960 F.2d 866, 869 (9th Cir. 1992), the Ninth Circuit rejected an argument that original NPRs qualify as "final determinations" under 42 U.S.C. 1395g(d), and asserted that the statute "does not provide for interest to accrue during the period of time it takes to determine that an error has been made." The Ninth Circuit concluded that the issuance of the revised NPRs constituted the final determination. *Id.* In the context of multiple ALJ rulings, the Fifth Circuit similarly found that an earlier ALJ ruling did not constitute the "final determination" for reasons such as its inclusion of "inappropriate claims." *Texas Clinical Labs, Inc. v. Sebelius*, 612 F.3d 771, 778 (5th Cir. 2010). Instead, the Fifth Circuit held that a later ALJ decision—which appropriately identified the exact amount of the principal due—was the final determination for the purpose of triggering actual accrual of interest on Medicare reimbursement. *Id*.

24) Likewise, in *Community Hospital of Santa Rosa v. Sullivan*, No. C-90-0972-RFP, 1991 WL 191250, *2 (N.D. Cal., Apr. 16, 1991), the district court noted that the Secretary published regulations in December 1982, with revisions in 1984, clarifying that "final determination" means the ***final NPR*** issued by the intermediary notifying the provider that amounts are due and specifying the actual amount of the overpayment and underpayment. The district court explained that, in that case, while there may "have been a determination as early as December 1984 that plaintiff had been underpaid in the fiscal year ending in 1985, there was no

determination that money was actually payable to plaintiff" ***until the fiscal intermediary issued a revised NPR*** for "the fiscal year ending in 1985 . . . ." *Id.* at *5.

25) The CMS Administrator has similarly concluded that the revised NPR is the final determination for payment purposes. In *University of Pittsburgh Medical Center*, 2014 WL 7213339 (H.C.F.A) (CMS Nov. 10, 2014) (Admin'r review of PRRB Dec. No. 2014-D26), the Administrator concurred with the Board's conclusion that the ***revised NPR*** constituted the final determination of the underpayment. *Id.* at *8. The Administrator drew the following language from the Board's reasoning in its opinion: "before the amount of interest on an underpayment or overpayment can be determined, CMS intended [in its rulemaking] to require that the debt be established or 'certain' before the 30 day clock to trigger interest can begin to tick." *Id.* at *6.

26) Finally, the Board itself has expressly found that revised NPRs constitute a "final determination" for purposes of calculating interest. In *Francis A. Bell Memorial Hospital,* Nos. 94-1039, 94-1040, 2001 WL 599886 (May 3, 2001) (PRRB Dec. No. 2001-D23), *reversed on other grounds by* 2001 WL 1092881 (H.C.F.A.) (CMS July 3, 2001) (Admin'r review of PRRB Dec. No. 2001-D23), the Board determined that a final determination was made upon issuance of ***revised NPRs***. *Id.* at *4. While certain cost reports were finalized and settled upon issuance of the original NPRs, the cost reports were reopened. As the Board notes, "[t]he reopening of the cost reports and subsequent issuance of NPRs . . . constituted the final determination of the Secretary within the meaning of the statute." *Id.* at *4.

27) These authorities make clear that the revised NPR—not the original, erroneous and incomplete NPR—is the final determination that triggers any duty to pay interest on the assessed overpayment. Moreover, the Hospital should not be liable for interest on any assessed overpayment amount that it ultimately did not owe.

Background on the MAC's Review and the Board's Jurisdiction

28) This dispute arose after the MAC prematurely assessed interest based on an erroneous NPR, in violation of its agreement with the Hospital. This was a mistake that both the MAC and the Board had a duty to correct.

29) The Medicare Financial Management Manual, Chapter 8, CMS Pub. 100-06 ("MFMM") requires that the MAC ensure during audits that the cost report is "in conformity with the Medicare principles of payment;" that it "reflects payment amounts and financial data in accordance with Medicare laws, regulations, and instructions;" that the "proper payment is made for services provided to Medicare beneficiaries;" and that the "primary goal is to arrive at a correct settlement of the cost report." MFMM, §§ 30.1, 70.1, 60.7.A, 30.2.

30) The Board's jurisdiction of Medicare reimbursement issues is set forth by 42 U.S.C. § 1395oo(a)(1):

> *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 [the Board] . . . *if* . . . such provider . . . is *dissatisfied*[3] *with a final determination* of the . . . *fiscal intermediary*[4] . . . *as to the* amount of *total* program *reimbursement* due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report . . . . (emphasis added).

31) Unlike § 1395oo(a), which sets forth jurisdiction, § 1395oo(d) "sets forth the powers and duties of the Board once its jurisdiction has been invoked[.]" *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 405 (1988). This section provides that the Board "shall have the power to affirm, modify, or reverse a final determination of the [MAC] with respect to a cost report and

[3] Also, Section 1395oo(a)(2) and (3) provide that a provider must file its request for hearing within 180 days of the NPR and meet the $10,000 amount in controversy requirement. These issues are not in dispute.

[4] Fiscal intermediaries are now referred to as "Medicare Administrative Contractors."

to make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the [MAC] in making such final determination." 42 C.F.R. § 1395oo(d) (emphasis added). In other words, the only requirement is that the matter be "covered by the cost report."[5]

32) The Board's scope of review over matters covered by the cost report is almost unlimited. The statute itself specifies just two issues—neither relevant here—that are beyond the Board's scope of review. 42 U.S.C. § 1395oo(g).

FACTS

33) This case's administrative record establishes the facts below. Except as otherwise noted, the facts relate to the Hospital's fiscal year ending June 30, 1995.

34) The Hospital timely filed its 1995 cost report. The cost report was audited in the summer of 1999. The MAC issued the NPR for this cost report on September 20, 1999, before the MAC's audit had been completed so that the MAC could meet CMS's September 30 deadline for the assigned work for that fiscal year.

35) The initial NPR indicated that the Hospital had an overpayment liability of $6,128,373. The Hospital protested the issuance of this NPR, as the audit was incomplete. The MAC agreed to immediately reopen the NPR and reprocess the report when all of the Hospital's documentation had been considered.

36) Consistent with Medicare rules and precedent, the parties agreed that interest would be calculated on the basis of overpayments determined from the revised October NPR, rather than the original, erroneous and incomplete September NPR.

[5] Although the current regulations limit the scope of the issues that can be brought before the Board, this was not part of the regulatory scheme at the time of these appeals.

37) Accordingly, the MAC and the Hospital entered into an agreement on September 24, 1999, memorialized in a letter from the Hospital's attorney, Dan Peterson, to David Korn, Regional Director of Provider Audit, TrailBlazer Health Enterprises, LLC. The agreement stated that the Hospital would request a reopening by October 15, 1999 (less than one month from the NPR date).[6] The MAC agreed to issue a revised NPR by October 31, 1999.

38) The MAC, however, did not issue its revised NPR until June 5, 2000—eight months after the agreed upon deadline.

39) Although the cause of the delay was attributable only to the MAC's inaction in issuing the revised NPR, the Hospital was charged interest on a monthly basis during the eight-month period between the initial NPR and the revised NPR.

40) When the second NPR was issued, the amount due to the program was reduced from $6,128,373 to $3,255,659. The interest due from the Hospital was reduced from $609,007.06 to $362,779.86. The Hospital submitted its payment (including interest) in July 2000, incurring two more months of interest, which was paid through claims withholding. The interest rate during this time period was 13.25%. Consistent with the parties' agreement, case law and agency practice, the Hospital requested a refund of the additional eight months of interest charges, which the MAC has not yet repaid.

41) Accordingly, there are two bases upon which CMS should refund interest to the Hospital. First, because the revised NPR constitutes the final determination, no interest should have been due for the period of September 1999 through June 2000, and interest was charged in error. The fact that the parties had agreed that an audit had not been completed further supports

[6] Provider submitted the reopening request on October 17, 1999, after corresponding about the timing with the MAC, (Letter to Melissa Halstead, Regional Audit Director (Houston Office) from Provider's attorney, Dan Peterson, dated October 15, 1999). On October 22, 1999, the MAC acknowledged the reopening request.

that the debt was not established or certain—and interest was not due—until the MAC issued the revised NPR in June 2000. The Hospital should receive a full refund for the improper charge of interest for the eight months preceding the issuance of this revised NPR.

42) Second, the Hospital recently settled the remaining issues on appeal for this year and CMS refunded an additional $2,367,689 to the Hospital through a further, final NPR issued in January 2018. This additional settlement indicates that interest charged to the Hospital should have been based on its ultimate overpayment liability of $887,970 ($3,255,659 less $2,367,689), and not on the overpayment liability assessed in the revised NPR issued in June 2000. That is, under the authorities set forth above, the 2018 NPR is the final revised NPR for the purposes of interest calculation.

43) Based on the full refund of interest for the eight months preceding the NPR and the recalculation of interest using the final settlement figure for the two-month period between the date of issuance of the final revised NPR in January 2018 and the date of the Hospital's payment in March 2018, the final amount of interest that should have been assessed for that two-month period is $88,242.03. Accordingly, the Hospital is due a refund of $274,537.83 from the $362,779.86 it originally paid.

44) The MAC challenged the Board's jurisdiction over this issue on the grounds that there was no adjustment to the cost report for the overpayment of interest expense and therefore no appealable issue. In addition, the MAC claims that interest assessed on an overpayment is not part of the reimbursement due a provider as determined on a cost report and therefore beyond the jurisdiction of the Board. As discussed above, federal courts have disagreed with this conclusion and this issue is, in fact, appropriate for Board review.

45) The Board agreed with the MAC, finding that it had no jurisdiction over the interest issue. The Board found that interest "is a matter outside the cost report, and the Board need not consider which final determination triggered interest accumulation." Board Dec. at 3. According to the Board, "[i]nterest cannot be a part of a cost report because it is not determined until there is a delinquency on the part of a provider or intermediary." *Id.*

46) By denying jurisdiction over this issue, the Board is essentially allowing the MAC to delay final settlement of cost reports, all while assessing interest charges on overpayments that providers would be unable to pay until the NPR is finalized. In this case, the MAC does not dispute that it entered into an agreement with the Hospital, that it assessed interest in error, or that this sum is owing and due to the Hospital. Instead the MAC tries to avoid its liability on a technicality that violates its agreement with the Hospital and deprives the Hospital of appropriate reimbursement of the excess interest that it paid.

47) Because the "final determination" for purposes of interest occurred with the issuance of the revised NPR, the Hospital should not have been liable for any interest payments while the parties were disputing the amount of the overpayment. Moreover, the Hospital should not be liable for any interest on money that it ultimately did not owe.

48) Accordingly, the Hospital should not have been liable for interest on any alleged overpayment until the issuance of the revised NPR and therefore requests that the excess interest be refunded to the Hospital.

STATEMENT OF CLAIMS FOR RELIEF

COUNT ONE

(Agency Action That Is Arbitrary, Capricious, Contrary to Law, and Unsupported by Substantial Evidence Under 5 U.S.C. § 706)

49) The allegations set forth above are realleged and incorporated by reference.

50) This agency wrongfully refused to exercise its undisputed jurisdiction to refund interest that was overcharged to the Hospital.

51) The Board improperly found that it did not have jurisdiction under 42 U.S.C. § 1395oo(a), which provides:

> *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 [the Board] . . . *if* . . . such provider . . . is *dissatisfied with a final determination* of the . . . *[MAC] . . . as to the* amount of *total* program *reimbursement* due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report . . . . (emphasis added).

52) Section 1395oo(a) also provides that the Hospital must file its request for hearing within 180 days of the NPR and meet the $10,000 amount in controversy requirement. These issues are not disputed in this case. That is, there is no dispute that the Hospital timely filed its request for hearing that met the amount-in-controversy requirement, and the relevant issue in this case was timely added to the appeal under the applicable Board rules.

53) The Board improperly considered interest assessed on a cost report overpayment to be "outside" the cost report. The Board cannot refuse to exercise its power over an issue that was properly before it, as doing so would give the MAC carte blanche to drag its feet when settling cost reports as a mechanism for assessing interest the provider cannot dispute and must pay. Construing §§ 1395oo(a) and (d) together, the Board must consider all matters timely raised before it. The phrase in § 1395oo(a) that a provider "may obtain a hearing" does not refer to discretion on the part of the Board to hold the hearing, but rather to the right of providers to be heard—if they choose to exercise that right. Once a provider has met the jurisdictional requirements to a Board hearing under § 1395oo(a), that provider has the right to be heard and to have a decision rendered on the merits.

54) The Board ignores the statutory mandate that the Board "affirm, modify, or reverse" final determinations by the MAC and "make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. § 1395oo(d). If part of this statute is discretionary, then it is all discretionary—a result that is illogical and inconsistent with the statute's purpose of providing for review.

55) There is no dispute that the Hospital timely appealed the final determination of these cost reports. Accordingly, the Board was required to adjudicate the interest issue.

56) Further, the Hospital was deprived of the reimbursement due to the failure by the federal government's own contractor to honor its agreement with the Hospital. The MAC itself had a duty to correct errors in reimbursement, and here failed to correct a clear mistake that flowed from the MAC's own instructions. Also, the MAC erroneously challenged jurisdiction, despite the clear claim for interest that the Hospital has based on the revised and settled cost year.

57) For all of these reasons, the Board's decision is arbitrary, capricious, an abuse of discretion, and not in accordance with law. The Board's decision is also unsupported by substantial evidence as it was reached by a clear error of judgment. Thus, the Board's decision must be reversed and set aside under 5 U.S.C. § 706.

COUNT TWO

(Agency Action That Violates Due Process Under 5 U.S.C. § 706)

58) The allegations set forth above are realleged and incorporated by reference.

59) The Administrative Procedure Act invalidates any decision that is reached in violation of a party's rights set forth in the United States Constitution, which includes the right to due process. *See* 5 U.S.C. § 706(b). Further, an agency must follow clear statutory mandates and

its own regulations and rules. If the agency's violation of its own rules results in prejudice to a party, then the agency's decision is "tainted" and cannot stand.

60) Based on the Board's disregard of its statutory mandate to provide the Hospital with a meaningful opportunity to be heard, the Board's decision is a violation of constitutional due process and of its own agency rules. It is thus arbitrary, capricious, an abuse of discretion, and not in accordance with law, and must be reversed and set aside under 5 U.S.C. § 706.

COUNT THREE

(Breach of Contract)

61) The allegations set forth above are realleged and incorporated by reference.

62) The Board denied the Hospital's right to a hearing on a properly claimed expense, refused to correct the results of the MAC's erroneous calculations and inaction under the federal government's own contract, and deprived the Hospital of proper reimbursement under Medicare. These actions breached the agreements between CMS and the Hospital.

63) CMS's breach of these agreements caused the Hospital significant damages.

COUNT FOUR

(Breach of Covenant of Good Faith and Fair Dealing)

64) The allegations set forth above are realleged and incorporated by reference.

65) Through the Board's actions, CMS violated the implied covenant of good faith and fair dealing, which is an implied covenant in the agreement between CMS and the Hospital. This breach caused the Hospital significant damages.

REQUEST FOR RELIEF

Plaintiff respectfully requests that this Court enter an order and judgment that:

1) Reverses and sets aside the Board's decision as arbitrary, capricious, and contrary to law; unsupported by substantial evidence; in violation of due process; in breach of CMS's agreement with the Hospital; and in violation of the implied covenant of good faith and fair dealing;

2) Awards the Hospital the full additional reimbursement to which it is entitled for interest overcharged by the MAC;

3) Finds and declares—to the extent that the Court has not awarded the Hospital its interest expenses, that the Board must exercise jurisdiction to hear and decide the issue of the Hospital's interest expense;

4) Awards the Hospital interest on any received reimbursement, based on 42 C.F.R. § 405.378, from the date of the revised NPR to the present;

5) Awards the Hospital its costs and reasonable attorneys' fees; and

6) Awards any other relief as may be warranted at law or in equity.

Dated: April 30, 2018

Respectfully Submitted,

/s/ R. Jeffrey Layne

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