PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D15

PROVIDER –
Long Island State Veterans Home Stony
Stony Brook, New York

Provider No. 33-5758

vs.

INTERMEDIARY –
Blue Cross and Blue Shield
Association/Empire Medicare Services

DATE OF HEARING-
January 10, 2002

Cost Reporting Period Ended
December 31, 1993

CASE NO. 96-1651

INDEX

ISSUE:

Is it proper for the Intermediary to apply the lower of cost or charges (LCC) principle in calculating the Provider's reimbursement on the Medicare cost report Worksheet E, Part I?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Long Island State Veterans Home (Provider) is a skilled nursing facility (SNF) operated by the State of New York through the State University of New York (SUNY). The facility was constructed as a result of a federal grant program established by the United States of America Veterans Administration (VA), which encouraged states to construct and operate such facilities in order to treat aging veterans that the VA anticipated it would be unable to accommodate in its own facilities. The Provider admits only veterans and "gold star mothers" of veterans. As a result, the population it serves is not the "general public," but veterans who would otherwise be served by a facility operated and funded by the VA.

When the New York State Department of Health (DOH) granted certificate of need approval to SUNY to construct an SNF with 350 beds, it required these beds to be phased in over several years.[1] Accordingly, although the facility opened its first 60 bed unit in October 1991, it was still in the process of phasing in units in 1993. Only 180 beds had been certified to open at the beginning of 1993. By the end of 1993, the year in dispute before the Provider Reimbursement Review Board (Board), all 350 beds had been certified to open, but only 295 of these were staffed.[2]

Medicare and Medicaid both treated the Provider as a "new provider" for 1993. Medicare granted the Provider an exemption from the routine cost limits as a new provider.[3] The state agency responsible for setting the Medicaid rate, DOH, also treated the Provider as a "new provider," establishing the Provider's Medicaid rate on a budgeted basis.

The Provider had no established charge structure and did not have a schedule of charges for individual services. Instead, it was an all-inclusive rate structure facility. Moreover, the Provider did not have a uniform all-inclusive rate for all services. Instead, it had two all-inclusive rates for Medicare: one for Part A ($150.00 per day) and another for Part B ($.25 per day). These rates were fixed throughout 1993. The rate for all other patients changed repeatedly during 1993 because the State of New York established the Medicaid rate for this new provider on a budgeted basis and required the rate to be adjusted throughout the year to

[1] See Provider Exhibit P-14.

[2] See Provider Exhibit P-7.

[3] See Exhibit P-15, which is a copy of Provider's request for an exemption to the Routine Cost Limits. See, also 1993 ICR Worksheet D-1, L.24, attached as Exhibit I-2, which shows the Intermediary granted this exemption.

reflect case mix from assessments that placed residents into one of several Resource Utilization Groups (RUGS).[4] In addition, the state made a number of retroactive changes in the Medicaid rate to reflect adjustments to actual costs and changes in the inflation factor which, by law, could not be passed on to private pay patients since state law required giving advance notice to patients of the rate they would be charged.

The Medicaid and private pay rates were each a single all-inclusive daily rate. These rates covered capital costs, routine operating costs and ancillary service costs, including the costs of professional services such as dentistry and physician services. These professional services were not included in the Medicare Part A rate.

The 1993 Medicaid rate was revised at least 23 times for services rendered during 1993. The Provider started 1993 with an all-inclusive Medicaid rate of $137.86. Thereafter, DOH changed the Provider's Medicaid rate at least five times during 1993, with most of these rate changes effective for Medicaid patients on a retrospective basis. In addition, DOH issued at least eighteen additional rate changes after 1993 which retrospectively affected the Provider's Medicaid rate for services rendered during 1993. DOH did not issue a final Medicaid rate for 1993 until after the Provider had filed its first Medicaid cost report, which it could not do until it had reached 90% occupancy of its fully certified capacity for a period of six months. Thus, it retroactively adjusted the Provider's Medicaid rate effective January 1, 1993 to $143.94 and retroactively adjusted the Provider's Medicaid rate effective December 1, 1993 to $169.57. These are the Provider's final Medicaid rates.[5]

In 1993, the Provider charged all veterans whose stay was not covered by Medicare and who had not yet qualified for Medicaid the same all-inclusive daily rate as the then existing Medicaid rate. The list of services covered by this all-inclusive daily rate was the same as the Medicaid list of covered services. The daily rate charged to these patients changed seven times during 1993.

As a result of these legal restrictions, although the Provider's final Medicaid rate for services rendered during 1993 ranged from $143.94 to $169.57, the Provider's private pay rate ranged from $137.86 to $151.12. The most frequently charged "private pay" rate was $150.08. Since the Provider phased in additional beds in the fall of 1993, the rate it charged to all private pay patients during the last two months of 1993 ($150.08) was the most frequently charged rate. Thus, in 1993 the Provider charged $150.08 for 4259 days of care to private

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[4] See 10 NYCRR § 86-2.15.

[5] See Provider Exhibit P-17, which includes a copy of each Medicaid rate computation sheet affecting rates for services rendered during 1993. Provider Exhibit P-19 is a summary of these Medicaid rate changes with a comparison to the private pay rate changes.

pay residents. The next most frequent rate was $151.12, which the Provider charged for 3813 days of care to private pay residents.[6] The most frequent charge to private pay patients who had no Medicare Part A or Part B coverage was also $150.08.[7] In 1993, the Provider served only five veterans who had no Medicare Part A or Part B coverage and had not yet qualified for Medicaid. A list of these veterans, with their dates of residence, total number of days in the Facility (738), and total billed charges ($108,054) is attached as part of Exhibit P-19.

When the Provider filed its Medicare cost report for 1993, it did not apportion any of its costs on the basis of charges. Instead, as an all-inclusive rate structure facility, it was required to and did apportion its Part A costs on the basis of days and its Part B costs on the basis of statistics (visits or treatments). In its as-filed cost report, the Provider listed charges for each of Part A and Part B that exceeded its reported costs. It did so because it believed that LCC did not apply. Indeed, New York State Medicaid did not apply LCC to the Provider. Its total Part A costs were $2,003,534, and it listed Part A charges of $2,600,000.[8] Its Part B costs were $834,923, and it listed $900,000 in Part B charges.[9]

After a field audit, the Intermediary issued 34 adjustments[10] and issued a revised cost report.[11] After audit, the Provider's total Part A inpatient reasonable costs increased to $2,138,184.[12] The Intermediary adjusted the Provider' s Part A charges to $1,429,194,[13] apparently using the Provider's charges to Medicare Part A patients as reported on the

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[6] See Exhibit P-19. Note that the data on Exhibit P-19 is for all "private pay" patients, including those who had Medicare Part B coverage.

[7] See Exhibit P-19.

[8] See Intermediary Exhibit I-2, ICR Worksheet E, Part I, Lines 11 and 14.

[9] See Intermediary Exhibit I-2, ICR Worksheet E, Part II, Lines 8 and 11. The Provider's actual Part B charges, as shown on the Part B remittances attached as Exhibit P-24, totaled $17,234.50.

[10] See Intermediary Exhibit I-3.

[11] See Provider Exhibit P-25.

[12] See Provider Exhibit P-25, ICR Worksheet E, Part I, L. 11.

[13] See Provider Exhibit P-25, ICR Worksheet E, Part 1, Line 20, which revised these charges to be $1,429,194. (Note - there is no audit adjustment which adjusts the Provider's reported Part A charges of $2.6 million down to $1.4 million.)

Medicare PS&R report.[14] The Intermediary then disallowed $708,990 of the Provider's reasonable inpatient Part A costs for 1993 on the ground that those costs exceeded the reduced charges the Intermediary had listed as the Provider's customary charges. The Intermediary reduced the inpatient ancillary service costs allocated to Part B to $605,093.[15] The Intermediary also issued an audit adjustment reducing the Provider's Part B charges to $ 206,765.[16] Despite this, it listed Part B charges of $430,318[17]on the Provider's revised cost report. The Intermediary then applied the lower of costs or charges to Part B, paying the provider $430,318 (the amount listed on the revised cost report as Part B charges), thereby disallowing $174,775 of its Part B costs.

The Provider filed a reopening request with the Intermediary disputing the application of LCC to Medicare Part B. The Intermediary agreed to reopen and on March 14, 1996 reversed the application of LCC to Part B. The audit adjustment issued by the Intermediary after the reopening increases the Provider's Part B charges from $430,318 to $700,000, so that the Provider's Part B charges are greater than its Part B ancillary service costs of $605,093. The Intermediary stated its reason for the audit adjustment as follows: "To adjust to increase charges to prevent all-inclusive provider from the lower of cost or charges adjustment." (Emphasis added.)[18] Thus, in the context of the Part B reopening, the Intermediary has taken the position that LCC does not apply to this Provider because of its all-inclusive rate structure.

This appeal challenges the Intermediary's application of LCC to disallow $708,990 of the Provider's Part A costs for 1993. The Provider's appeal meets the jurisdictional requirements

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[14] See Provider Exhibit P-26, which is a workpaper prepared by the Intermediary. It appears that the Intermediary based this number on the Provider's Part A charges, as reported on the PS&R, adjusted by 1.5% to estimate late claims.

[15] See Provider Exhibit P-25, ICR Worksheet E, Part II, L.8.

[16] See Audit Adjustment 11 in Intermediary Exhibit I-3. See also the Workpaper prepared by the Intermediary's auditors, attached as Provider Exhibit P-26, where the Provider was recognized as an "all-inclusive rate provider."

[17] See Provider Exhibit P-25, ICR Worksheet E, Part II., L. 11. There is no worksheet or audit adjustment supporting the amount the Intermediary listed on this cost report for the Provider's Part 13 charges. In fact, the Provider charged Medicare $.25/day for each resident with Part B coverage. Its Medicare Part B remittances show that its actual Part B charges totaled $17,234.50. See Exhibit P-24.

[18] A copy of the Audit Adjustment is attached as Exhibit P-27. The final cost report issued after the reopening is Exhibit I-2.

of 42 C.F.R. §§ 405.1835-.1841. The Provider is represented by Robert J. Lane, Esquire, of Hodgson Russ. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

INTERMEDIARY CONTENTIONS:

The Intermediary contends that there are two critical issues which the Board must decide. They are:

A. Whether the determination of a nominal charge public provider is made based solely on Medicare patients; and,

B. Whether the Provider's charging pattern is so aberrational or discordant that it negates applying LLC.

Regarding nominal charges, the Intermediary argues that the LCC regulation at 42 C.F.R. § 413.13(a) offers a definition of public provider. Both the appealing Provider and the Intermediary agree that the facility is a public provider. 42 C.F.R § 413.13(c) exempts public providers and certain non-public providers
from application of LCC. The nominal charge measure that is the same for public and qualifying non-public providers is found at 42 C.F.R. § 413.13(f). All of the Provider's patients were inpatients so all costs and revenues related to inpatients. It offers no outpatient services.

The Intermediary argues that the 60% charge to cost maximum test for nominality was exceeded based on the Provider's financial statements,[19] Schedule of Revenue and Expenses:

Private	$ 2,778,040
Medicare	$ 1,416,150
Medicaid	$ 7.551.760
Net Patient Revenues	$ 11,746,000

Total expenses were $17,794,056. The resulting percentage exceeded 66%. While the Provider took issue with the accuracy or interpretation of its own financial statements,[20] the revenue figures are reflective of charges for the year. The Provider witness urged the Board to read the comparable figures used in the nominality calculation as being isolated to Medicare only.[21] To refute that argument one should interface 42 C.F.R. § 413.13(c)(ii)

[19] See Intermediary Exhibit 5.

[20] Transcript (Tr.) at 209.

[21] Tr. at 189-192.

with the nominality standard added in. It would read public providers furnishing services free of charge or at a nominal charge [60% of reasonable cost] are paid fair compensation. The Intermediary asserts that one must next ask the one question as to whether 60% should be calculated solely off the one category of patients who do not pay charges. The plain reading is to use all patient charges and costs to determine whether a facility furnishes services at a nominal charge. 42 C.F.R. § 413.13(c)(iii) applies to non-public providers and requires a facility seeking relief to identify its low-income patients. In a public provider, the impact or presence of high a volume of low-income patients is presumed. The math is the same.

The Intermediary observes that the second branch of the Provider's attack on the LLC limitation focused on HCFA Pub. 15-1 § 2602.2. The Provider's argument that the charge structure was so erratic that it should be disregarded, and that it should be given an LCC exemption does not leap out of the section cited. The facts do not justify relief, even under the questionable legal premise.

The Intermediary argues that the Provider has an all-inclusive rate structure that in a conceptual sense is uniformly applied to all patients. There is a single rate applied for most services. The qualifier applies to dental services whose costs after step-down on Worksheet B of the Medicare cost report are less than 1% of total costs. The total therapy and physicians costs which were part of the services covered by Part B which the Provider used to define nominality of Medicare services only account for 5.6% of total service costs ($994,019 out of $ 17,774,651). Routine costs account for 93.3% of costs after step-down, and the all-inclusive charge structure is conceptually applied in a consistent manner to Medicare, Medicaid, and private paying patients.

The Intermediary notes that the reason why the private rates were less than the Medicaid rate was timing. The Medicaid rate was consistently being revised upwards. A revision might apply retroactively. Rates to the private patients could only be raised after notice. That difference does not invalidate the use of actual charge structure and serve to exempt the Provider from LCC. At best, the Provider's argument would suggest plugging in some average rate charged to private pay in the charge side of the LCC calculation. In reviewing the timing of the rate charges, the outcome would be a lower rate than $146.00. The Intermediary is not advocating that result.

The Intermediary observes that, as its name implies, the Provider is a state owned skilled nursing facility that takes qualified military veterans and other qualified non-veterans as patients. The Provider contends that its admissions come from veterans on the lower end of the economic spectrum. Looking at patient classifications for inpatient coverage, the payor categories and days for the period in dispute are:

	Days	Percent
Medicare	9,789	12.2 %
Medicaid	50,700	62.9 %
Other	20,010	24.9 %
Total	80,499	100 %

The other category generally does not include patients with third party coverage. They are responsible for payment of their care. The Provider contends that the self-pay or other patients are, in reality, those who exhausted their Part A Medicare coverage and have no Medicaid coverage. Their personal estates are being "spent down" so as to qualify for Medicaid. What services that are covered under Medicare Part B must be considered. Part B covers certain ancillary services if coverage conditions are satisfied. Part B comes into play only when coverage under Part A has been exhausted. In an all-inclusive no charge provider, cost apportionment to Medicare is more complicated. Instead of simply using charges as an apportionment tool, a statistical record based on payor class users of services must be kept. A separate charge must be kept for Medicare Part A and Part B patients, so costs for the Medicare services can be appropriately identified between programs. There are no patients other than the Part B recipients who have ancillary type services paid one way and routine costs paid differently. There is no identifiable charge assessed a self-pay patient for the ancillary services alone in a comparable circumstance because it is likely that there are none.

The Intermediary observes that the Provider complains that the Medicare regulations in place during the fiscal period at issue reflect an elimination of an LCC adjustment carryover to future periods for new providers. 42 C.F.R. § 413.13(h)(5). The argument is that the elimination is contrary to Congressional intent. There are two responses. First, the Board must accept the regulation at face value, 42 C.F.R. § 405.1867, and the carryforward was clearly eliminated. Second, the argument is premature. A challenge to the regulation would have a procedural basis only in a period in which charges exceed costs and could absorb the loss.

PROVIDER'S CONTENTIONS:

The Provider contends that the policy underlying the Medicare reimbursement methodology supports the Provider's position. The Medicare statute requires that skilled nursing facilities be reimbursed for the reasonable cost of providing services to Medicare beneficiaries. 42 U.S.C. § 1861(v)(1). The policy behind this provision is straightforward and clear: Congress wanted to ensure that medical services would be available to Medicare beneficiaries, and it recognized that providers could not continue offering services to Medicare beneficiaries unless they were reimbursed at a rate which at least allowed them to cover their costs. 42 C.F.R. § § 413.5 and 413.50. The Provider observes that the LCC limitation was adopted because of Congress' finding that it is inequitable for the Medicare program to pay more for services than the provider charges the general public. Congress was

concerned about cost shifting from other payors to Medicare. 42 C.F.R. § § 413.50(a) and 413.53(a).

The Provider asserts that the LCC limitation on reimbursement is not applicable to a provider that charges for its services based on a non-uniform, all-inclusive rate structure. It also argues that Congress' purpose in authorizing the LCC limitation does not apply to the facts of this case. First, the Provider does not offer services to the general public; it serves only veterans of the United States armed forces.[22] Moreover, almost every patient in the facility during 1993 was covered by either Medicare or Medicaid. In fact, only 5 patients out of 285 were not paid for by either Medicare or Medicaid.[23] Utilizing rates applied to a *de minimus* number of patients (here, 1.7%) to disallow 33% of a facility's total reasonable Medicare Part A costs is directly contrary to Congress' clearly expressed intent. Second, the Provider does not bill patients on the basis of charges. Instead, it has an all-inclusive rate structure.

The Provider observes that the Intermediary's argument that the lack of uniformity in the Provider's rate schedule is a mere "technicality," and that it should nevertheless be used as a customary charge, ignores the nature and purpose of the LCC limitation and is factually inaccurate. The Intermediary did not dispute any of the foregoing facts relating to lack of uniformity among the various all-inclusive rates charged by the Provider to different types of patients. Instead, the Intermediary essentially argued that, while the Provider's all-inclusive rate structure may not be uniform, it is "uniform enough" that it should be used as a customary charge in applying the LCC limitation. The Provider argues this position ignores the fact that the LCC limitation is a narrow exception to the general rule that a provider should be reimbursed for its reasonable costs.

The Provider contends that it had no customary charges. It is important to recognize the LCC principle for what it is--a payment limitation. The presumption underlying the Medicare reimbursement methodology is that Medicare would reimburse skilled nursing facility providers for the reasonable cost of providing services. The principle underlying the LCC limitation requires a comparison of the amount Medicare pays to the amount of the provider's customary charges to non-Medicare patients for specific services. As a result, the LCC limitation can only be applied where the provider has charges for specific services. Without such charges, there is no basis for applying the LCC to reduce reimbursement to a provider.

The Provider observes that the applicable regulation and manual provision also make clear that the LCC principle can be applied only where a provider has customary charges. 42 C.F.R. § 413.13(b); Provider Reimbursement Manual (PRM) § 2600. Patients who pay an all-inclusive rate are not charged for specific services rendered. Indeed, the amount they are charged is fixed and bears no relation to the amount of medical services consumed. The Provider observes that the Intermediary's arguments are also contrary to the PRM, which

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[22] Tr. at 38, 51.

[23] See Exhibits P-7, P-19 (page 2), and P-28; Tr. at 135-36.

recognizes that, in general, providers that charge on the basis of an all--inclusive rate are excluded from application of the LCC principle because an all--inclusive rate is not a

customary charge. As set forth in HCFA Pub. 15-1 § 2604.3, a customary charge is the most frequent or typical charge imposed uniformly for given items and/ or services. HCFA Pub. 15-1 § 2606.2 (B) then sets forth an extremely limited exception to this exclusion: an all-inclusive rate structure may be used as a customary charge for purposes of the LCC calculation if it is uniformly applied to all patients. Because this is, by its very terms, a limited exception to the general rule that an all-inclusive rate structure cannot be considered a customary charge, it should be narrowly construed.

The Provider observes that both the Medicare regulations and the PRM make clear that an all-inclusive rate structure cannot be considered a customary charge for purposes of applying the LCC limitation. Indeed, customary charges are defined by 42 C.F.R. § 413.13(e) as "the charges for services, as defined in 413.53(b)" (the cost apportionment regulation). 42 C.F.R. § 413.53(b) defines "customary charges" as the regular rates for various services that are charged to both beneficiaries and other paying patients who receive the services.

The Provider notes that the Medicare Part A, Part B and Medicaid rates were not set by the Provider, but were mandated by Medicare and Medicaid. The Provider had no input in the setting of these rates.[24] In these circumstances, given that almost all of the Provider's patients were either Medicare or Medicaid beneficiaries, the concept of a customary charge does not apply. It is clear that the all-inclusive rate structure utilized by a provider must be applied to all patients without variance in order for that rate structure to be used for LCC purposes. The Provider's rate structure failed this test for many reasons:

- There were different rates for Medicare patients, Medicaid patients, and private pay patients.

- The Medicare Part A rate remained constant throughout 1993 at $150.00 per day. The Medicare Part B rate remained constant throughout 1993 at $.25 per day.[25]

- The Medicaid rate was established on a budgeted basis and was adjusted throughout the 1993 year and thereafter to reflect case mix, adjustments to actual costs, and changes in the inflation factor. The Provider's 1993 Medicaid rate was revised at least 23 times for services rendered during 1993.[26] The Medicaid rate varied from a low of $136.57 per day in June, 1993 to a high of $169.57 per day.[27]

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[24] Tr. at 54- 56, 57.

[25] Tr. at 55-56.

[26] Tr. at 58.

[27] See Exhibit P-19.

- The rate for patients not covered by either Medicare or Medicaid was different from both the Medicaid and Medicare rates. Private patients were charged a rate that was equal to the interim Medicaid rate in effect at the time the services were rendered and could not, by state law, be retroactively adjusted.

- The Medicaid and private all-inclusive rates covered different services than the Medicare Part A rates. Specifically, the costs of professional services such as dentistry and physician services were not covered in the Medicare Part A rate.[28]

Finally, the Provider argues that the foregoing does not even take account of the fact that its rates are actually for different services. The Medicare Part A rate does not include certain professional services such as the professional component of physician services, which are instead included in the Medicare Part B rate. The Medicare Part B rate does not include certain services such as dental services. The private and Medicaid rates include all services offered by the Provider. This is further evidence that the all-inclusive rates charged by the Provider are not uniformly applied to all patients. None of these facts have been disputed by the Intermediary. In addition, the Provider further observes that the Intermediary previously admitted that LCC should not be applied to the Provider because it was an all-inclusive rate provider.

The Provider contends that even if the Board finds that the Provider's all-inclusive rates can be considered customary charges for LCC purposes, the LCC limitation cannot be applied to the Provider because it is a public provider with nominal charges. See, 42 C.F.R. § 413.13 (c)(1)(ii) and HCFA Pub. 15-1 § 2616. The Provider's calculation shows that its charges are only 51.47% of reasonable costs and are, therefore, clearly nominal.[29] The Intermediary argues that Provider's charges are not nominal, and criticizes the method the Provider applied in making the nominality determination. The Provider counters that, the methodology it utilized conforms with the nominality regulation, while the methodology utilized by the Intermediary is directly contrary to it.

The Provider observes that nominality regulation 42 C.F.R. § 413.13 provides that a provider's charges will be considered nominal and therefore not subject to the LCC limitation if total charges are 60 percent or less of the reasonable cost of services or items represented by these charges. This is illustrated in HCFA Pub. 15-1 § 2606.1. The Provider's method is identical to the methodology for comparing costs to charges set forth in 42 C.F.R. § 413.13(e)(2) and HCFA Pub. 15-1 § 2606.1, except for two differences. First, those provisions compare charges collected with costs, while the Provider's method

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[28] Tr. at 62, 120, 151.

[29] See Exhibit P-28.

compares charges billed with costs. This difference is mandated by 42 C.F.R. § 413.13(f)(2)(ii), which

specifically requires that the nominality calculation be based on charges billed, rather than collected. Second, 42 C.F.R. § 413.13(e) requires separate LCC calculations for Part A and Part B patients. See 413.13(g). In contrast, the nominality regulation, 42 C.F.R. § 413.13(f)(2)(ii), requires that the calculation be performed separately with respect to inpatient and outpatient services. All of the Provider's patients are inpatients.

CITATION OF LAW, REGULATIONS & PROGRAM INSTRUCTIONS:

1. Law 42 U.S.C.:

§ 1861 (v) (1) (a)	-	Reasonable Cost

2. Regulations – 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jursidiction
§ 405.1867	-	Sources of Board Authority
§ 413.5	-	Cost Reimbursement: General
§ 413.13, et seq.	-	Amount of Payment If Customary Changes For Services Furnished Are Less Than Reasonable Costs
§ 413.50, et seq.	-	Apportionment of Allowable Costs
§ 413.53 et seq.	-	Determination of Cost of Services to Beneficiaries

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

§ 2600	-	Principle
§ 2604.3 et seq.	-	Customary Charges
§ 2606.1	-	Treatment of Providers Which Do Not Satisfy the

		Customary Charges Provisions of Section 2604.3
§ 2606.2 et seq.	-	Treatment of Providers With Special Charge Structures
§ 2616	-	Public Providers

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board, after considering the Medicare law, regulations, program instructions, the facts, parties' contentions and post-hearing briefs finds and concludes that the Intermediary inappropriately applied the LCC regulation to this Provider's costs.

The Board finds the following facts as undisputed. First, the filed Medicare cost report reflects allowable and reasonable incurred costs. All costs were allocated to appropriate cost center areas, including routine, ancillary and non-allowable Medicare services such as dentistry. Costs were further properly apportioned between Medicare Part A and Part B services based on appropriate statistics. Services were rendered primarily to U.S. veterans and not to the general public. Medicare share of days was 12.2%. Medicaid share of days was 62.9%, and private pay share of days was 24.9%. There were only five private pay patients in 1993. Private pay patients all inclusive rates were based on relevant Medicaid rates set by the State of New York. Rate changes for private pay patients required a 30 day notice. They were based on charged Medicaid patient rates and were prospective in nature. Medicaid rates were revised at least five times in 1993 and eighteen times after 1993, or a total of twenty-three for 1993. The Intermediary did not apply the LCC regulation limitation to the Provider's Part B costs because the Provider was an all-inclusive rate provider.

An analysis of these findings of fact shows that all charges made by the Provider for all types of patients were based either on the Medicare or Medicaid patient rates. This includes the all-inclusive rate charged by the Provider for private pay patients. However, the Board finds that the Provider did not have a uniform all-inclusive rate for all patients. The regulation at 42 C.F.R. § 413.13 requires a comparision of the Provider's allowable costs with the customary charges for these services. 42 C.F.R. § 413.13(e) states that customary charges are those defined in 42 C.F.R. § 413.53(b). That latter section defines customary charges as those charges which are regular charges for various services that are charged to both Medicare beneficiaries and all other patients who receive the services.

In reviewing the evidence, the Board concludes that the Provider had no customary charges within the regulatory definition. The Provider had rates by payor type: Medicare, Medicaid (a state based rate modified 23 times) and Private Pay (based on revised Medicaid rates and applied prospectively, after notification). These are multiple rates, not a customary, uniform rate applied to all patients, including Medicare patients. As such, the Board concludes that

the Intermediary's application of the LCC regulatory limit for Medicare Part A costs was improper. This conclusion is supported by the Intermediary's reversal of its original denial of Medicare Part B costs under the LCC provision. The Intermediary essentially allowed full Part B costs based on the premise that LCC does not apply to an all-inclusive provider.

The Board notes that extensive arguments were presented by both parties regarding whether or not the Provider is a public provider with nominal charges under 42 C.F.R. § 413.13(c)(1)(ii)(iii) and therefore not subject to the LCC provisions. The Board finds these arguments moot since it has already determined that LCC does not apply to this Provider because it does not have the required regulatory customary charges that need to be compared with the Provider's costs.

DECISION:

The Intermediary inappropriately applied the LCC regulatory limitation to the Provider's Medicare Part A costs. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Stanley J. Sokolove, CPA
Gary B. Blodgett, DDS

DATE OF DECISION: February 26, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman