PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2005-D30

PROVIDER -
Community Care Hospital
New Orleans, LA

Provider No.: 19-4056

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
TriSpan Health Services

DATE OF HEARING -
December 20, 2004

Cost Reporting Period Ended
April 30, 1999

CASE NO.: 03-0901

INDEX

ISSUE:

Whether the Intermediary erred when it adjusted the method of reimbursing the Provider's skilled nursing facility (SNF) from cost-based reimbursement to the prospective payment system (PPS).

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This dispute arises under the Federal Medicare program administered by the Centers for Medicare and Medicaid Services ((CMS) formerly the Health Care Financing Administration (HCFA)). The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395-1395cc. CMS is the agency of the Department of Health and Human Services responsible for administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies know as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law, regulations and interpretative guidelines published by CMS. See, 42 U.S.C. § 1395(h), 42 C.F.R. §§ 413.20-413.24.

Section 4432 of the Balanced Budget Act of 1997 (Public Law 105-33) mandated the implementation of a per diem PPS for SNFs for all costs of covered services furnished to beneficiaries under Part A of the Medicare program effective for cost reporting periods beginning on or after July 1, 1998. 64 Fed. Reg. 41664 (July 30, 1999). Under PPS, SNFs are no longer paid under the reasonable cost-based system, but rather through per diem prospective case-mix adjusted payment rates applicable to all covered SNF services. Id. at 41645.

SNF PPS uses per-diem Federal payment rates based on mean SNF costs in the base year updated for inflation to the first effective period of the system. The Federal payment rates were developed using allowable costs from hospital-based and free-standing SNF cost reports during the base year, i.e., for cost reporting periods that began in fiscal year 1995. The rates were then updated to the first effective year of the PPS (the 15 month period beginning July 1, 1998) using the SNF market basket index and standardized for facility differences in case-mix and for geographical variations in wages. Id.

Beginning with a provider's first cost-reporting period beginning on or after July 1, 1998, there was a transition period covering three cost-reporting periods. During this transition period, SNFs received a payment rate comprised of a blend of the Federal rate and a facility-specific rate based on each facility's fiscal year (FY) 1995 cost report. Id. SNFs that received their first payment from Medicare on or after October 1, 1995, received payment according to the Federal rates only. 42 U.S.C. 1395yy(a)(2)(D)(ii).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Community Care Hospital (Provider) is a 40-bed psychiatric hospital that was certified for participation in the Medicare program in 1994. For the FY under dispute, the

Provider filed a 13-month cost report for the period beginning April 1, 1998, and ending April 30, 1999. [1] The Provider's usual cost reporting period begins on May 1 and ends on April 30.

On April 8, 1999, one floor of the Provider was certified as a hospital-based SNF. On its as-filed cost report, the Provider claimed reimbursement for the SNF on the reasonable cost basis. When it audited the cost report, the Intermediary adjusted the reimbursement methodology to PPS. However, on August 20, 2001, the Centers for Medicare and Medicaid Services (CMS) indicated that the SNF should be reimbursed under the cost-based methodology because its FY 1999 cost report began on April 1, 1998, which was prior to the first cost reporting period to which SNF PPS was applicable—July 1, 1998.[2] The Intermediary accordingly reversed its adjustment to allow the SNF to be paid on a reasonable cost basis. Subsequently, on October 1, 2001, the CMS Administrator indicated that the Provider should be reimbursed under PPS because its first cost reporting period began after July 1, 1998.[3] The Intermediary withdrew its reversal and adjusted reimbursement for the SNF from cost-based to PPS.

PARTIES' CONTENTIONS

The Provider contends that it should not be reimbursed under SNF PPS for the FY ended April 30, 1999, because this was not the Provider's first cost reporting period ending on or after July 1, 1998. The first cost reporting period to which the Provider should be subject to SNF PPS began on May 1, 1999. The fact that a provider does not admit its first patient until after July 1, 1998, does not impact the timing of the application of SNF PPS. Provider Reimbursement Manual (PRM) (CMS Pub. 15-1) §2414.5 requires that a provider submit one cost report for both the hospital and the SNF, and, therefore, the Administrator's policy is inconsistent with that articulated by the statute and CMS staff.

The Intermediary argues that the Provider's initial cost reporting period could not have begun prior to its certification on April 1, 1999,[4] and it admitted its first patient on April 10, 1999. Therefore, the Intermediary reasons, the initial cost reporting period for the SNF began after July 1, 1998.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law, parties' contentions and evidence presented, finds that the Provider should have been reimbursed on a reasonable cost basis. The statute, 42 U.S.C. §1395yy(e), provides for the implementation of a prospective payment system for cost reporting periods beginning on or after July 1, 1998. The cost reporting period under appeal in this case began prior to that date, and, therefore, the SNF was not subject to PPS during the FY ended April 30, 1999.

[1] Intermediary Position Paper at 3.
[2] Provider Position Paper Ex. P-8.
[3] Intermediary Position Paper Ex. I-4
[4] Intermediary Position Paper Ex. I-4

It is undisputed that the Provider admitted its first Medicare patient on April 10, 1999.[5] Pursuant to PRM §2414.5, a multi-facility complex which includes hospitals and hospital–based SNFs is required to submit one cost report. Provider Reimbursement Manual (CMS Pub. 15-2) §102.1 permits providers to file 13-month cost reports to conform to the Medicare cost reporting period it wishes to use. In this case, the Provider had chosen its cost reporting period to conform to the requirements of the manual. The SNF admitted its first Medicare patient one month before the end of the cost reporting period April 1, 1998 through April 30, 1999. Since the cost reporting period under dispute began prior to July 1, 1998, SNF PPS was not applicable to the period. Consequently, the Provider should have been reimbursed on a cost basis.

DECISION AND ORDER:

The Board finds that the Provider's hospital-based SNF should have been reimbursed on a cost basis for the period under dispute. The Intermediary's adjustment is reversed, and the case is remanded to the Intermediary to calculate the Provider's reimbursement on a cost basis.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq.
Martin W. Hoover, Jr., Esq.
Gary B. Blodgett, DDS
Elaine Crews Powell, CPA
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FOR THE BOARD:

DATE: April 8, 2005

Suzanne Cochran, Esq.
Chairman

[5] Intermediary Position Paper Ex. I-6.