PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D55

PROVIDER -
Saint Anthony's Health Center – SNF
Alton, Illinois

Provider No.: 14-5314

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
AdminaStar Federal Illinois

DATE OF HEARING -
June 6, 2006

Cost Reporting Periods Ended -
December 31, 1991 and December 31, 1992

CASE NOs. 98-0580 and 98-0463

INDEX

ISSUE:

Whether the Provider's exception requests to the skilled nursing facility (SNF) routine service cost limits under 42 C.F.R. §413.30(f) was properly denied because the Provider did not request the exceptions within 180 days of the original notices of program reimbursement.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA),[1] is the operating component of the Department of Health and Human Services charged with administering the Medicare program. HCFA's payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

At its inception, the Medicare Program reimbursed providers the "reasonable cost" of furnishing covered services to program beneficiaries pursuant to Section 1861 (v)(1)(A) of the Act. In response to rising costs, and realizing that the original structure provided little incentive for providers to operate efficiently in delivering services, Congress authorized the Secretary (under Section 223 of the Act of 1972) to:

> [p]rovide for the establishment of limits on the direct or indirect overall incurred costs . . . based on estimates of the costs necessary in the efficient delivery of needed health services . . .

[1] For events that took place before CMS changed its name, and to maintain consistency with the evidence, HCFA will be used.

Recognizing that providers under some circumstances would incur costs in excess of the routine cost limit, exceptions to the routine cost limit (RCL) were established in 42 C.F.R. §413.30(f), which states:

> (f) Exceptions. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section . . . An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

SNF cost limits are established based upon reported costs; however, those limits can later be adjusted for actual or projected cost changes by applying the SNF market basket index. The market basket index is used to adjust the limits to reflect cost changes occurring between the time of the cost reporting periods represented in the data collection to the time when the limits are applied. However, the market basket index itself cannot be determined until the cost reporting period to which the limits apply has already passed. Therefore, when the cost limits are calculated, the limits are based on an estimated market basket index which is based upon forecasts of economic trends. If these economic forecasts prove erroneous, the limits may be retroactively adjused to reflect the actual index. Medicare's policy is to adjust the limit if the market basket index for a fiscal year differs from the estimated rate of change by at least 0.3 of one percentage point.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Anthony's Health Center (the Provider) is a hospital-based skilled nursing facility located in Alton, Illinois. In 1992, the Provider's fiscal intermediary changed from Health Care Services Corporation to Administar Federal (both hereinafter referred to as the Intermediary). The Intermediary issued the Provider's original Notices of Program Reimbursement (NPRs) on September 2, 1993 for its fiscal year ended (FYE) December 31, 1991 cost report and on April 1, 1994 for its FYE December 31, 1992 cost report. In the original NPRs, the Provider exceeded the RCL for both FYEs 1991 and 1992. The Provider did not file exception requests with the Intermediary within 180 days of the original NPRs for either fiscal year.

In 1996, HCFA determined that the estimated market basket index for fiscal years 1991 and 1992 exceeded actual market basket figures by more than 0.3 of one percentage point. Pursuant to its rules,[2] HCFA instructed intermediaries to retroactively adjust cost limits to include the actual market basket index figures.[3]

On August 29, 1996, the Intermediary issued Notices of Reopening for the Provider's FYE 12/31/91 and 12/31/92 cost reports to update the Provider's SNF cost limits based

[2] See 56 Fed. Reg. 13317, 13319 (April 1, 1991).
[3] HCFA Memorandum, May 1996.

on the change in the market basket index. For FYE 12/31/91, the RCL was decreased by $3.41, and for FYE 12/31/92 the RCL was decreased by $6.26. The Provider filed exception requests with the Intermediary within 180 days of the revised NPRs, both dated 10/31/1996. The Intermediary notified the Provider that HCFA had denied its exception requests and stated "[i]t is HCFA's policy that is [sic] an exception is submitted after 180 days of the original NPR but within 180 days of /a revised NPR, an exception may only be granted for the incremental increase in the amount that the provider's costs exceeds its revised cost limit."[4] The Intermediary's exception recommendations were revised and subsequently approved by HCFA on October 14, 1997 for the incremental increase in the amount of the routine cost limits between the original NPRs and the revised NPRs.[5] The Provider filed timely appeals with the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The total amount of relief sought under the exception requests was $253,545 for FYE 1991 and $241,212 for FYE 1992.

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

PARTIES' CONTENTIONS:

Exception requests are governed by 42 C.F.R. § 413.30(c) which provides that a request for an exception to the SNF cost limits must be made to the intermediary within 180 days of the NPR. The Provider argues that because the regulation does not distinguish between an initial and revised NPR, its request was timely as to the full amount of its exception request.

The Provider acknowledges that the regulation at 42 C.F.R. § 413.30(c)has been interpreted as incorporating the restrictions of 42 C.F.R. §405.1889[6] which limits review of a revised NPR to only those issues specifically affected by the revised NPR. The Provider argues that these two sections should be viewed as separate because NPR appeals are filed with the Board but RCL exception requests are filed with the intermediary. This distinction was noted in Hurley Medical Center v. Blue Cross Blue Shield Association/Health Care Service Corporation, HCFA Adm. Dec. August 7, 1998, Medicare & Medicaid Guide (CCH) ¶80,058. In Hurley, the provider failed to make its TEFRA exception request to the intermediary in accordance with the regulations but mistakenly made the request to the Board and sent a copy to the intermediary. The Board concluded that the intermediary had adequate notice of an exception request, but the HCFA Administrator overturned the Board's decision because the request was not made to the intermediary as the regulation explicitly provided. The Provider asserts that application of the same literal interpretation in this case would allow a full exception request from any NPR since the regulation does not specify otherwise.

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[4] Intermediary Exhibit 1-6.
[5] Exhibit I-7.
[6] See St. Joseph Medical Center v. Blue Cross Blue Shield Association/Blue Cross of California, PRRB Case No. 98-D27, January 29, 1998, Medicare & Medicaid Guide (CCH) ¶46,070.

The Provider also contends that, even if 42 C.F.R. §405.1889 applies, the instant cases are distinguishable because the revised NPRs specifically adjusted the SNF's RCLs and because the RCLs in the original NPRs were provisional. As a result, the RCLs were not finalized until the revised NPRs were issued. In support, the Provider refers us to French Hospital Medical Center v. Shalala, 89 F.3d 1411 (9th Cir. 1996). There, the court upheld the refusal to grant the exception request on the grounds that it was untimely filed because:

> [T]he intermediary reopened the hospital's cost report for the sole purpose of applying the RCL to malpractice insurance costs. Neither the RCL nor components of the RCL were at issue in the revised NPR. Furthermore, the revised NPR did not alter the RCL or any of its components. Only the RCL's application to malpractice insurance costs was at issue in the revised NPR.

Id. at 1420. The Provider asserts that the French Court decision clearly implies that a revision to the RCL itself or any of its components would reopen the RCL issue and allow the provider to request and receive an exception to its RCLs. The Provider also points out that the revised NPR was issued to effect the changes in the SNF market basket indices, which are components of the SNF RCLs.

In addition, the Provider asserts that the strictures on 42 C.F.R. §405.1889 should not apply because the policy considerations for exception requests are different than policy considerations applicable to appeals of cost adjustments. Exception requests involve limits that are applied to all costs incurred by a provider. Thus, an adjustment of allowable costs affects whether a provider wishes to seek an exception. In contrast, appeals of cost adjustments involve discrete categories of claimed costs. When an intermediary reopens the cost report to adjust discrete costs centers, there is no effect on the costs included in other discrete cost centers. As cost limits are dependent upon all reimbursement, any change in allowable costs does influence how the cost limit applies.

Finally, the Provider points out that during this time period, there were no guidelines issued on how to apply for an atypical cost exception, and RCLs were pending subject to finalization of the market basket index; therefore, providers could not be sure whether to make exception requests from the initial or revised NPRs. The method for contesting the RCL was not fully explained until the issuance of Transmittal No. 378 in July 1994.

The Intermediary responds that the Provider did not file requests for an exception to the SNF RCLs upon its original NPRs even though its costs exceeded the cost limits. Correcting the cost limits therefore did not convert the Provider from a position of being within the cost limits to a position of exceeding the cost limits. Consequently, the reopenings did not create any new rights to file exception requests. The reopenings merely corrected the amount of the cost limits and HCFA granted a partial exception for the additional amount applicable to that correction. As no requests were filed from the original NPRs, no relief is available as to the excess cost calculated under the original RCL limits.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, finds and concludes that that the Provider is entitled to consideration of the full amount of the exception request based on the appeal of its revised NPR.

The first evidence in our record of HCFA's position to limit any relief from a revised NPR adjustment to the incremental increase in the amount that the provider's costs exceeds its revised cost limit is in the Intermediary's letter to the Provider dated July 18, 1977.[7] Apparently, the Intermediary was previously unaware of HCFA's position because the Intermediary had recommended to HCFA acceptance of more than the incremental increase in the adjustments on the revised NPRs.[8] HCFA's notice to all intermediaries concerning the adjustments to the RCLs authorizes adjustments to exceptions already granted and it addresses how new exception requests will be handled.[9] That communication demonstrates that HCFA anticipated that exception requests would be filed from revised NPRs yet there is no mention of a limit on any relief from a revised NPR adjustment to the incremental increase only.

The Board has also carefully considered both 42 C.F.R. §§405.413.30(c) and 405.1889, and we do not find any basis for HCFA's limitation in either regulation. 42 C.F.R. §413.30(c) states that the "provider's request for an exception must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement." The regulation does not make a distinction between types of NPRs; therefore, a provider should be allowed to make an exception request for the full amount from any NPR in which the RCL is at issue.

Even when §405.1889 is applied, we find the appeal from the revised NPR proper. This case is distinguishable from French, supra, in which a provider was not allowed to contest its cost limits from a revised NPR where the provider sought an exception from an adjustment for malpractice insurance costs. The court held the denial of the exception request was proper because "[n]either the RCL, nor components of the RCL, were at issue in the revised NPR." Id. at 1420. Here, the Intermediary did adjust the RCLs in the revised NPRs; therefore, the Provider is entitled to make its exception requests from the revised NPRs.

In summary, the Board finds the Provider may request an exception to the RCL from any NPR in which the Intermediary adjusts its RCL, and there is no basis to limit a provider's exception request made from a revised NPR.

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[7] Provider Exhibit D.
[8] Intermediary Exhibit 5.
[9] Intermediary Exhibit 3 at p. 2.

DECISION AND ORDER:

HCFA's partial denial of the Provider's SNF exception requests was improper. The matter is remanded to the fiscal intermediary to consider the Provider's full request for relief from the RCLs.

Board Members Participating:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: September 26, 2006

Suzanne Cochran, Esquire
Chairperson