PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2001-D21

PROVIDER -
Southwest Medical Center-Moore, Inc.
Moore, OK

Provider No. 37-0161

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
Blue Cross and Blue Shield of Oklahoma

DATE OF HEARING-
January 10, 2001

Cost Reporting Period Ended -
December 31, 1993

CASE NO. 97-1287

INDEX

ISSUE:

Were the Intermediary=s adjustments reducing the loss on asset disposal proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider is a 76-bed, general, acute care hospital located in Moore, Oklahoma. This appeal involves the Provider=s terminating cost report for the period November 1, 1993 through December 31, 1993.

The Provider ceased operations on December 31, 1993 and filed a terminating cost report. Upon the sale of the facility in October 1994, it was determined that the Provider had incurred a loss on the sale of the facility. The Provider filed an amended cost report for the terminating cost reporting period reflecting the loss on the sale. The Provider also completed a prior period adjustment on Worksheet E of the amended terminating cost report for the years ending October 31, 1990 through October 31, 1993.

Upon audit of the Provider=s terminating cost report, the Intermediary disallowed portions of the loss allocated to Medicare Part A resulting from the sale of the facility. The Intermediary made these adjustments as the Provider had already been paid for old capital under the hold-harmless payment methodology at 100 percent of the Federal rate.

The Provider was dissatisfied with the Intermediary=s disallowance of its loss and timely appealed to the Provider Reimbursement Review Board (ABoard@). The Board determined that the Provider has met the relevant regulatory requirements of 42 C.F.R. '' 405.1835-.1841. The Medicare reimbursement effect in dispute is approximately $115,000.[1]

The Provider was represented by Cindy Burnett, Esquire, of Vinson & Elkins, L.L.P. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

Medicare Statutory and Regulatory Background:

By statute, HCFA was required to establish a mechanism for Capital PPS beginning with the 1991 federal fiscal year as per 42 U.S.C. ' 1395ww(g). The regulations provide for a ten-year transition period to phase in Capital PPS payments per 42 C.F.R. ' 412.324(a). Capital reimbursement during

[1] Intermediary Position Paper at p. 3.

this ten-year transition period is determined, in large part, by the provider=s Capital PPS Hospital Specific Rate (AHSR@). Id.

A hospital=s Capital PPS HSR is ordinarily based on its capital cost-per-discharge during its 1990 cost-reporting period. If a hospital=s base year cost-per-discharge, and thus its Capital PPS HSR is less than the Capital PPS Federal rate, the hospital is reimbursed under the fully prospective payment methodology during the ten-year transition period. Under this methodology, the hospital is provided with a payment per discharge based on a blend of the Federal rate and the hospital=s HSR, as per 42 C.F.R. ' 412.340. As the ten- year transition period progresses, the percentage of the Federal rate included in the blend increases until the hospital is paid at 100 percent of the Federal rate at the end of the transition period.

If a hospital=s base year cost-per-discharge, and thus its Capital PPS HSR, exceeds the Federal rate, the hospital is reimbursed under the hold-harmless payment methodology during the ten-year transition period. The hold-harmless payment method provides a hospital with a payment per discharge based on the higher of: (1) 85 percent of reasonable costs for the hospital=s old capital plus an amount for new capital costs, or (2) 100 percent of the Federal rate. See 42 C.F.R. ' 412.344(a)(1), (2).

PROVIDER=S CONTENTIONS:

The Provider contends that the Intermediary improperly disallowed reimbursement for the portions of the loss on the sale of the Provider's facility allocated to Medicare Part A for FYEs 1992 and 1993. The Provider notes that Medicare has established rules on the treatment of gains or losses on the sale of a facility owned by a Medicare provider while the provider is participating in the program. Medicare regulations provide that if the disposal of depreciable assets through sale results in a loss, an adjustment upward is necessary in the provider's allowable cost, as per 42 C.F.R. ' 413.134(f)(l). The amount of loss allowed is Alimited to the undepreciated basis of the asset permitted under the program@ and is recognized in the cost reporting period in which the loss occurred. Id. Generally, the total amount of the losses is allocated to all cost reporting periods under the Medicare Program, based on the ratio of the depreciation allowed on the assets in each cost reporting period to the total depreciation allowed under Medicare. The amounts allocated to each cost reporting period are then multiplied by the ratio of Medicare reimbursable cost to total allowable cost for that cost reporting period and the results of this multiplication for all prior periods are added. Id.

The Provider points out that several exceptions to this standard treatment of gains and losses on the sale of a depreciable asset by a Medicare provider are contained in this regulation. These exceptions specifically address adjustments for the portion of gains and losses allocated to hospital inpatient services for cost reporting years covered by Capital PPS. The regulations at 42 C.F.R. ' 413.134 (f)(2)(iii)(D) provide that no adjustment will be made for the portion of gains or losses allocated to inpatient hospital services for which a hospital is paid under the fully prospective payment methodology. In addition, the regulations provide that no adjustment will be made when a hospital is paid under the

hold harmless methodology based on the federal rate for all capital costs or on the federal rate for new capital costs. Id. While the exceptions prohibit adjustments for losses allocated to hospital inpatient services for years covered by Capital PPS in several instances, the preamble to the Capital PPS Regulations (the APreamble@) states that the Medicare Program does allow a prior period adjustment for the portion of losses qualifying as old capital for hospitals receiving a hold harmless payment for old capital under Capital PPS. See 56 Fed. Reg. (August 31, 1991) 43,358, 43,388.

While addressing the treatment of the loss on a sale of a depreciable asset under Capital PPS, neither the Preamble nor the Capital PPS regulations expressly prohibit the inclusion of this loss when the allowance of the loss would increase a provider's old capital costs enough to change the provider's payment under the hold harmless methodology from 100 percent of the federal rate to 85 percent of reasonable cost for old capital. The Provider contends it is in just that situation. If the loss on the sale of the Provider's facility allocated to Medicare Part A for FYEs 1992 and 1993 is allowed in the loss computation for FYE 1993T, then the Provider's old capital costs for those fiscal years would increase. Based on this increase, the Provider's reasonable cost payment for old capital would exceed payment under the federal rate applicable to the Provider for those periods, resulting in the Provider receiving payment under the hold harmless methodology on the basis of reasonable cost instead of the federal rate. Since the Preamble and the Capital PPS Regulations do not expressly preclude the allowance of the loss in the specific situation at hand, the applicable portions of the loss on the sale of the Provider's facility should be allowable under 42 C.F.R. ' 413.134.

The Provider is not in the position where the disputed increase to its allowable costs would still place it in the position of being reimbursed for capital costs at the federal rate. The Intermediary's adjustment fails to take into account that the computation of the loss on the terminating cost report essentially adjusts the allowable depreciation expense in each of the prior periods in which the assets were used for patient care purposes. The computation of the loss does not relate solely to the terminating cost reporting period but instead concerns the proper amount of depreciation expense for prior periods including FYEs 1992 and 1993. The Provider also contends that HCFA Pub. 15-1 ' 132.4.A.3. recognizes that the reasonable cost for depreciation expense relating to prior periods is being recomputed by permitting the Provider to Acompute the adjustment to reimbursable cost by recalculating, for each reporting period, all necessary cost reporting schedules applicable to each cost reporting period covered by the depreciation adjustments.@ Because of the additional depreciation expense relating to prior periods resulting from the loss on disposal, the payment to the Provider for old capital that would be made based on reasonable cost under the hold harmless methodology is greater than the payment that would be made under the federal rate for FYEs 1992 and 1993.

Therefore, the Provider should be reimbursed for the portions of the loss resulting from the sale of the Provider=s facility that were allocated to Medicare Part A for FYEs 1992 and 1993.

The Provider also contends that if the Intermediary denies the claimed losses because of the federal rate exception for treatment of certain losses under capital PPS, the regulation would create arbitrary and

capricious results. The denial of the loss based on the Intermediary interpretation of the regulation disproportionately affects the Provider, since the Medicare Program has for a long time provided for prior period adjustments on the terminating cost report.

If the Board determines that the regulation compels the Intermediary disallowance, the provider further contends that the regulation itself is invalid because it is arbitrary and capricious. The Provider is asserting this argument to preserve this issue for judicial review, in recognition of the fact that the Board does not have the authority to invalidate the regulatory provision.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that upon audit of the Provider=s terminating cost report it disallowed portions of the loss allocated to Medicare Part A resulting from the sale of the Provider=s facility. This was done because the Provider had been paid for old capital under the hold-harmless payment methodology at 100 percent of the Federal rate.

The Intermediary asserts that 42 C.F.R. ' 413.134(f)(2)(iii)(D) states that:

> Effective for cost reporting periods beginning on or after October 1, 1991, no adjustment will be made for the portion of gains or losses allocated to inpatient hospital services for which the hospital was paid under the fully prospective payment methodology as described in 412.340 of this chapter or under the hold-harmless methodology based on the Federal rate as described in 412.344(a)(1) of this chapter for new capital costs or in 412.344(a)(2) of this chapter.

The Intermediary contends that it is bound by the cited regulations and properly disallowed the portions of the loss allocated to Medicare Part A for years in which payment was made under the hold-harmless provisions at 42 C.F.R. ' 412.344. The regulation at 42 C.F.R. '413.134(f)(2)(iii)(D) sets forth the proper treatment of gains or losses allocated to inpatient hospital services for which the Provider was paid under the hold-harmless payment methodology. The Intermediary further contends that its determination to designate the Provider as a hold-harmless Provider was properly made and communicated to the Provider.

Based on the above, the Intermediary believes its adjustments should be affirmed.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law 42 U.S.C.:

' 1395 ww(g) - Capital-related costs for inpatient

hospital services

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

'' 405.1835-.1841	-	Board Jurisdiction
' 412.324 (a)	-	General Description
' 412.340	-	Fully Prospective Payment Methodology
' 412.344 et seq.	-	Hold-harmless Payment Methodology
' 413.134	-	Depreciation
' 413.134 (f)(1)	-	Gains and Losses on Disposal of Assets
' 413.134 (f)(2)(iii)(D)	-	Bona Fide Sale or Scrapping

3. Program Instructions - Provider Reimbursement Manual (HCFA Pub. 15-1)

' 132.4.A.3.	-	Methods Available for Determination of Adjustment to Reimbursable Cost

4. Other:

56 Fed. Reg. 43,358, 43,388 (August 1991)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties= contentions and evidence finds and concludes as follows:

The Board finds that the Provider=s Capital PPS HSR exceeded the Federal rate; thus the Provider was reimbursed under the hold-harmless payment methodology. In the instant case, the Provider received a payment per discharge based on 100 percent of the Federal rate.

The Board finds that the key issue centers around the Intermediary=s disallowance of portions of a loss allocated to Medicare Part A. The loss in question resulted from the sale of the Provider=s facility. The Board notes that the controlling regulation at 42 C.F.R ' 413.134(f)(2)(iii)(D) states the following:

> AEffective for cost reporting periods beginning on or after October 1, 1991, no adjustment will be made for the portion of gains or losses allocated to inpatient hospital services for which the hospital was paid under the fully prospective payment methodology as described in ' 412.340 of this chapter or under the hold-harmless methodology based on the Federal rate as described in '412.344(a)(1) of this chapter for new capital costs or in '412.344(a)(2) of this chapter.@

The Board finds that in view of the fact that the Provider had been paid for old capital under the hold-harmless payment methodology, the Intermediary was correct in disallowing losses allocated to Medicare Part A for FYEs 1992 and 1993, based on the regulation cited above.

The Board notes that the Provider has argued that in addressing the treatment of the loss on the sale of assets under Capital PPS, neither the Preamble nor the Capital PPS regulations expressly prohibit the inclusion of the losses when their allowance would increase a provider=s old capital costs enough to change the payment under the hold-harmless methodology from 100 percent of the federal rate to 85 percent of reasonable cost. While acknowledging the Provider=s position, the Board finds that the Secretary could have chosen to address this particular issue in the Capital regulations but has opted not to do so. Therefore, absent any specific law or regulation supporting the allowability of the Provider=s claimed losses, the Board finds that the Intermediary is bound by the cited regulation.

The Provider also argues that if the Board finds that the governing regulation compels the Intermediary=s disallowance, the regulation itself is invalid because it is arbitrary and capricious. The Board finds that this argument is without merit as the Board does not have the authority to invalidate any regulatory provisions.

The Board also notes that in addition to the issue dealing with the loss on the disposal of assets, there were also three smaller adjustments made as per Intermediary adjustments 8, 14, and 17. These adjustments were set forth in the Intermediary=s position paper but were not briefed or addressed by the Provider.[2] The Board finds that the information submitted by the Intermediary supports the proposed adjustments.

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[2] Intermediary Position Paper at p. 2 & 3.

DECISION AND ORDER:

The Intermediary=s=s disallowance of the portions of the loss on the Provider=s sale of its facility allocated to Medicare Part A for the fiscal years 1992 and 1993 was proper. The Intermediary=s other adjustments to reduce the loss on asset disposal were found to be proper. The Intermediary=s adjustments are sustained.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: Apr. 26, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman