PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON -THE - RECORD
99-D35

PROVIDER -
The Parkway Hospital, Inc.

Provider No. 33-0041

vs.

INTERMEDIARY -
Empire Medicare Services

DATE OF HEARING-
February 3, 1999

Cost Reporting Periods Ended -
December 31, 1986 & 1987

CASE NO. 89-1782R

INDEX

ISSUE:

Were the Intermediary's adjustments reclassifying the lease rental costs reported as capital costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case is based upon arguments and evidence presented to the Provider Reimbursement Review Board ("Board") in case number ("CN") 89-1782. Except where otherwise noted, all references contained herein pertain to position papers, testimony, and post-hearing briefs developed for that case.

The Parkway Hospital, Inc. ("Provider") is a 227 bed proprietary facility located in Forest Hills, New York.[1] As an acute care hospital located in New York, the Provider became subject to the Medicare prospective payment system ("PPS") on January 1, 1986.[2] The Provider's Medicare cost reporting periods ended December 31, 1986 and 1987, which are at issue in this appeal, were PPS transition periods. This means that part of the Provider's reimbursement for inpatient
hospital services was based upon a hospital-specific rate ("HSR") per discharge derived from the Provider's 1982 base period, while certain other costs, such as capital-related costs, were classified as "pass-through" items which continued to be reimbursed on the basis of reasonable cost.

Empire Medicare Services ("Intermediary") audited the Provider's cost reports for the subject reporting periods and found that the Provider had claimed capital pass-through reimbursement for certain equipment lease payments pursuant to 42 C.F.R. § 412.71(b)(2). The Intermediary determined, however, that these costs were classified as operating costs during the Provider's base period and were included in the Provider's HSR. Therefore, to avoid paying for the same costs twice, once through the HSR and again as capital pass-through costs, the Intermediary reclassified the lease payments back to their respective cost centers as operating expenses.[3]

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1 Intermediary's Position Paper at 1.

2 Most hospitals located outside of New York became subject to PPS with cost reporting periods beginning on or after October 1, 1983. New York hospitals were exempt from PPS until December 31, 1985 pursuant to 42 U.S.C. § 1395b-1. Provider's Post-Hearing Brief at 3.

3 Provider's Post-Hearing Brief at 3-4. Intermediary's Position Paper at 2.

On November 28, 1988, the Intermediary issued a Notice of Program Reimbursement ("NPR") reflecting the reclassifications for the Provider's 1986 cost reporting period, and on March 24, 1989, the Intermediary issued an NPR reflecting the reclassifications for the Provider's 1987 cost reporting period. On May 8, 1989, the Provider appealed each of the Intermediary's determinations to the Board pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The case was designated CN:89-1782. The amount of Medicare reimbursement in controversy was approximately $168,000 for the 1986 cost reporting period, and $222,000 for 1987.

Both parties submitted position papers with respect to the propriety of the Intermediary's adjustments, and a hearing before the Board was held on September 23, 1997. On February 24, 1998, the Board issued decision number 98-D29 finding that the Intermediary properly reclassified all of the lease rental costs at issue except for the costs pertaining to a 1986 lease of mammography equipment and a 1984 lease of a coulter counter. The Board's finding were predicated on 42 C.F.R. § 412.113 and Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2802, which generally require that capital-related costs be determined consistently with the way they were treated during the PPS base period, i.e., as either capital-related costs or operating expenses to avoid duplicate program payments.

On April 27, 1998, the Administrator of the Health Care Financing Administration ("the Administrator") ("HCFA") vacated and remanded the Board's decision. The Administrator found that the Board's application of 42 C.F.R. § 412.113 ("the consistency rule"), although applicable to the Provider's 1986 cost reporting period, would not be applicable to the Provider's 1987 cost reporting period. Specifically, the Provider's 1987 reporting period began on January 1, 1987, which is after the October 1, 1986 effective date of the rule. The Administrator referenced 42 C.F.R. § 412.113, which states:

> [f]or cost reporting periods beginning before October 1, 1986, the capital-related costs for each hospital must be determined consistently with the treatment of such costs for purposes of determining the hospital-specific portion of the hospital's prospective payment rate. . .

42 C.F.R. § 412.113 (emphasis added).

The Administrator also found statements made by HCFA to be relevant to this case. The Administrator explains that when HCFA was eliminating the consistency rule it stated:

> [c]ommenters supported the elimination of the consistency rule which required that classification of capital-related and direct medical education costs remain consistent for each hospital during the prospective payment transition period.

> Several commenters asked that we stipulate the effective date of the expiration of the consistency rule. . .
>
> As noted in the preamble of the proposed rule at 53 FR 19520 the consistent application of classification for capital-related costs and direct medical education costs is no longer necessary due to the expiration of the prospective payment transition period. . . However, just as the regulation previously required, consistency for capital-related costs must be applied only to cost reporting periods beginning before October 1, 1986 and for direct medical education costs only for cost reporting periods beginning before October 1, 1987.

53 Fed. Reg. 38476 at 38517 (1988) (emphasis added).

Although the Administrator held that the Board properly applied the consistency rule to the Provider's 1986 cost reporting period, the Administrator also vacated that portion of the Board's decision to prevent bifurcation of the case.

On May 28, 1998, the Board reopened CN:89-1782, and ordered the Provider and the Intermediary to file position papers addressing the Administrator's concern that the effective date of the consistency rule for capital-related costs applied only to cost reporting periods beginning before October 1, 1986. The case was redesignated as CN:89-1782R.

The Provider was represented by Roy W. Breitenbach, Esquire, of Garfunkel, Wild & Travis, P.C. The Intermediary was represented by Michael F. Berkey, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

In response to the issue initially placed before the Board as CN:89-1782, the Provider argues as follows:

> The Provider contends that the Intermediary improperly reclassified rental payments made on various equipment leases from capital-related expenses to operating expenses for its 1986 and 1987 cost years. The reclassifications denied the Provider capital pass-through treatment for the subject rental payments thereby reducing the Provider's overall Medicare reimbursement.[4]

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[4] Provider's Post-Hearing Brief at 23.

The Provider asserts that two requirements must be met in order for items of expense to be reimbursed as capital pass-through costs during PPS transition years.[5] First, the costs must meet HCFA's definition of a capital-related cost. 42 C.F.R. § 413.130, HCFA Pub. 15-1 § 2806. This requirement is not relevant to the case since the Intermediary has not contested that the rental payments at issue meet the pertinent definition.[6]

Secondly, however, the provider must demonstrate that the subject costs were also treated as capital-related costs during its PPS base year, which is commonly referred to as "the consistency rule."[7] Manual instructions at HCFA Pub. 15-1 § 2802 B.1 state:

> [d]uring this [the PPS transition] period, classification of an item as either a capital-related expense or a current operating expense must not be changed in subsequent fiscal years from its classification status in the base period cost report. Further, hospitals will not be permitted to change their policies during the transition period from those used in the base period regarding capitalizing or expensing the items. Intermediaries will assure that any cross-over of items from operating expense categories to capital-related categories will not be allowed in reimbursing hospitals during the transition period.

HCFA Pub. 15-1 § 2802 B.1.

With respect to this requirement, the Provider contends that the Intermediary denied capital pass-through treatment for the subject lease payments because the Provider could not demonstrate that these costs had also been treated as capital-related costs during its base year.[8] The Provider argues, however, that the Intermediary's position is flawed because all of the costs at issue pertain to equipment that was acquired after the 1982 base year. The Provider asserts that the costs at issue relate to new equipment which it did not possess during the PPS base year, nor was acquired to replace equipment that was available in the PPS base year.

The Provider cites Kaiser Foundation Hospitals Group -- Pass Through Costs v. Ætna Life Insurance Company, PRRB Dec. No. 92-D10, February 12, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,016 ("Kaiser"). In that case, the Board held that HCFA's consistency rule

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5 Id.

6 Provider's Post-Hearing Brief at 25.

7 Provider's Post-Hearing Brief at 26.

8 Provider's Post-Hearing Brief at 27.

is satisfied where a provider can show that the equipment was acquired after the PPS base year and, therefore, constituted "new, non-replacement equipment."[9]

The Provider adds that all the appellants in Kaiser had a 1982 PPS base year, and leased or purchased various assets during their 1984, 1985, and 1986 cost years. Then, these providers claimed the rental payments and purchase prices of the assets as capital-related costs. After auditing the cost reports, the intermediary reclassified these capital-related costs as operating expenses thereby denying capital pass-through treatment for the costs associated with the newly acquired equipment. The intermediary based its decision on HCFA's consistency rule. The Board, however, rejected the intermediary's position, stating:

> [t]he Board finds the Intermediary's argument that it must consistently apply the base-year treatment to assets purchased after 1983 incorrect. The law and regulations must be applied each year to a provider's incurred costs. In 1984, 1985, and 1986, the Providers incurred costs for newly leased and purchasedassets. Reimbursement for these costs is dictated by whatever regulations apply at that time. The Board believes that this treatment of post-1983 purchases and leases of assets also meets the intent of HCFA Pub. 15-1 §2802 B.1. That section limits consistent treatment of base-year period operating or capital-related costs to assets purchased or leased in the base period. It does not "lock in" the treatment of assets purchased after the base year. Thus, the Board concludes that this section is in accord with the Medicare law and regulations. The Intermediary has improperly applied the consistency standard.

Kaiser, Medicare & Medicaid Guide (CCH) ¶ 40,016 at 29,587.

In accordance with the Board's decision in Kaiser, the Provider asserts that it is also entitled to capital pass-through reimbursement for the subject rental payments because it can demonstrate that the equipment was acquired after its 1982 base year, and that the equipment was "new, non-replacement equipment."[10]

The Provider contends that the fact the subject equipment was acquired after its PPS base period is evidenced by testimony rendered by its witness. Before the Board, the witness testified that a 1983 Chevrolet Van was leased in June 1983,[11] and that a 1986 Chevrolet Van

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9 Id.

10 Provider's Post-Hearing Brief at 29.

11 Transcript ("Tr.") at 39.

was leased in August 1986.[12] Similarly, the witness testified that EKG monitoring equipment was acquired in 1983,[13] mammography equipment was acquired in 1986,[14] and angiography equipment was

acquired in 1984.[15] Additionally, a coulter counter was acquired in 1984,[16] enhanced operating room lights and tables in 1985,[17] and C-arm x-ray equipment in 1984.[18] Finally, the witness testified that the Provider acquired a computerized registration system, enhanced patient beds, and a CT scanner in late 1986.[19]

The Provider contends that the fact the subject equipment was not acquired to replace equipment it had possessed during the 1982 base year is also evidenced by testimony. In this regard, the Provider's witness testified that the Provider never had, or needed, a van to transport records and other materials from its off-site storage facility before June 1983.[20] Likewise, the Provider never had mammography equipment before 1986,[21] or angiography equipment before 1984.[22] Also, the coulter counter acquired in 1984 was the first coulter counter possessed by the Provider.[23] The C-arm x-ray equipment acquired in 1984 was the

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12 Tr. at 44.

13 Tr. at 45.

14 Tr. at 50.

15 Tr. at 60.

16 Tr. at 57.

17 Tr. at 53 and 55, respectively.

18 Tr. at 61.

19 Tr. at 63-65.

20 Tr. at 40.

21 Tr. at 50.

22 Tr. at 60.

23 Tr. at 57.

first C-arm x-ray equipment the Provider had ever possessed [24] and, finally, the Provider never had a computerized registration system,[25] or a CT scanner on its premises before 1986.[26]

With respect to the remaining equipment at issue in this appeal, the EKG monitoring equipment, the operating room tables and lights, and patient beds, the Provider asserts that it had possessed similar equipment during its PPS base year. However, the equipment at issue was specially enhanced and could perform so many more features than the equipment available in 1982, that it should not be considered replacement equipment, but rather, entirely new equipment of a different category.[27]

For example, the Provider asserts that while it had several freestanding analog EKG monitors in use during 1982, the EKG monitors acquired in 1983 were computerized, connected to a central station network, and provided physicians with simultaneous interpretation of the results. These are all features that the 1982 EKG monitors lacked.[28] The new EKG monitors also gave physicians on the Provider's medical staff who did not specialize in cardiology the ability to read and interpret the EKG results without having to await the arrival of cardiologists, which is an essential function that the earlier EKG monitors did not provide.[29]

Similarly, the Provider possessed operating room tables, operating room lights, and patient beds during its 1982 base year. However, the operating room tables, operating room lights, and patient beds acquired after 1982 all had enhanced capabilities and many more features than the equipment previously possessed. The operating room tables available in 1982 were the original tables installed by the Provider when the hospital was built in 1963. These tables did not enable surgeons to place patients in different positions during an operation or for the post-operation recovery period. The tables acquired by the Provider in 1985 were mechanical, thereby allowing patients to be placed in different positions.[30]

Likewise, the lights acquired by the Provider in 1985 replaced lights that had been in the Provider's operating room since 1963, and were unsatisfactory because they cast large

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[24] Tr. at 61.

[25] Tr. at 64.

[26] Tr. at 65.

[27] Provider’s Post-Hearing Brief at 30.

[28] Tr. at 46-47.

[29] Id.

[30] Tr. at 54.

shadows on the operating field. The new lights had enhanced technology which enabled surgeons to view more of the operating field.[31]

The Provider disagrees with the Intermediary's suggestion that the operating room lights, operating room tables, and patient beds that were acquired after 1982 were actually replacement equipment pursuant to the Board's decision in Kaiser.[32] The Provider asserts that in Kaiser the Board defined replacement equipment in terms of the potential for duplicate reimbursement, as follows:

> [t]he Board does recognize that a potential for duplicate reimbursement may exist for leases or assets that replace existing leases or assets. Without proper accountability of these capital-related costs, duplication will result. Treating a capital-related cost as an operating expense in the base year and continuing to reimburse the Providers on this basis during the PPS transition period, while treating replacement assets and leases subsequent to 1983 on a capital-related cost reimbursement basis, can result in duplicate reimbursement . . . . The costs of those replacements should not be treated as capital-related costs, since the costs of the original assets are included in the hospital-specific portion of the Providers' PPS rates.

Kaiser, Medicare & Medicaid Guide (CCH) ¶ 40,016 at 29,587.

With respect to the instant case, the Provider argues that there is no risk for double reimbursement. The operating room tables, operating room lights, and patient beds had been in the Provider's possession since the hospital was built in 1963. Therefore, this equipment was fully depreciated before the 1982 base year and, accordingly, no costs associated with this equipment were included in the Provider's hospital specific rate.[33]

The Provider also disagrees with the Intermediary's suggestion that it did not establish the subject equipment to be new, non-replacement equipment, because it relied solely upon the testimony of a witness who did not become affiliated with the Provider until 1987.[34] The Provider asserts this argument is misplaced because the witness' testimony was based not only on his personal knowledge, but on his extensive review of the Provider's records and the available lease documents. In addition, as the witness explained, he obtained additional information from members of the Provider's medical staff, technical staff, and administration

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31 Tr. at 55-56.

32 Provider's Post-Hearing Brief at 32.

33 Provider's Post-Hearing Brief at 33.

34 Id.

who were present and working for the Provider during the periods of the equipment acquisitions.

The Provider asserts that the Intermediary's criticism of its witness' testimony as unreliable "hearsay" is also misplaced.[35] Both the Board and the Administrative Procedure Act give the Board the right to accept hearsay and other testimony that would be inadmissible under the Federal Rules of Evidence or traditional court procedures. See HCFA Pub. 15-1 § 2925.2, (Board not bound by traditional evidentiary rules); Mercy Hospital of Miami v. Blue Cross and Blue Shield Association, PRRB Dec. No. 91-D66, Aug. 23, 1991, (accepting hearsay evidence introduced at hearing); See also 5 U.S.C. § 556(d), (all oral or written evidence admissible in federal administrative hearings except evidence that is irrelevant, immaterial, or unduly repetitious); Richardson v. Perales, 402 U.S. 389, 402 (1971) ("Richardson") (hearsay evidence properly admitted in federal administrative hearing); Bennett v. National Transportation Safety Board, 66 F.3d 11 30, 1137-38 (10th Cir. 1995) (same); Calhoun v. Bailar, 626 F.2d 145, 148 (9th Cir. 1980) (same) ("Calhoun"). As the Ninth Circuit stated in Calhoun:

> [p]erhaps the classic exception to strict rules of evidence in the administrative context concerns hearsay evidence. Not only is there no administrative rule of automatic exclusion for hearsay evidence, but the only limit to the admissibility of hearsay evidence is that it must bear satisfactory indicia of reliability. We have stated the test of admissibility as requiring that the hearsay be probative and its use fundamentally fair.

Calhoun, 626 F.2d at 148.

The Provider adds that the reason for the relaxed rules of evidence in administrative proceedings was best explained by the Supreme Court when discussing the administrative hearing rules under the Social Security Act.[36] The Court stated:

> [i]t is apparent that (a) the Congress granted the Secretary [of Health and Human Services] the power by regulation to establish hearing procedures; (b) strict rules of evidence, applicable in the courtroom, are not to operate at social security hearings so as to bar the admission of evidence otherwise pertinent; and (c) the conduct of the hearing rests generally in the examiner's discretion. There emerges an emphasis upon the informal rather than the formal. This, we think, is as it should be, for this

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35 Id.

36 Provider's Post-Hearing Brief at 34.

> administrative procedure, and these hearings, should be understandable to the layman claimant, should not necessarily be stiff and comfortable only for the trained attorney, and should be liberal and not strict in tone and operation. This is the obvious intent of Congress so long as the procedures are fundamentally fair.

Richardson, 402 U.S. at 400-01 (Blackmun, J.).

The Provider concludes that its witness' testimony meets the requirements of relevance, materiality, and fundamental fairness.[37] The witness explained in detail what information was based on his personal knowledge, what information was based on his review of pertinent records, and what information was obtained from specified other persons. In total, the witness' testimony was corroborated by the relevant Provider records and lease documents, and the Provider offered to submit corroborative affidavits from the persons with whom the witness spoke.

Finally, the Provider contends that the Intermediary's argument regarding discrepancies in its lease documentation is improper, and that it has met its burden to establish that the rental payments at issue are entitled to capital pass-through treatment.[38] The Provider argues that it claimed capital pass-through reimbursement for the subject costs in each of the pertinent Medicare cost reports. The Intermediary audited these cost reports and raised no questions regarding lease documentation or costs. Furthermore, although the Intermediary had several opportunities to express any concerns it may have had regarding the Provider's documentation, it waited until the day of the hearing, after the Provider's witness had completed his testimony, to raise them. Accordingly, the Provider asserts that the Board should reject these Intermediary arguments as untimely and inappropriate.

The Provider explains that the Intermediary raised only one objection to its claim, and that was the classification of the rental payments as capital-related costs violated the consistency rule. The Intermediary did not raise any audit or verification objections to the rental payments in either its 1986 or 1987 NPRs. Clearly, after audit, the Intermediary accepted the amount of rental payments claimed by the Provider in their entirety, and only reclassified these total amounts from capital-related costs to operating expenses.

In addition, the Intermediary did not include any audit and verification objections in its List of Issues submitted to the Board after the Provider filed its request for a Board hearing. Similarly, the Intermediary did not raise any audit and verification objections in its Position Paper. Also, several months before the hearing, the Provider submitted a letter brief which set

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[37] Provider's Post-Hearing Brief at 35.

[38] Provider's Post-Hearing Brief at 36.

forth, in detail, what the Provider's claims would be at the hearing. Accompanying this brief was a complete set of the Provider's exhibits. Even after receiving and reviewing this documentation, the Intermediary still did not inform either the Board or the Provider that it intended to raise any audit and verification objections at the hearing. Clearly, for the Intermediary to raise audit and verification objections with respect to information it had audited more than five years earlier is unfair.

The Provider adds that it has long been a fundamental principle of administrative law that an agency's decision may be upheld, if at all, solely upon the grounds stated by the agency itself. Burlington Truck Lines, Inc. v. United States, 371 U.S.156,168-69(1962) ("Burlington Truck Lines"); SEC v. Chenery, 332 U.S. 194, 195-97 (1947) ("Chenery II"); SEC v. Chenery, 318 U.S. 80, 93-95 (1943) ("Chenery I"); Phelps Dodge Corp. v. NLRB, 313 U.S. 177, 195-97 (1941). A reviewing body may not rely upon "post-hoc rationalization" regarding legal conclusions in support of agency action but not appearing on the face of the decision. Burlington Truck Lines, 371 U.S. at 168-69; Chenery I, 318 U.S. at 94; Compania De Gas DeNuevo Laredo, S.A. v. FERC, 606 F.2d 1024, 1031 (D.C. Cir. 1979).

Here, however, the Intermediary seeks to do precisely what administrative law forbids, i.e., use a legal argument not appearing on the face of its NPRs to sustain its reclassification of the rental payments after the Provider demonstrated that its stated reason for reclassification was without merit. The Intermediary's actions are particularly egregious given that it waited more than five years after it audited the Provider's cost reports and supporting documentation to raise its audit and verification objections. Had the Intermediary raised its objections at the time it issued the NPRs, the Provider could have addressed them and provided additional documentation. By waiting so long after the NPRs were issued to raise the objections, the Intermediary effectively denied the Provider the ability to respond because neither the Intermediary nor the Provider has records documenting the Intermediary's audit of the necessary information. The Provider explains that it had repeatedly asked the Intermediary for information concerning its 1986 and 1987 lease schedules, but the Intermediary never provided any information supporting or disproving the schedules.[39]

In response to the Administrator's remand of CN:89-1782 and the Board's reopening of that case, the Provider filed a position paper reflecting the Administrator's conclusion that the consistency rule applied only to cost reporting periods beginning before October 1, 1986 and, therefore, did not apply to the lease payments made by the Provider during its 1987 cost year. Accordingly, the Provider asserts that it does not have to demonstrate that its 1987 lease payments were for equipment whose costs were not reflected in its HSR. Notwithstanding the Administrator's finding, the Provider also maintains that all of the lease payments at issue should be treated as allowable capital-related pass-through costs for the following reasons:[40]

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[39] Tr. at 163.

[40] See Provider's Position Paper on Reopening (CN:1782R) at 34-62.

- The lease payments at issue meet HCFA's definition of capital-related costs found at 42 C.F.R. § 413.130 (a)(3) and (b)(1).

- The Provider met its obligation to furnish adequate cost data to support its claim for program reimbursement. Supporting documentation regarding the subject lease expenses was made available to the Intermediary for audit and verification pursuant to 42 C.F.R. § 413.20 (d). After completing its audit of the underlying data the only objection raised by the Intermediary was the classification of the lease payments as capital-related costs. There was no question raised regarding the propriety of these expenses. In this regard, arguments made by the Intermediary with respect to documentation should be rejected as untimely. Should the Board determine that there are concerns regarding documentation, it should direct the Intermediary to perform additional audit procedures to resolve them.

- The lease payments at issue comply with the intent of the consistency rule, i.e., their classification as capital-related costs will not result in a duplication of program payments. Each of the lease payments at issue relate to equipment that was acquired after the 1982 PPS base period, and to equipment that was not acquired to replace similar equipment owned or rented in the base period. Therefore, the costs at issue pertain to "new, non-replacement" equipment whose costs are not reflected in the HSR.

INTERMEDIARY'S CONTENTIONS:

In response to the issue initially placed before the Board as CN:1782, the Intermediary argues as follows:

> The Intermediary contends that its adjustments reclassifying the subject lease rental costs as operating expenses are proper. The Provider treated the costs of equipment leases as operating expenses during its 1982 PPS base period. Accordingly, these costs were included in the Provider's HSR, and they must be treated the same way in the subject cost reporting periods to avoid duplicate payments. The Intermediary asserts its adjustments are proper based upon HCFA's rules pertaining to the consistent treatment of capital-related costs found at 42 C.F.R.

§ 412.113(a) and HCFA Pub. 15-1 § 2802.[41]

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[41] Intermediary's Position Paper at 2, 4 and 5.

The Intermediary contends that there are three issues that refute the Provider's claim that the subject costs should be treated as capital pass-through costs. First, there is no proof that the lease costs the Provider wishes to claim as capital pass-through costs were not reimbursed in its HSR.[42] As shown on Exhibit I-H, which is a form showing adjustments to the Provider's 1982 PPS base period cost report, there is a Memorandum Entry indicating that the Provider treated all lease payments as operating expenses. The Memorandum Entry states:

> [i]t should be noted for ceiling computations the Provider has no capitalized lease obligations. The lease rental expense included in the cost centers are for operating leases only.

Adjustments to the Institutional Cost Report for the Year Ended December 31, 1982 at 9.[43] Accordingly, the Intermediary contends that the Provider claimed no lease expenses as capital-related costs in its PPS base period, and that all lease expenses that were incurred were claimed as operating costs that are reimbursed through the Provider's HSR.[44] The Intermediary asserts that the immediate problem is that no records are available to indicate which equipment lease expenses were actually included in the Provider's HSR. Therefore, there is no way to determine whether or not the lease payments now being claimed by the Provider as capital pass-through costs pertain to the same equipment whose costs are included in the HSR, and whether or not such pass-through treatment will result in duplicate payments. The Intermediary explains that it simply has no records or listing of the leases included in the Provider's HSR, and neither does the Provider.[45]

The Intermediary also asserts that it would be improper to rely upon Provider testimony to determine whether or not certain capital lease expenses were included in the Provider's HSR, and which expenses were not. The Intermediary argues that pursuant to Medicare regulation 42 C.F.R. §§ 413.20 and 24, adequate cost data must be available to support provider claims.[46] Also, regarding the parties' inability to identify the specific lease costs included in the Provider's HSR, the Intermediary rejects the Provider's reliance on the Board's conclusions in Kaiser to help support its position. The Intermediary argues that a complete reading of the decision reveals that capital pass-through treatment is allowed for

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42 Tr. at 13.

43 Exhibit I-H

44 Tr. at 16.

45 Tr. at 18.

46 Tr. at 19.

capital lease costs incurred after the base period only where the asset acquired was totally "new" to the Provider, as follows:[47]

> capital-related lease and depreciation costs incurred after the PPS base year are allowed pass-through treatment unless the assets replace those which were treated as operating costs in the base year. All hospitals, whether paid under the prospective payment system or excluded, must treat capital-related costs in a manner consistent with the way identical or similar costs were treated in the base year.

Kaiser, Medicare & Medicaid Guide (CCH) ¶ 40,016 at 29,586 (Emphasis added).

Accordingly, the Intermediary asserts that where the Provider incurred lease expenses in the PPS base year for items such as cars and operating tables, as in the instant case, the Medicare program cannot treat expenses for those items as capital pass-through costs in the transition years. The Intermediary argues that it does not have to be the same cars or operating tables, and it does not even have to be identical equipment, only equipment that is similar to that used in the base period. For the purpose of this case, the Intermediary argues that if the lease expenses of an X-ray machine were included in the Provider's HSR, then the costs of a CAT scan leased after the base period should not be allowed capital pass-through treatment because it is a similar piece of equipment.[48]

The Intermediary again refers to the Board's conclusion in Kaiser, which states in part:

> [t]he Board does recognize that a potential for duplicate reimbursement may exist for leases or assets that replace existing leases or assets. Without proper accountability of these capital-related costs, duplication will result. Treating a capital-related cost as an operating expense in the base year and continuing to reimburse the Providers on this basis during the transition period, while treating replacement assets and leases subsequent to 1983 on a capital-related cost reimbursement basis, can result in duplicate reimbursement.

Kaiser, Medicare & Medicaid Guide (CCH) ¶ 40,016 at 29,587.

Next, the Intermediary contends that the Provider's claim for capital pass-through treatment must be denied because there is no evidence that the subject purchases were even made. The

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47 Tr. at 20.

48 Tr. at 21.

Intermediary explains that for all but about $35,000 worth of the lease expenses at issue in this case there are no actual lease documents available to verify the transactions. The Intermediary argues that Exhibits P-10 and P-12 are the only two leases available.[49] However, the Provider is claiming that it entered about 10 leases totaling approximately $125,605 in capital pass-through costs in 1986, and $392,275 in 1987. The Intermediary explains that the actual leases are necessary to determine exactly what the Provider purchased, the terms of the transaction, who has ownership, etc.[50]

Finally, the Intermediary contends that the Provider's claim for capital pass-through treatment must be denied because there are numerous reconciliation problems and inconsistencies in the Provider's records which cannot be audited or verified. For example, the Intermediary asserts that Exhibit I-I shows where certain lease costs are inexplicably claimed in some years but not in others, and where there are significant differences in the amount of certain lease costs claimed from one year to the next.[51] Additionally, the Intermediary refers to its cross-examination of the Provider's witness, Tr. at 66, which discloses numerous differences in lease amounts in various different Provider documents which could not be explained.

In addition, the cross-examination revealed differences in the amount of the Intermediary's adjustments being disputed by the Provider. The pertinent adjustment made by the Intermediary to the Provider's 1986 cost report was the reclassification of $246,297 in lease rental costs. While the Provider originally challenged this entire adjustment, it reduced its challenge to $125,605 just prior to its hearing before the Board.[52] The Provider did not have a reconciliation of these two amounts.[53]

Conversely, the Provider increased the amount of the adjustment it disputes for the 1987 cost reporting period from approximately $322,000 in lease rental costs to $392,275. The Intermediary notes that the amount now challenged by the Provider for 1987 is greater than the actual adjustment it made to the Provider's cost report. Moreover, the Provider did not produce a reconciliation of these two amounts, as well.[54]

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49 Tr. at 76.

50 Tr. at 13 and 23.

51 Tr. at 169.

52 Tr. at 104-107.

53 Tr. at 134.

54 Tr. at 104, 105, and 116.

In response to the Administrator's remand of CN:89-1782 and the Board's reopening of that case, the Intermediary asserts that the consistency rule must be applied to the Provider's 1987 cost reporting period to avoid duplicate payments in accordance with the enabling statute, notwithstanding the October 1, 1986 effective date of the regulations.[55] The Intermediary believes that amendments to the PPS statute which extended the PPS transition period and the period of time that capital-related costs were to be treated differently than operating costs, effectively extended the application of the consistency rule. The Intermediary does not believe an omission of a conforming change to a regulation when such omission conflicts with statutory intent should form the basis to grant improper program payments.

The Intermediary explains that PPS for inpatient operating costs began October 1, 1983, with a three year transition period. The statute at 42 U.S.C. § 1395ww(a)(4) excluded capital-related costs and the costs of approved educational activities from the definition of operating costs for periods beginning before October 1, 1986. Accordingly, regulations at 42 C.F.R. § 405.477 (c)(1) and (2) (recodified at 42 C.F.R. § 412.113) were promulgated to require that capital-related costs and direct medical education costs, respectively, continue to be reimbursed on the basis of reasonable cost. The regulations also required that for cost reporting periods beginning before October 1, 1986, i.e., the transition years, that capital-related costs and direct medical education expenses had to be treated consistently with the way they were treated in the PPS base period, which would prevent a duplication of program payments.

On April 7, 1986, however, P.L. 99-272 extended the PPS transition period by one full year to cost reporting periods beginning before October 1, 1987. 42 U.S.C. § 1395ww(d). Shortly thereafter, on July 2, 1986, P.L. 99-349 extended the period during which capital-related costs and direct medical education costs would be treated separately from inpatient operating costs-- through cost reporting periods beginning before October 1, 1987. In response to these amendments, HCFA, on May 6, 1986, revised 42 C.F.R. § 412.113 to extend the consistency rule for medical education expenses also to cost reporting periods beginning before October 1, 1987. However, for some inexplicable reason, perhaps administrative oversight or the fact that HCFA had proposed to incorporate capital costs into PPS beginning in 1987, 51 Fed. Reg. 19971 (June 3, 1986), the same change was not made to 42 C.F.R. § 412.113 regarding capital-related costs. The Intermediary believes this omission should not prevent the application of the consistency rule to capital-related costs to avoid duplicate payments. The Intermediary asserts that the application of the consistency rule to capital-related costs in the 1987 cost year at issue seemingly conflicts with 42 C.F.R. § 412.113, however, it comports with the requirements of the statute. The consistency rule applies to the four PPS transition periods for both capital-related costs and for medical education expenses. It is illogical to distinguish between these two categories of costs for cost reporting periods beginning before October 1, 1986 and October 1, 1987, and such a distinction is inconsistent with the cited amendments to 42 U.S.C. § 1395ww(a).

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[55] See Supplemental Intermediary Position Paper (CN:89-1782R) at 5-13.

The Intermediary also asserts that the Board should affirm its exclusion of mammography and coulter counter equipment expenses as capital-related pass-through costs and reverse that portion of its decision. The Intermediary believes there are two problems with the Board's initial findings. First, the Board relied exclusively upon testimony to determine which assets the Provider had in the 1982 base period; there was no documentation at all of what assets existed in 1982, much less auditable and verifiable documentation as required by 42 C.F.R. § § 413.20 and 413.24. Secondly, the Board's decision lacks consistency in determining what equipment in the disputed years was "similar" to equipment in the PPS base period. For example, the Board found that new EKG equipment, though far superior to old EKG equipment, was still similar and, therefore, the costs associated with that equipment could not be treated as capital-related pass through costs. Accordingly, the Board should have reached the same conclusion for the mammography equipment and the coulter counter. According to testimony, there was previously mammography equipment and equipment for analyzing blood counts.

Also regarding the coulter counter, the Intermediary asserts there were unexplained discrepancies between the amounts claimed for 1986 and 1987, which is the same kind of discrepancy the Board used to rule against the Provider for its 1984 x-ray equipment lease. Moreover, there was no lease presented for the coulter counter, which is the same kind of problem the Board found persuasive in disallowing capital-related cost treatment for the 1984 x-ray.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395b	-	Option to Individuals to Obtain Other Health Insurance Protection
§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395ww(a) et. seq.	-	Limits on Operating Costs for Inpatient Hospital Services (as amended by P.L. 99-349)
§ 1395ww(d)	-	PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS(as amended by P.L. 99-272)

2. Law - 5 U.S.C.:

§ 556(d)	-	Administrative Procedure Act

3. Regulations - 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 412.71(b)(2)	-	Determination of Base Year Costs
§ 412.113 et seq.	-	Payments Determined on a Reasonable Cost Basis.
§ 413.9 et. seq.	-	Cost Related to Patient Care
§ 413.20 et. seq.	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.130 et seq.	-	Capital-Related Costs

4. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2802	-	Payment Rates During Transition
§ 2806	-	Capital-Related Costs - General
§ 2925.2	-	Evidence

5. Case Law:

Kaiser Foundation Hospitals Group -- Pass Through Costs v. Ætna Life Insurance Company, PRRB Dec. No. 92-D10, February 12, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,016.

Mercy Hospital of Miami v. Blue Cross and Blue Shield Association, PRRB Dec. No. 91-D66, Aug. 23, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,589.

Richardson v. Perales, 402 U.S. 389, 402 (1971).

Bennett v. National Transportation Safety Board, 66 F.3d 1130 (10th Cir. 1995).

Calhoun v. Bailar, 626 F.2d 145, 148 (9th Cir. 1980).

Burlington Truck Lines, Inc. v. United States, 371 U.S. 156 (1962).

SEC v. Chenery, 318 U.S. 80 (1943).

SEC v. Chenery, 332 U.S. 194 (1947).

Phelps Dodge Corp. v. NLRB, 313 U.S. 177 (1941).

Compania De Gas DeNuevo Laredo, S.A. v. FERC, 606 F.2d 1024 (D.C. Cir. 1979).

6. Other:

51 Fed. Reg. 19971 (1986).

53 Fed. Reg. 38476 (1988).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that a portion of the Intermediary's adjustments is improper.

The Provider claimed certain lease expenses as capital-related pass-through costs in its 1986 and 1987 cost reports. The Intermediary reclassified these expenses from capital-related costs to operating costs based upon Medicare's consistency rule at 42 C.F.R. § 412.113. In effect, the Intermediary concluded that the subject lease expenses were for equipment similar to that leased by the Provider in its PPS base period and whose costs were treated as operating expenses and included in the Provider's HSR. Consistent with the intent of 42 C.F.R. § 412.113, the Intermediary made its adjustments to prevent the program from paying for these costs twice, i.e., once through the HSR and once again as capital-related pass-through costs.

The Administrator, upon review of this matter, acknowledged that reliance upon 42 C.F.R. § 412.113 to adjust the Provider's 1986 cost reporting period is proper, however, reliance upon this rule to adjust the Provider's 1987 cost report is not. The Provider's 1987 cost reporting period began on January 1, 1987, and the Administrator noted that 42 C.F.R. § 412.113, with respect to capital-related costs, is effective only with cost reporting periods beginning before October 1, 1986.

The Board, having also considered this matter based upon the Administrator's remand, acknowledges that it is bound by program regulations. Since the language of 42 C.F.R. § 412.113 is clear, the Board finds that the basis of the Intermediary's adjustments to the Provider's 1987 cost report is improper. Contrary to the Intermediary's arguments, the Board concludes that 42 C.F.R. § 412.113 is not effective for cost reporting periods beginning on or after October 1, 1986.

Notwithstanding, the Board finds that there is a regulatory basis relevant to the Intermediary's adjustments to the Provider's 1987 cost year. And, even though this basis was not cited by the Intermediary when effectuating its adjustments, it must be applied to determine the Provider's total allowable program reimbursement.

Specifically, the Board finds that the requirements of 42 C.F.R. § 413.9 apply to the Provider's 1987 cost reporting period. Moreover, these requirements have the exact same effect on the Provider's capital-related costs in the 1987 cost year as the consistency rule would have if it were applicable. This means that if the 1987 lease expenses at issue in this case are reflected in the Provider's HSR they may not be reimbursed in any other manner through the Medicare cost finding process, i.e., they may not be treated as capital-related pass-through costs.

Pursuant to 42 U.S.C. 1395ww(a)(4), capital-related costs are excluded from the definition of inpatient operating expenses under PPS for cost reporting periods beginning before October 1, 1987. And, pursuant to 42 C.F.R. § 412.113, these capital-related expenditures continue to be reimbursed in accordance with Medicare's "reasonable cost" principles. In this regard, regulations at 42 C.F.R. § 413.9 provide rules effecting program payments made on the basis of reasonable cost. In part, 42 C.F.R. § 413.9(a) states:

> [a]ll payments to providers of service must be based on the reasonable cost of services. . . Reasonable cost includes all necessary and proper costs incurred in furnishing services. . .

42 C.F.R. § 413.9.

The Board concludes from this portion of the program's rules that duplicate costs, which is the precise circumstance that would exist if costs reflected in an HSR were also recognized as pass-through costs, are not necessary and proper, and the program is prohibited from making payments for them.

The Board notes that 42 C.F.R. § 413.9(b)(2) defines necessary and proper costs as: "costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." Respectively, the Board does not dispute the Provider's need to incur the subject lease expenses in its 1987 cost reporting period. Rather, the Board's focus is on

the methodology used to determine that portion of the expenses applicable to the Medicare program. In this regard, regulations at 42 C.F.R. § 413.9(b)(1) state, in pertinent part:

> [r]easonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used. . . The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.

42 C.F.R. § 413.9(b).

The Board finds that if the program were to recognize the subject lease expenses as capital-related pass-through costs in the Provider's 1987 cost reporting period, and if those costs are already reflected in the Provider's HSR, then the program would bear costs attributable to non-Medicare patients inconsistent with 42 C.F.R. § 413.9(b).

And finally, the Board notes 42 C.F.R. § 413.9(c) which explains the intent of the Medicare program that payments meet a provider's "actual" costs, and that such payments be "fair" to the provider as well as the contributors to the Medicare trust fund. Clearly, these requirements would not be met if the program were to pay for the same costs twice.

The Board, having concluded that the lease costs at issue in this case must be treated consistently in both the Provider's 1986 and 1987 cost reporting periods as they were treated in the Provider's PPS base period, turns to the substantive issue. In this regard, the Board finds that the fundamental issue in this case, whether or not the Intermediary properly reclassified certain lease rental payments from capital costs to operating costs, must be decided on a lease by lease basis considering each individual item involved. This type of analysis is necessary because there are several factors to be considered which may or may not apply in each instance. Initially, it must be determined if a leased item is totally new to the Provider or whether it actually replaced an item that existed in the PPS base period. This review is necessary because there is no record of the lease costs included in the Provider's HSR and, therefore, only costs attributable to "totally new non-replacement" equipment could be treated as capital pass-through costs without jeopardy of paying for the same costs twice, i.e., once through the HSR and again as a pass-through. This review is consistent with the Board's decision in Kaiser.

It must also be determined if there is adequate documentation to support the Provider's claim in each particular instance, and whether or not the Provider's claim is consistent with the financial data placed into evidence. The Board notes that much of its analysis must be based upon Provider testimony since a copy of each applicable lease is not available.

With respect to the individual leases at issue in this case and the specific items of equipment involved, the Board finds as follows:[56]

- 1983 and 1986 Automobiles - The Intermediary's adjustment is proper. The Board is not convinced that the subject vehicles were "totally new"to the Provider's operation. The Provider testified that it owned vehicles during the base period. Therefore, a potential for duplicate payments exists if the 1983 and 1986 automobile lease expenses were allowed capital pass-through treatment, since the costs of the previously owned vehicles may have been included in the HSR. Additionally, the Provider's claim is inconsistent with its financial documentation. Although the term of the 1986 automobile lease extended through July 1989, the Provider did not claim automobile rental expenses in 1987.

- 1983 EKG Equipment- The Intermediary's adjustments are proper. The Board finds that the Provider obtained sophisticated, computerized EKG equipment through the subject lease. However, the Provider possessed EKG equipment in its PPS base period. Although the newer equipment may be far superior to the equipment that was available to the Provider in its PPS base period, it is clearly similar equipment whose costs would create a potential for duplicate payments if they were allowed capital pass-through treatment.

- 1986 Mammography Equipment - The Intermediary's adjustments are improper. The subject mammography equipment was acquired after the Provider's PPS base period, and was not acquired to replace similar equipment. The Board finds that the Provider had no mammography equipment before 1986. Prior to this time, the Provider relied upon a filtered radiography machine to get images of the breast. The Board agrees with the Provider that the filtered radiology process does not produce the same, or even similar results as that obtained from mammography equipment. The Provider's claim is also supported by copies of the applicable leases.

- 1985 Operating Room Tables and Lights - The Intermediary's adjustments are proper. The subject equipment was clearly obtained to replace equipment possessed by the Provider in its PPS base period. Although the subject tables and lights are portrayed to be far superior to the equipment they replaced, they are not so dissimilar as to be considered "new" to the Provider in the context of HCFA's consistency rule.

  In addition, the Board rejects the Provider's argument that the costs of the subject tables and lights can be afforded capital pass-through treatment because there is no risk of double payment, i.e., because the original tables and lights had been fully depreciated by the time of the PPS base period, and thus none of their costs are

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56 See Provider's Post-Hearing Brief at Exhibit 1.

included in the HSR. The Board finds this argument inconsistent with a fundamental intent of the HSR, which is to reflect actual base period activity.

- 1984 Coulter Counter - The Intermediary's adjustments are improper. The coulter counter was acquired after the Provider's PPS base period, and was not acquired to replace similar equipment. Prior to obtaining the coulter counter the Provider used a microscope to make random sample analyses of blood counts. A coulter counter is too far advanced from the microscope process to be considered a similar piece of equipment. The Board also notes that evidence of the Provider's costs for the coulter counter are included in its lease schedules.

  The Board emphasizes that the amount of costs improperly reclassified by the Intermediary for the coulter counter are $37,346 for 1986 and $951 for 1987, as shown in Provider's Post-Hearing Brief at Exhibit 1. The Provider explains that the vast difference in these two amounts is attributable to a 1986 refinancing, and that some portion of the 1987 costs for the coulter counter are included in another lease. However, there is no evidence in the record that identifies other costs for the coulter counter and, therefore, the Board restricts its decision to the amounts noted.

- 1984 X-Ray (Angiography) - The Intermediary's adjustment is proper. The subject X-ray appears to have been a "new, non-replacement" piece of equipment considering its unique ability to view the interior structure of a patient's veins and arteries. However, the Board rejects the Provider's claim based upon inconsistencies in the financial evidence presented. Purportedly, the subject lease began in 1984 and ran through 1989. Therefore, the Provider should have incurred costs for this equipment in each of the subject cost reporting periods. However, the Provider is not claiming any costs for the angiography equipment in 1986. In light of this material discrepancy and the lack of any additional substantive documentation such as a copy of the lease, the Board concludes there is insufficient data to support the Provider's claim.

- 1984 Mobile X-Ray - The Intermediary's adjustment is proper. The Board finds that the subject C-arm X-ray is similar to X-ray equipment possessed by the Provider in its PPS base period. Although the C-arm X-ray is portable for ease of operation, it is not so dissimilar in function and purpose from the equipment possessed by the Provider in its base period to be considered "new, non-replacement" equipment. In addition, there are inconsistencies in the financial evidence presented for the C-arm equipment identical to the inconsistencies noted for the angiography equipment, discussed above.

- 1986 Keamed-Hill ROM Lease - The Intermediary's adjustment is proper. Included in this lease are the costs of a CAT scan, a computerized registration system, and patient beds. The Board agrees with the Provider, in that the CAT scan and registration system are "new, non-replacement" items. However, the Board finds that the patient beds are clearly replacement items that may not be allowed capital pass-through

treatment due to the risk of duplicate program payments. Since the costs of the items in this lease are commingled, and the costs attributable specifically to the patient beds cannot be isolated, none of the costs associated with this lease may be treated as capital pass-through costs.

- 1987 U.S. West Equipment Leases - The Intermediary's adjustments are proper. The Provider explained that these leases were used to obtain "various pieces" of laboratory equipment. The Provider did not, however, identify the specific items acquired and explain their relationship to laboratory items that it possessed in the PPS base period. Based upon the evidence submitted, the Board is not persuaded that the different pieces of equipment acquired through these leases are, in fact, "new, non-replacement" items.

DECISION AND ORDER:

The costs applicable to the Provider's 1986 Mammography Equipment Lease, amounting to $21,387 in each of the subject cost reporting periods, are capital pass-through costs. The costs applicable to the Provider's 1984 Coulter Counter Lease, which amount to $37,346 in the Provider's 1986 cost reporting period and $951 in the Provider's 1987 cost reporting period, also are capital pass-through costs. All other lease costs were properly reclassified by the Intermediary from capital pass-through costs to operating expenditures. The Intermediary's adjustments are affirmed in part, and reversed in part.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

Date of Decision: April 07, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman