PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D56

PROVIDER -
Innovis Health
Fargo, North Dakota

Provider No.: 35-0070

vs.

INTERMEDIARY-
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING -
March 14, 2007

Cost Reporting Period Ended -
December 31, 2000

CASE NO.: 04-0823

INDEX

ISSUE:

Whether the Provider is entitled to Transitional Outpatient Payments (TOPs).

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), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' 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 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 portion 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.

When the Medicare program was first implemented, it paid for hospital services (inpatient and outpatient) based on hospital-specific reasonable costs attributable to serving Medicare beneficiaries. Section 42 U.S.C. §1395x(v)(1)(A) of the Social Security Act (Act) provides, in part, that the reasonable cost of any service shall be the cost actually incurred, excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services.

Effective with cost reporting periods beginning on or after October 1, 1983, short-term acute care hospitals became subject to Medicare's Prospective Payment System (PPS). Under this system, Medicare's payment for hospital inpatient Part A operating costs is made on prospectively determined rates and applied on a per discharge basis. Medicare discharges are classified into diagnostic related groups (DRGs), and a hospital-specific payment rate is assigned to each DRG with respect to resource use or intensity. Hospital inpatient operating costs include general routine service costs, ancillary service costs, and intensive care-type unit service costs, but exclude certain other costs such as the costs of medical education training programs and organ acquisition expenses.

The Balanced Budget Act of 1997 (BBA), enacted on August 5, 1997, amended section 1833 of the Act by adding subsection (t), which provides for the implementation of a hospital outpatient PPS (OPPS) effective for services furnished on or after July 1, 2000. Under OPPS, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Healthcare Common Procedure Coding System (HCPCS).

On November 29, 1999, the Balanced Budget Refinement Act of 1999 (BBRA), P. L. 106-113, was enacted. Section 202 of the BBRA amended section 1833(t) of the Act by re-designating paragraphs (7) through (11) as paragraphs (8) through (12), and adding a new paragraph (7) which provides for a transitional adjustment to limit payment reductions under the hospital outpatient PPS, i.e., Transitional Corridors.[1] In general, for the years 2000 through 2003, a provider will receive an adjustment if its payment-to-cost ratio for outpatient services furnished during the year is less than a set percentage of its payment-to-cost ratio for those services in its cost reporting period ending in 1996 (the base year).

CMS promulgated 42 C.F.R. §419ff to implement Medicare's hospital outpatient PPS. Section 419.70 of the regulations specifically implements the transitional adjustment payments enacted by the BBRA. In general, this regulation explains that a provider will receive a transitional adjustment when its OPPS payments are less than its pre-BBA amount. For example, 42 C.F.R. §419.70(a) states in part:

> . . . for covered hospital outpatient services furnished before January 1, 2002, for which the prospective payment system amount. . . is-
>
> > (1) At least 90 percent, but less than 100 percent, of the pre-BBA amount. . . the amount of payment under this part is increased by 80 percent of the amount of this difference.

42 C.F.R.§419.70(f) defines the "pre-BBA amount" as follows:

> (1) *General Rule.* In this paragraph, the "pre-BBA amount" means, with respect to covered hospital outpatient services furnished by a hospital or a community mental health center (CMHC) in a year, an amount equal to the product of the reasonable cost of the provider for these services for the portions of the provider's cost reporting period (or periods) occurring in the year and the base provider outpatient payment-to-cost ratio for the provider (as defined in paragraph (f)(2) of this section).

Initially, 42 C.F.R. §419.70(f)(2) defined the "base payment-to-cost-ratio" as the ratio of:

> (i) [t]he provider's payment under this part for covered outpatient services furnished during the cost reporting period ending in

[1] Also referred to as "Transitional Outpatient Payments" or "TOPs."

1996, including any payment for these services through cost-sharing described in paragraph (e) of this section; and

(ii) The reasonable cost of these services for this period. . . .

However, the definition at 42 C.F.R. §419.70(f)(2) was revised retroactively to August 1, 2000, in accordance with section 403 of the Benefits Improvement Act of 2000 (BIPA), to state that the "base payment-to-cost ratio" means the ratio of:

(i) [t]he provider's payment under this part for covered outpatient services furnished during one of the following periods, including any payment for these services through cost-sharing described in paragraph (e) of this section:

(A) The cost reporting period ending in 1996: or

(B) If the provider does not have a cost reporting period ending in 1996, the first cost reporting period ending on or after January 1, 1997, and before January 1, 2001; and

(ii) The reasonable costs of these services for the same cost reporting period. (Emphasis added)

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Innovis Health (Provider) is a 60-bed, general short-term hospital located in Fargo, North Dakota. The Provider began operations on November 14, 2000, and submitted its first Medicare cost report for the short period ended December 31, 2000. Noridian Administrative Services (Intermediary) reviewed the Provider's cost report and disallowed the Provider's claim for TOP payments which was shown on the cost report as a protested amount. Generally, the Provider believed it was entitled to TOPs because it filed a cost report prior to January 1, 2001 that would be used to establish its base payment-to-cost ratio pursuant to 42 C.F.R. §419.70(f)(2). The Intermediary, however, believes that a full 12-month cost report is required to establish a base payment-to-cost ratio and to comply with the intended purpose of TOPs.

The Provider appealed the Intermediary's adjustment to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $154,274.

The Provider was represented by Ross C. D'Emanuele, Esq., of Dorsey & Whitney, LLP. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediary contends that Program Memorandum A-01-51 clarifies that a full 12-month cost report is required to calculate a provider's payment-to-cost ratio.[2] Since the Provider began operations on November 15, 2000, it does not have either a 1996 cost report or a full 12-month cost report ended before January 1, 2001. The Intermediary relies upon Page 2 of the memorandum, which states:

> Clarifications
>
> In the case of mergers, acquisitions and other such changes the PCR [payment-to-cost ratio] for the surviving provider number should be used. If less than a full year is reflected in the provider's cost report for a base year, use the next full year cost report that ended prior to January 1, 2001 instead. (Emphasis added).

In addition, the Intermediary asserts that the purpose of TOPs is to restore some of the decrease in payments a hospital may experience when it transitions from its previous cost and other outpatient payment methodologies to Medicare's OPPS. Since the Provider did not begin operations until November 14, 2000, subsequent to the implementation of Medicare's OPPS, it could not have experienced any decrease in payment, having never been reimbursed under a cost-based or other methodology. The Intermediary notes that under this circumstance, the Provider's payment-to-cost ratio would be calculated based on the ratio of its actual OPPS payments to its reasonable costs as opposed to a comparison to cost-based and other reimbursement methodologies (pre-BBA) contemplated by 42 C.F.R. §419.70(f)(2).[3]

The Provider contends that there is nothing in the enabling statute that excludes new providers from receiving TOPs. Rather, BIPA modified the statute to specifically address new providers by stating that a base payment-to-cost ratio may be calculated from a provider's first cost reporting period ending on or after January 1, 1997 and before January 1, 2001, if it does not have a cost reporting period ending in 1996. Since the Provider had a cost reporting period that ended before January 1, 2001, a base payment-to-cost ratio can be calculated, and the Provider is eligible for TOPs.[4]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions, and the evidence presented, the Board finds and concludes as follows:

TOPs were provided to ease the transition from reasonable cost and other payment methods to an outpatient PPS for hospital outpatient services under Medicare. The

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[2] Intermediary Position Paper at 5. Exhibit I-2.
[3] Id. Intermediary's Post-Hearing Brief at 6.
[4] Provider's Post-Hearing Brief at 4.

regulations make TOPs payable for services provided from the date of implementation of OPPS (August 1, 2000) through 2003. The amount of TOPs in any period is, essentially, a specified percentage of the difference between: (1) payment the hospital would have received if the pre-OPPS system were still in effect during the period in question (i.e, prior to 2001, 2002, or 2003, the "Pre-BBA Amount"); and (2) payment under OPPS.

The Pre-BBA amount is meant to represent the amount that a hospital would have received in any TOPs period (e.g., 2001, 2002 or 2003) if the pre-OPPS had continued. It is defined as:

> . . . an amount equal to the product of the reasonable cost of the provider for these services for the portions of the provider's cost reporting period (or periods) occurring in the year and the base provider outpatient payment-to-cost ratio for the provider. . . .

42 C.F.R. §419.70(f)(1).

The "base payment-to-cost ratio" for a hospital is defined as the ratio between: (1) the provider's payment for covered outpatient hospital services furnished during the cost reporting period ending in 1996 or the first cost reporting period ending on or after January 1, 1997 and before January 1, 2001 and (2) the reasonable costs of these services for the same cost reporting period. 42 C.F.R. §419.70(f)(2).

Because the Provider had a cost reporting period ending before January 1, 2001, a base payment-to-cost ratio can be calculated for the Provider. If the Provider has a base-payment-to-cost ratio, then a TOPs amount can be calculated for the Provider, and the Provider is eligible for such TOPs.

The Intermediary argues that if the Provider was not open prior to implementation of OPPS (August 1, 2000), then, even though there is a base payment-to-cost ratio for the Provider, there can be no pre-BBA amount for the Provider. This argument fundamentally misreads the definition of the pre-BBA amount.

The pre-BBA amount multiplies the base payment-to-cost ratio by the hospital's reasonable costs for hospital outpatient services *in the period for which the TOPs calculation is being made* (i.e., prior to 2001, 2002, or 2003). There is no comparison of the base payment-to-cost ratio to amounts received prior to August 1, 2000. Nowhere in the TOPs formula is there any mention of amounts the hospital <u>actually</u> received prior to August 1, 2000. Nor is there any stated condition for receipt of TOPs, i.e., that the hospital received Medicare reimbursement for outpatient hospital services prior to August 1, 2000. The Intermediary's technical reading of 42 C.F.R. §419.70 is simply incorrect.

The Intermediary then argues that Congress and CMS could not have meant that all hospitals with a cost reporting period ending prior to January 1, 2001 are eligible for

TOPS. If the purpose of TOPs was to ease the transition to OPPS, such a conclusion regarding eligibility for TOPs simply does not make sense.

The Board finds the Intermediary's rationale for what it believes was the ultimate intent of TOPs compelling. However, after diligently reviewing the enabling statute and regulations, the Board finds nothing to support the Intermediary's position.

Allowing TOPs for all hospitals having a cost reporting period ending prior to January 1, 2001, as set forth in 42 C.F.R. §419.70, makes as much public policy sense as any other eligibility criteria CMS could have used. Hospitals opening between August 1, 2000 and December 31, 2000 most certainly relied on payment forecasts made under the pre-OPPS in setting hospital budgets, debt structures, and hospital building and bed size. It is undoubtedly rational and certainly reasonable to contend that 42 C.F.R. §419.70 means precisely what the formula produces: all hospitals with a cost reporting period ending prior to January 1, 2001 are eligible for TOPs. The Intermediary's assertion to the contrary is a policy preference with no supporting authority in Federal law.

CMS promulgated a clear, easily-administered rule: hospitals with a cost reporting period ending prior to January 1, 2001 are eligible for TOPs. The clear line drawn is as rational as any other. Furthermore, determining TOPs eligibility based on an objective date avoids the inconsistency that would inevitably result from a system in which each intermediary could determine TOPs eligibility based on subjective criteria.

Furthermore, if CMS found that 42 C.F.R. §419.70 did not reflect the agency's intent, CMS could have modified the regulation. Every year CMS makes changes to the OPPS to account for new statutory provisions as well as the agency's "continuing experience with this system," including changes promulgated *after* this case had worked its way to the Board. See, e.g., 71 Fed. Reg. 67960. Certainly, CMS had ample opportunity to change 42 C.F.R. §419.70, or even express in the preamble to the regulations any indication of an intent that differs from the 42 C.F.R. §419.70 formula. However, CMS has made no such changes or comments. Indeed, every OPPS regulation CMS promulgates without change further reaffirms that CMS intends the TOPs eligibility criteria to be precisely as set forth in the regulation.

In conclusion, the Board finds that the Provider is entitled to receive TOPs as set forth in 42 C.F.R. §419.70. The regulation is: (1) unambiguous; (2) easily administered; and (3) as rational a policy decision as any other rule for determining TOPs eligibility. Moreover, since the inception of Medicare's OPPS, CMS has had ample opportunities and numerous rule promulgations to alter 42 C.F.R. §419.70 and the TOPs qualification rule but has chosen not to make any changes.

DECISION AND ORDER:

The Provider is entitled to TOPs in accordance with 42 C.F.R. §419.70. The Intermediary's adjustment disallowing the Provider's claim for TOPs is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West
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DATE: August 2, 2007

FOR THE BOARD:

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