PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D20

PROVIDER –
Mountain View Regional Medical Center

Provider No.: 32-0085

vs.

INTERMEDIARY –
Wisconsin Physician Services

DATE OF HEARING -
December 8, 2011

Cost Reporting Period Ended -
March 31, 2003

CASE NO.: 07-0401

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ISSUES:

Whether the Intermediary's determination that the Provider should be reimbursed under the federal rate of the inpatient prospective payment system for capital costs for the fiscal year end 2003 was proper.[1]

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 under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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 to insurance companies known fiscal intermediaries and Medicare Administrative Contractors ("MAC"). Intermediaries and MACs[2] determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS.[3]

At the close of its accounting period, 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 the Medicare program.[4] 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").[5] 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 receipt of the NPR.[6]

TEN-YEAR TRANSITION TO CAPITAL IPPS (1991-2001)

Section 4006(b) of the Omnibus Budget Reconciliation Act of 1987[7] amended 42 U.S.C. § 1395ww(g) to establish the prospective payment system for hospital inpatient capital-related costs ("capital IPPS") for cost reporting periods beginning on or after October 1, 1991. Prior to this, the Medicare program reimbursed hospitals for allowable inpatient capital-related costs on a reasonable cost basis.

In accordance with § 1395ww(g), CMS issued a final rule on August 30, 1991 ("1991 Final Rule") to implement capital IPPS.[8] Capital-related costs allowable under the Medicare program

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[1] Transcript ("Tr.") at 5-6.
[2] The Medicare contractor in this case was an intermediary at the time it made its adjustments.
[3] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20(b) and 413.24(b).
[4] 42 C.F.R. § 413.20.
[5] 42 C.F.R. § 405.1803.
[6] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1837.
[7] Pub. L. No. 100-203, 101 Stat. 1330, 1330-52 – 1330-53 (1987).
[8] *See* 56 Fed. Reg. 43358 (Aug. 30, 1991).

include costs such as depreciation, interest, taxes, insurance, and similar expenses for movable plant, and fixed equipment.[9]

In the preamble to the 1991 Final Rule, CMS recognized that the transition to the capital IPPS would be difficult for hospitals and, as a result, exercised its discretion to establish a ten-year transition period spanning from October 1, 1991 to October 1, 2001 to allow existing hospitals to adjust to the new payment system.[10] For purposes of this transition period, CMS established a federal rate for hospital inpatient capital-related costs on a per discharge basis ("federal capital IPPS rate").[11] Then, CMS determined a hospital-specific rate for each existing hospital based on that hospital's Medicare allowable inpatient capital costs per discharge for its latest 12-month cost report ending on or before December 31, 1990 ("hospital-specific capital rate").[12]

During the ten-year transition period to capital IPPS, hospitals with a hospital-specific capital rate below the federal capital IPPS rate would not be subject to the transition but rather would be paid at 100 percent of the federal capital IPPS rate. Hospitals with a hospital-specific capital rate above the federal capital IPPS rate would be held harmless and would be paid based on the higher of a "hold harmless" blended payment methodology or 100 percent of the federal capital IPPS rate.[13] After the ten-year transition, for cost reporting periods beginning on or after October 1, 2001, all the hospitals existing in 1991 would be paid solely under the federal capital IPPS rate.[14]

In connection with new hospitals, CMS originally proposed that such hospitals "would be paid on a fully prospective payment basis during the transition period."[15] However, in the following discussion in the preamble to the 1991 Final Rule, CMS recognized that new hospitals may be disadvantaged under the new payment system because, during their first few years of operation, new hospitals have a disproportionately high amount of capital-related costs. CMS created special rules for new hospitals:

> *Comment*: Several commenters opposed our proposal to pay new hospitals under the fully prospective methodology. They expressed concern that such payment levels may not be adequate for hospitals that are built late in the transition period. Also, the hospital's first year costs per case may not be sufficiently representative to establish an appropriate hospital-specific rate.
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> *Response*: We agree with the concerns expressed by the commenters and provide in the final rule to exempt new hospitals from the capital prospective payment system for the first 2 years of operation and pay them 85 percent of their reasonable cost during

[9] *Id.*
[10] *See id.* at 43362, 43385-43386; 56 Fed. Reg. 8476, 8477, 8478 (Feb. 28, 1991); 66 Fed. Reg. 39828, 39910 (Aug. 1, 2001); 42 C.F.R. § 412.304(b) (1992).
[11] 56 Fed. Reg. at 43361.
[12] *Id.*
[13] *See id.* at 43359; 42 C.F.R. §§ 412.304(b) and 412.324(a) (1992).
[14] 42 C.F.R. § 412.304(c)(1992); 56 Fed. Reg. at 43360.
[15] 56 Fed. Reg. at 8494.

> that period. The base year costs would qualify as old capital. Effective with the third year of operation, we will pay the hospital under either the fully prospective methodology, using the appropriate transition blend in that Federal fiscal year, or the hold-harmless methodology. If the hold harmless methodology is applicable, the hold-harmless payment for assets in use during the base period would extend for 8 years, even though the hold-harmless payments may extend beyond the normal transition period.[16]

Accordingly, as part of the 1991 Final Rule, CMS established certain protections for new hospitals designed to reduce the impact of the capital IPPS. First, CMS defined the term "new hospital" in 32 C.F.R. § 412.300(b) as follows:

> *New hospital* means a hospital that has operated (under previous or present ownership) for less than 2 years and does not have a 12-month cost reporting period ending on or before December 31, 1991, or a combination of cost reporting periods ending on or before December 31, 1990 that covers at least 12 months.[17]

Further, as part of the capital IPPS regulations addressing "Determination of Transition Period Payment Rates for Capital-Related Costs,"[18] CMS added regulatory provisions addressing the payment of "new hospitals" to the proposed 42 C.F.R. § 412.324 so that the final regulation read:

> **§ 412.324 General Description.**
> (a) *Hospitals under Medicare in FY 1991.* During the ten-year transition period, payments to a hospital with a hospital-specific rate below the Federal rate are based on the fully prospective payment methodology under § 412.340 or for a hospital with a hospital-specific rate above the Federal rate, the hold-harmless payment methodology under § 412.344.
> (b) *New hospitals.* (1) A new hospital, as defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost reporting period ending at least 2 years after the hospital accepts its first patient.
> (2) For the third year through the remainder of the transition period, the hospital is paid based on the fully prospective payment methodology or the hold harmless payment methodology using the base period determined under § 412.328(a)(2).
> (3) If the hospital is paid under the hold-harmless methodology described in § 412.344, the hold harmless payment for old capital described in 412.344(a)(1) is payable for up to and including 8

[16] 56 Fed. Reg. at 43418.
[17] 42 C.F.R. § 412.300(b) (1992).
[18] 56 Fed. Reg. at 43449.

> years and may continue beyond the first cost reporting period beginning on or after October 1, 2000.
> (c) *Hospitals with 52-53 week fiscal years ending September 25 through September 29.* For purposes of this subpart, a hospital with a 52-53 week fiscal year period beginning September 26 through September 30, 1992 is deemed to have the same beginning date for all cost reporting periods beginning before October 1, 2000 (unless the hospital later changes its cost reporting period).[19]

Thus, during the ten-year transition period, CMS specified that, under the capital IPPS, a new hospital would be paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its first two full fiscal years of a hospital's operation. Further, in addition to receiving 85 percent reasonable cost reimbursement for the first full two cost reporting periods, new hospitals which opened prior to October 1, 2001 have the right to receive the same hold-harmless payment methodology that is also available to existing hospitals for up to eight years even if that eight years extends beyond October 1, 2001 which is the end of the ten-year transition period.

Over time, CMS elaborated upon the regulatory definition of "new hospital" at 42 C.F.R. § 412.300(b). However, the relevant portion for purposes of the current appeal remained the same: "a new hospital means a hospital that has operated (under previous or present ownership) for less than 2 years."[20] CMS did not make any substantive changes to 42 C.F.R. § 412.324 prior to 2002.

NEW HOSPITALS AFTER THE TRANSITION PERIOD

In the final rule published on August 1, 2002 ("2002 Final Rule"),[21] CMS states the following regarding the special protections for new hospitals that are delineated in 42 C.F.R. § 412.324(b):

> This payment provision [at § 412.324(b)] was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals. These hospitals may not have sufficient occupancy in those initial 2 years and may have incurred significant capital startup costs, so that capital prospective payment system payments may not be sufficient. . . . Because capital prospective payment system payments are made on a per discharge basis, a hospital only receives payments for its capital-related costs upon discharge of its Medicare patients. In addition, these hospitals did not have an opportunity to reserve previous years'

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[19] 42 C.F.R. § 412.324 (1992) (reflecting minor corrections that CMS made to the 1991 Final Rule via notice published at 57 Fed. Reg. 3015, 3016 (Jan. 27, 1992)).
[20] 42 C.F.R. § 412.300(b) (2002).
[21] 67 Fed. Reg. 50101 (Aug. 1, 2002)

capital prospective payment system payments to finance capital projects.

> While the regulations provided for payments based on a percentage of costs for new hospitals for the first 2 years during the 10-year transition period, no provision was made for new hospitals once the 10-year transition was completed. However, we believe that the rationale for the policy applies equally to new hospitals even after the completion of the 10-year transition period. Accordingly, . . . we proposed, under § 412.304(c)(2), to provide special payment to new hospitals for cost reporting periods beginning on or after October 1, 2002. That is, we proposed to pay new hospitals . . . 85 percent of their reasonable costs for their first 2 years of operation. Effective with their third year of operation, a new hospital would be paid based on the Federal rate . . . .[22]

Thus, based on its continued concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals,[23] CMS promulgated additional regulations to ensure that new hospitals would continue to receive 85 percent of cost reimbursement for their first two full fiscal years, even though the capital IPPS transition period would have ended for most hospitals by that time.[24]

CMS added these additional protections for new hospitals in 42 C.F.R. § 412.304(c) which is entitled "Cost reporting periods beginning on or after October 1, 2001." Specifically, as part of the 2002 Final Rule, CMS added paragraph (2) to § 412.304(c) to address the treatment of new hospitals for cost reporting periods beginning on or after October 1, 2002:

> (2) *Payment to new hospitals*. For cost reporting periods beginning on or after October 1, 2002—
> (i) A new hospital, as defined under § 412.300(b), is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs through its cost report ending at least 2 years after the hospital accepts its first patient, unless the new hospital elects to be paid under the capital prospective payment system based on 100 percent of the Federal rate.
> (A) If the new hospital elects to be paid based on 100 percent of the Federal rate, the new hospital must submit a written request to the fiscal intermediary by the later of December 1, 2002 or 60 days before the beginning of its cost reporting period.

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[22] *Id.* at 50101.
[23] *Id.*
[24] *Id.* Hospitals that were new prior to October 1, 2001 were still eligible for hold-harmless payment (for their third through tenth full fiscal years). *See* 42 C.F.R. § 412.324(b)(3). Therefore, while most hospitals had fully transitioned to the capital IPPS, hospitals that were new during the ten-year transition period continued to receive transition hold-harmless payments after 2001.

> (B) Once a new hospital elects to be paid based on 100 percent of the Federal rate, it may not revert to payment at 85 percent of its allowable Medicare inpatient hospital capital-related costs.
> (iii) For the third year and subsequent years, the hospital is paid based on the Federal rate as described under § 412.312.[25]

Thus, for cost reporting periods beginning on or after October 1, 2002, new hospitals would be permitted to choose between the following reimbursement methodologies for their initial two year periods: (1) the traditional 85 percent of costs for its first two full years of operation based on the new hospital exemption from capital IPPS, or (2) payment under the federal capital IPPS rate.

In the preamble to the 2002 Final Rule, CMS stated that the "new hospital" protections in 42 C.F.R. § 412.324(b) only applied during the ten-year transition and that, as a consequence, the protections then being added in § 412.304(c)(2) left a gap period between October 1, 2001 and October 1, 2002 in which "new hospitals" would receive no special payment protections. However, CMS maintained that it could only apply the new § 412.304(c)(2) protections on a going-forward basis. Specifically, CMS stated the following:

> *Comment:* Three commenters addressed our proposed policy for new hospitals after the 10-year transition period for cost reporting periods beginning on or after October 1, 2002. One commenter asked whether new providers would have the option of electing payment at 100 percent of the Federal rate for their first 2 years of operation rather than the special payment provision of 85 percent of their reasonable costs. Another commenter expressed concern about the negative impact the proposed policy would have on its facility if the policy were applied retroactively, while still another commenter requested that the policy be effective for new hospitals with cost reporting periods beginning on or after October 1, 2001 rather than October 1, 2002.
>
> *Response:* We agree with the commenter's suggestion that new hospitals (as defined in § 412.300(b) should have the option of electing payment for their first 2 years of operation through either the special payment provision for new hospitals at 85 percent of their reasonable costs, or beginning immediately to receive payments based on 100 percent of the Federal rate. However, the payment method that the new hospital selects would remain in effect through the hospital's first 2 years of operation; the hospital would not be allowed to revert to the alternate payment method. If 100 percent of the Federal rate is the payment method selected, the new hospital must make the request to the fiscal intermediary in

[25] 42 C.F.R § 412.304(b) (2002); 67 Fed. Reg. at 50113. The Provider was paid 85 percent of its reasonable costs, presumably according to this provision, for its FYs 2004 and 2005 – its first two full fiscal years. The fiscal year at issue in the present case is the *short* fiscal year ending March 31, 2003, which began prior to October 1, 2002.

> writing by the later of December 1, 2002, or within 60 days of the start of the provider's cost reporting period. We are revising the regulations at 412.304(c)(2) to reflect this change.
>
> *While we are making this change effective for cost reporting periods beginning on or after October 1, 2002, we are not making this change effective for any periods prior to that date because doing so would constitute retroactive rulemaking.*[26]

COST REPORTING INSTRUCTIONS FOR NEW HOSPITALS

The Provider Reimbursement Manual, CMS Publication 15-2 ("PRM 15-2") contains cost reporting instructions specific to the treatment of new hospitals under capital IPPS.

Instructions Prior to 2003

Prior to 2003 (and including the time at issue), PRM 15-2 § 3604 included the following instructions for completing Lines 33 and 36 in Worksheet S-2:

> Line 33 -- Is this a new hospital under 42 CFR 412.300 (PPS capital)? Enter "Y" for yes or "N" for no in column 1.
>
> Line 36 -- Do you elect the fully prospective payment methodology for capital costs? (See 42 CFR 412.340.) Enter "Y" for yes or "N" for no in the applicable columns. [27]

2003 Instructions

In June 2003, CMS issued a transmittal to revise, among other things, the cost reporting instructions for Line 33 of Worksheet S-2 as delineated in PRM 15-2 § 3604.[28] Specifically, CMS revised the cost reporting instructions for Lines 33 and 36 located in PRM 15-2 § 3604 to state:

> Line 33 -- Is this a new hospital under 42 CFR 412.300 (PPS capital)? Enter "Y" for yes or "N" for no in column 1. If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100 percent Federal capital payment? Enter "Y" for yes or "N" for no in column 2.
>
> Line 36 -- Do you elect the fully prospective payment methodology for capital costs? (See 42 CFR 412.340.) (This also

[26] 67 Fed. Reg. at 50101-50102 (emphasis added).

[27] PRM 15-2 § 3604 (2002). A comparison of Transmittal 2 (Nov. 1996), Transmittal 9 (Aug. 2002) and Transmittal 10 (June 2003) from PRM 15-2, Chapter 36, confirm that these cost reporting instructions as quoted for Lines 33 and 36 had existed at least from November 1996 to June 2003.

[28] PRM 15-2, Ch. 36, Transmittal 10 (June 2003).

> includes providers that were previously hold harmless, but are not considered 100 percent fully prospective for purposes of completing WS L, Part 1 in lieu of Worksheet L, Part II.) Enter "Y" for yes or "N" for no in the applicable columns. (For cost reporting periods beginning on or after October 1, 2001, the response is always "Y", except for new providers with fiscal years beginning *before October 1, 2002* under 412.300(b) which the response is "N" for the provider's first 2 years.) Questions 36 and 37 are mutually exclusive.[29]

In other words, in June 2003, CMS revised the PRM 15-2 cost reporting instructions to state that new providers with fiscal years beginning before October 1, 2002 are exempt from the fully prospective payment methodology for the provider's first 2 years.

2008 Instructions

In December 2008, CMS again revised the cost reporting instructions located in PRM 15-2 § 3604 for Lines 33 and 36 of Worksheet S-2 to state as follows:

> Line 33 -- Is this a new hospital under 42 CFR 412.300 (PPS Capital)? Enter "Y" for yes or "N" for no in column 1. If yes for new providers with initial cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100 percent Federal capital payment? Enter "Y" for yes or "N" for no in column 2.
>
> Line 36 -- Do you elect the fully prospective payment methodology for capital costs? (See 42 CFR 412.340.) (This also includes providers that were previously hold harmless, but are now considered 100 percent fully prospective for purposes of completing Worksheet L, Part I in lieu of Worksheet L, Part II.) Enter "Y" for yes or "N" for no in the applicable columns. (For cost reporting periods beginning on or after October 1, 2001, the response is always "Y", *except for new providers under 42 CFR 412.304(c)(2), with initial cost reporting periods beginning* ***on or after*** *October 1, 2002, for which the response may be "N" for the provider's first 2 years.*) Questions 36 and 37 are mutually exclusive.[30]

The 2008 amendments to the instructions for Line 36 changed the new hospital exemption status from providers opening *before* October 1, 2002 to providers opening *on or after* that date.

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[29] PRM 15-2 § 3604 (2003) (emphasis added) (copy included as Provider Exhibit P-10).
[30] PRM 15-2, Ch. 36, Transmittal 19 (Dec. 2008) (emphasis added) (revising, among other provisions, PRM 15-2 § 3604 and excerpt included as Intermediary Exhibit I-11).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mountain View Regional Medical Center ("Provider") obtained Medicare certification and began operations on August 27, 2002.[31] The Provider's first cost reporting period was the short fiscal year ("FY") spanning from August 21, 2002 to March 31, 2003 ("Short FY 2003").[32] Thereafter, the 12-month period for the Provider's fiscal year ended on March 31. The Provider's first cost reporting period is the fiscal year at issue in this appeal – Short FY 2003.

At the time the Short FY 2003 cost report was settled, the fiscal intermediary was Mutual of Omaha. Wisconsin Physicians Service assumed the role of fiscal intermediary after Mutual of Omaha and became the intermediary for this appeal ("Intermediary").

On the Short FY 2003 cost report, the Provider completed Worksheet S-2, Line 33, Column 1 with an election of "Y," thereby asserting that the Provider was a "new hospital" under 42 C.F.R. § 412.300.[33] Through Audit Adjustment 27, the Intermediary changed the Provider's election to "N," finding that the Provider was *not* a "new hospital" under 42 C.F.R. § 412.300 for purposes of capital IPPS.[34]

The Provider also completed Worksheet S-2, Line 36 with an election of "N," thereby asserting that it did *not* elect the fully prospective payment methodology for its capital related costs (*i.e.*, the federal capital IPPS rate) in accordance with the cost reporting instructions at PRM 15-2 § 3604.[35] Through Audit Adjustment 27, the Intermediary changed the Provider's election of "N" to "Y," finding that the Provider had to elect payment under the fully prospective payment methodology for capital costs.[36]

The Intermediary's adjustments to the Provider's elections through Audit Adjustment 27 resulted in a negative aggregate reimbursement impact to the Provider of $924,889 for Short FY 2003.[37]

The Provider was paid as a "new hospital" for its following two *full* fiscal years, FYs 2004 and 2005.[38] This payment was made according to 42 C.F.R. § 412.304(c)(2) (2002), which provides for payment at 85 percent of reasonable costs for new hospitals for cost reporting periods beginning on or after October 1, 2002. There is no issue regarding payment for these two fiscal years. As stated above, it is the payment for the Short FY 2003 that is at issue in this appeal.

The Provider timely filed this appeal with the Board and met the jurisdictional requirements of 42 C.F.R §§ 405.1835 - 405.1841. The Board conducted a hearing on December 8, 2011 at which the Provider was represented by Gregory N. Etzel, Esq., and Krista Barnes, Esq., of King and Spalding, LLP. The Intermediary was represented by Stacy Hayes and Betsey Schneider, of Wisconsin Physicians Service.

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[31] Stipulation Agreement at ¶ 1 (Dec. 1, 2011).
[32] *Id.* at ¶ 3.
[33] *Id.* at ¶ 4 (referencing Provider Exhibit P-3).
[34] *Id.* at ¶ 5 (referencing Provider Exhibit P-3).
[35] *Id.* at ¶ 6 (referencing Provider Exhibits P-3 and P-10).
[36] *Id.* at ¶ 7 (referencing Provider Exhibit P-3).
[37] *Id.* at ¶ 9.
[38] Tr. at 51; Intermediary Exhibit I-9 at 2 and 3.

PROVIDER'S CONTENTIONS:

The Provider contends that its election to be exempt from fully federal capital IPPS and to receive payment at 85 percent of its allowable capital-related costs for its first short fiscal year, based on its status as a "new hospital," is consistent with the plain language of the regulations governing the capital IPPS and the cost reporting instructions in PRM 15-2. The Provider states that the Intermediary is arbitrarily refusing to apply the applicable regulation at 42 C.F.R. § 412.324(b)(1) and instead is applying cost reporting instructions that were not in place until December 2008, long after the Short FY 2003. Such retroactive application of a substantive policy change is prohibited by the Administrative Procedure Act.[39]

In connection with its cost report for Short FY 2003, the Provider maintains that it met the regulatory definition of a "new hospital" (*i.e.*, "it has operated (under previous or present ownership) for less than 2 years"[40]) and that it answered the question on Worksheet S-2, Line 33, correctly when it elected "Y." The Provider contends that the Intermediary's reversal of its election on Line 33 to "N" is contrary to the correct, factual response elicited by the question and contrary to the intent of the capital IPPS regulations.[41]

Similarly, with respect to Worksheet S-2, Line 36, the Provider answered "N" in accordance with the PRM 15-2 cost reporting instruction[42] (*i.e.*, that it was a "new hospital" with its FY beginning before October 1, 2002) to indicate that it was not electing the fully prospective payment methodology for capital costs. Again, the Provider maintains that this was the correct response because Short FY 2003 began on August 21, 2002 which was "before October 1, 2002" As before, the Provider contends that the Intermediary's reversal of its election on Line 36 to say "Y" is contrary to the intent of the capital IPPS regulations.[43]

The Provider asserts that the support for its responses on Worksheet S-2, Lines 33 and 36 is found at 42 C.F.R. § 412.324(b)(1). This regulation addresses the treatment under the capital IPPS of new hospitals prior to October 1, 2002. Although the Intermediary counters that this regulation is inapplicable because the Provider began operations (and, therefore, its status as a "new hospital") after October 1, 2001 (*i.e.*, after the transition period for the capital IPPS had ended),[44] the Provider contends that § 412.324(b) remained in effect during federal fiscal years 2002 and 2003 and, indeed, still remains an active regulation.[45] In particular, the Provider argues that the text of the regulation does not limit the application of the transition payment methodology only to hospitals that opened prior to October 1, 2001 and that the "transition period" is not necessarily a strictly defined time period beginning on October 1, 1991 and ending on October 1, 2001. As a result, the Provider concludes that the applicability of § 412.324(b)(1) did not automatically cease on October 1, 2001.

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[39] *See* Provider's Post-Hearing Brief at 9.
[40] 42 C.F.R. § 412.300(b) (2002).
[41] *See* Provider's Post-Hearing Brief at 9-10 (referencing Provider Exhibit P-3).
[42] *See id.*
[43] The Intermediary's representative admitted at hearing that the Provider's elections "actually did make sense with what the cost-reporting instructions suggested at that time…" *See* Tr. at 52.
[44] Provider's Post-Hearing Brief at 11 (citing to Tr. at 40-43).
[45] *See id.*

In support of its position, the Provider cites both the language of the regulation and CMS' discussion of the transition period in the preamble to various final rules that make it clear that the relevance and applicability of § 412.324 did not abruptly cease on October 1, 2001 with the end of the "normal" transition period for existing hospitals.[46] Rather, it remained in place and governed the capital cost reimbursement for new hospitals until an amendment to § 412.304 in 2001 which applied specifically to new hospitals after October 1, 2002.

Additionally, the Provider argues that, while § 412.304 states the "general rule" that "for cost reporting periods beginning on or after October 1, 2001, the capital payment amount is based solely on the Federal rate,"[47] § 412.324(b) provides the exception from that general rule for "new hospitals." This "new hospital" exception was clearly established by the language of the regulation and the public rulemaking notices issued in the Federal Register at the beginning and end of the capital IPPS transition period.[48]

The Provider points out that, in the final rule published on August 1, 2001 ("2001 Final Rule"),[49] CMS extended the new hospital exception to hospitals opening after October 1, 2002 under § 412.304(c)(2). That addition made it clear that CMS did not intend to limit this exemption to only those hospitals that opened before October 1, 2001. Specifically, in the preamble to the 2001 Final Rule, CMS stated:

> With the end of the capital prospective payment system transition period, all hospitals, (except "new" hospitals under § 412.324(b)) will be paid based on 100 percent of the Federal rate in FY 2002 . . . .
>
> New hospitals, as defined under § 412.300, are exempted from the capital prospective payment system for their first two years of operation and are paid 85 percent of their reasonable costs during that period.[50]

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[46] The Provider asserts that CMS has often referred to the 1991-2001 capital IPPS transition period for hospitals in existence in 1991 as the "normal" transition period, which necessarily suggests that the term "transition period" is a fluid concept. For example, new hospitals opened during the "normal" transition period had their own "individualized" ten-year transition periods that extended beyond October 1, 2001. The Provider cites to the following rulemakings as examples of where CMS refer to the "normal transition period": 56 Fed. Reg. at 43418; 57 Fed. Reg. 23618, 23697 (June 4, 1992); 57 Fed. Reg. 39746, 39845 (Sept. 1, 1992); 58 Fed. Reg. 30222, 30282 (May 26, 1993); 59 Fed. Reg. 27708, 27778 (May 27, 1994); 60 Fed. Reg. 29202, 29268 (June 2, 1995); 60 Fed. Reg. 45778, 45864 (Sept. 1, 1995); 61 Fed. Reg. 27444, 27504 (May 31, 1996); 61 Fed. Reg. 46166, 46237 (Aug. 30, 1996); 62 Fed. Reg. 29902, 29953 (June 2, 1997); 62 Fed. Reg. 45966, 46050 (Aug. 29, 1997); 63 Fed. Reg. 25576, 25619 (May 8, 1998); 63 Fed. Reg. 40954, 41017 (July 31, 1998); 64 Fed. Reg. at 24716, 24763 (May 7, 1999); 64 Fed. Reg. 41490, 41556 (July 30, 1999); 65 Fed. Reg. 26282, 26337 (May 5, 2000); 65 Fed. Reg. 47054, 47125 (Aug. 1, 2000); 66 Fed. Reg. 22646, 22736 (May 4, 2001). *See* Provider's Post-Hearing Brief at 11-12.

[47] 42 C.F.R. § 412.304(c)(1) (2002).

[48] *See* 56 Fed. Reg. at 43358. *See also* 66 Fed. Reg. at 39910-39911, 39951-39952.

[49] 66 Fed. Reg. 39828 (Aug. 1, 2001).

[50] *Id.* at 39951-39952.

Further, CMS clearly states its intention regarding reimbursement of capital costs after October 1, 2001 in stating:

> For cost reporting periods beginning on or after October 1, 2001, payment for capital-related costs for all hospitals, except those defined as new hospitals under § 412.324(b),[51] will be determined based solely on the capital standard Federal rate.[52]

The Provider notes that, when the 2001 Final Rule was published, the only regulatory provision governing the treatment of "new hospitals" was located at 42 C.F.R. § 412.324(b) — hence the repeated reference to this provision. The other "new hospital" provision at § 412.304(c)(2) was not promulgated until a year later.[53]

In response to a Board question at the hearing on whether or not the proposed rule published on May 4, 2001 ("2001 Proposed Rule")[54] sheds any light on the applicability (if any) of the amendments made by the 2001 Final Rule to § 412.304(c),[55] the Provider responded that the 2001 Final Rule essentially finalized the amendments in the 2001 Proposed Rule. Further, both the 2001 Proposed Rule and 2001 Final Rule state that, while the general rule for payment of capital related costs for all hospitals will be determined solely on the federal capital IPPS rate beginning on or after October 1, 2001, the exception at § 412.234(b)(1) remained for "new hospitals."[56]

In response to the Intermediary's argument that the Provider simply fell into a "gap" in the regulatory scheme and that there is no rule applicable to a new hospital in the Provider's situation (*i.e.*, a "new hospital" that opened between October 1, 2001, and October 1, 2002),[57] the Provider argues that CMS simply injected confusion into this capital cost question by first stating in the 2002 preamble that "no provision was made for new hospitals once the 10-year transition was completed"[58] and then subsequently allowing the extension in the 2001 Final Rule. The

[51] The Provider contends that 42 C.F.R. § 412.324(b)(1) governs the treatment of new hospitals opened prior to October 1, 2002 and 42 C.F.R. § 412.304(c)(2) governs hospitals opened after October 1, 2002. The Provider notes that CMS did not limit the "new hospital" exception language in the prior, or later, preamble discussions in the same Federal Register to hospitals defined as new "during the transition period," nor did it use the phrase "continue to be paid." *See id.* at 39910 and 39952. It is a general canon of statutory construction that, when different language is used in different parts of the same law or discussion, such use is presumed to be intentional. *See Florida Pub. Telecomms. Ass'n, Inc. v. FCC*, 54 F.3d 857, 860 (D.C. Cir. 1995) (applying "the usual canon that when Congress uses different language in different sections of a statute, it does so intentionally").

[52] 66 Fed. Reg. at 39910.

[53] *See* Provider's Post-Hearing Brief at 14-16. As the Provider's fiscal year at issue began *before* October 1, 2002, it is clear that it is not governed by 42 C.F.R. § 412.304(c)(2). The Provider asserts that there is no dispute that the Provider's FYs 2004 and 2005 are governed by § 412.304(c)(2) and, accordingly, the Provider was paid as a "new hospital" for those fiscal years. *Id.* at 21 n.19.

[54] 66 Fed. Reg. 22646 (May 4, 2001)

[55] Tr. at 69.

[56] Provider's Post-Hearing Brief at 16. *See also:* 66 Fed. Reg. at 22702.

[57] Tr. at 40-41, 53.

[58] 67 Fed. Reg. at 50101.

bottom line is that the Provider argues there is nothing in § 412.324(b) limiting applicability of the "new hospital" payment provision to hospitals that opened prior to October 1, 2002 and the cost reporting instructions, discussed below, resolve any apparent conflict in its favor.[59]

The Provider turns to the PRM 15-2 cost reporting instructions to resolve the apparent confusion caused by the 2001 Final Rule preamble statement. The June, 2003 revisions to the cost reporting instructions clearly allowed new providers with fiscal years beginning before October 1, 2002 to elect a fully prospective payment methodology under 42 C.F.R. § 412.304(b) or 85 percent of its allowable Medicare inpatient hospital capital-related costs under 42 C.F.R. § 412.324(b)(1). Because this instruction was worded as it was, the Provider could elect "N" and, therefore, not be paid under the prospective payment methodology. The Provider argues that CMS clearly intended to allow a new hospital filing a cost report year beginning before October 1, 2002 to be paid under the 85 percent of its costs methodology.

The Provider points to CMS' cost report instructions as a "proto-typical example" of an interpretive rule "issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers"[60] which "should be accepted by the courts unless . . . shown to be unreasonable or inconsistent with statutory authority." [61] Therefore, to the extent that there was any ambiguity or conflict in the regulatory scheme with respect to the treatment of hospitals that opened between October 1, 2001 and October 1, 2002, PRM 15-2 § 3604 serves as CMS's contemporaneous interpretation of its own regulations.[62]

Additionally, in response to the Intermediary's argument that the December, 2008 revisions to PRM 15-2 are simply corrections of an oversight, the Provider asserts that the December, 2008 revisions are a prohibited retroactive application of a substantive policy change and that the PRM 15-2 cost reporting instructions applicable to this case are those that CMS issued in June, 2003 (just after the 2002 Final Rule). These revised cost reporting instructions allowed "new providers with fiscal years beginning before October 1, 2002 under § 412.300(b)"[63] to elect capital reimbursement at 85 percent of reasonable costs for the first two full years of operation. Thus, while CMS may have recognized in the preamble to the 2002 Final Rule that a regulatory "gap" for providers filing their first cost report between October 1, 2001 and October 1, 2002 existed, CMS later deliberately "filled the gap" in June, 2003 by revising the cost reporting instructions to specify that providers opening before October 1, 2002 (like the Provider in this case) were entitled to the same "new hospital" treatment applicable to providers that opened before October 1, 2001 or after October 1, 2002. The cost reporting instructions are contemporaneous evidence of CMS' interpretation that new hospitals opened prior to October 1,

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[59] *See* Provider's Post Hearing Brief at 17-18.
[60] *Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87, 99 (1995).
[61] *Stormont-Vail Reg. Health Ctr. v. Shalala,* 947 F. Supp. 1526, 1530 (D. Kan. 1996) (quoting *Lexington County Hosp. v. Schweiker*, 740 F.2d 287, 288 (4th Cir. 1984) (quoting *Fairfax Nursing Ctr. Inc. v. Califano*, 590 F.2d 1297, 1301 (4th Cir. 1979))).
[62] The Provider notes that the preamble to the 2002 Final Rule that promulgated § 412.304(c)(2) was published on August 1, 2002 and that, subsequently in June 2003, CMS revised the cost reporting instructions at PRM 15-2 § 3604 to state that new hospitals opened prior to October 1, *2002* may elect to be exempt from the federal capital IPPS rate for their first 2 years.
[63] PRM 15-2 § 3604 (as revised by Transmittal 10 (June 2003)).

2002 were entitled to the exception.[64] The Provider asserts that 42 C.F.R. § 405.1867 requires the Board to "afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."[65]

Finally, the Provider contends that the Intermediary's interpretation is contrary to longstanding CMS policy. The Provider asserts that, since 1991, CMS has consistently indicated its desire to extend the opportunity for exemption from capital PPS to new hospitals during their first two years of operation. In the 1991 Final Rule, CMS stated that they "agree with the concerns expressed by the commenters," (*i.e.*, that payments under the fully prospective payment methodology may not be adequate for new hospitals) and created a rule exempting new providers from the capital IPPS for the first two cost reporting periods and instead reimbursing them at 85 percent of reasonable costs.[66] In the 2001 Final Rule, CMS stated that "[n]ew hospitals, as defined under § 412.300, remain exempt from the capital prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable costs during that period."[67] A year later as part of the 2002 Final Rule, CMS stated that "we believe that the rationale for the policy [exempting new hospitals from capital IPPS for the first 2 years during the ten-year transition period] applies equally to new hospitals even after the completion of the 10-year transition period."[68]

There is no dispute that the "two years of 85 percent reasonable cost reimbursement" policy has been in effect for new hospitals from 1991-2001 and from 2002 to the present date. The Provider argues that the Intermediary's interpretation not only ignores the discussion in the Federal Register and the PRM 15-2 instructions during the time period, but also creates a reimbursement scheme that is inconsistent with stated policy and arbitrarily treats providers opening during a small window of time differently from every other hospital in the country. The Intermediary even paid the Provider 85 percent of reasonable costs for two full years after the short fiscal period under appeal.[69] In other words, the Intermediary's interpretation produces absurd and inequitable results.

In summary, the Provider contends that the Intermediary's current interpretation — that CMS intended to exclude only new hospitals opened between October 1, 2001 and October 1, 2002 from two-year exemption from the capital IPPS — does not mesh with CMS's longstanding policy exempting new providers from the capital IPPS for their first two full years, nor does it comply with the explicit and contemporaneous cost reporting instructions published for providers in PRM 15-2. The Supreme Court has ruled that, "with respect to agency regulations,

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[64] It was not until December 2008 that CMS revised PRM 15-2 § 3604 to exclude providers that opened between October 1, 2001 and October 1, 2002 from "new hospital" reimbursement eligibility. The Provider notes that this change to the PRM occurred *after* the Provider had filed its final position paper in this appeal. Under the Administrative Procedure Act, a policy change made in 2008 cannot be applied retroactively to the Provider's FY 2003 cost report. *See* 5 U.S.C. § 551.

[65] *See* Provider's Post Hearing Brief at 18-21.

[66] 56 Fed. Reg. at 43418.

[67] 66 Fed. Reg. at 39952.

[68] 67 Fed. Reg. at 50101.

[69] In fact, had the Provider withheld services to Medicare beneficiaries for 34 days and not opened until October 1, 2002, it would have been paid pursuant to the 85 percent reasonable cost methodology without question by the Intermediary.

a court shall not defer to an agency's interpretation of its own regulation when an "alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation."[70] Because the Intermediary's current interpretation of the regulatory scheme cannot be squared with CMS's contemporaneous interpretations of the same regulation, the Intermediary's current interpretation is impermissible.[71]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that CMS did not intend to provide hospitals opening between October 1, 2001 and October 1, 2002 with the same "new hospital" exemption from payment under the fully federal capital IPPS methodology that is available to hospitals opening before October 1, 2001 and hospitals opening after October 1, 2002. There is simply no provision for the Provider to receive 85 percent of its allowable Medicare inpatient-capital related cost for the Short FY 2003 period. This cost reporting period begins after the end of the transition period but prior to the revision of the regulations. Specifically, because the Provider obtained Medicare certification on August 27, 2002 and Short FY 2003 period began on August 21, 2002, the Intermediary contends that the Provider is not eligible for reimbursement at 85 percent of reasonable cost payment for Short FY 2003 period.[72]

The capital IPPS regulation at 42 C.F.R.§ 412.304(c) (2001), which is applicable for cost reporting periods beginning on or after October 1, 2001, is based solely on the federal capital IPPS rate and does not reference the "new hospital" regulations at 42 CF.R § 412.324. The preamble to the 2002 Final Rule discusses the changes for the treatment of the new hospitals and this discussion makes CMS' position clear that no provision was made for new hospitals once the transition period was completed.[73] Therefore, under § 412.304(c)(2), a special payment provision was to be implemented for new hospitals with cost reporting periods beginning only on or after October 1, 2002. Further, this preamble discussion makes clear CMS' position that, while a gap was created between October 1, 2001 and October 1, 2002, CMS could not cover that gap by making this provision effective prior to October 1, 2002 because that regulatory change would constitute a prohibited retroactive rulemaking.[74]

The Board asked the Intermediary to address how capital costs would be treated for cost reporting periods beginning on or after October 1, 2001 for situations where the provider was a new hospital during the transition period.[75] To fully address the inquiry, the Intermediary submitted Intermediary Exhibit I-15 to address various scenarios. The only exception for a provider where it would not receive capital IPPS payments for a cost reporting period beginning on or after October 1, 2001 but prior to October 1, 2002 is when the provider began operations during the transition period and was paid hold harmless payments during that cost reporting

[70] *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (quoting *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988)).
[71] *See* Provider's Post-Hearing Brief at 21-25.
[72] *See* Intermediary Post-Hearing Brief at 7-8.
[73] 67 Fed. Reg. at 50101-50102.
[74] *Id.*
[75] *See* Tr. at 88-89.

period.[76] The Intermediary maintains that the illustrations in the Intermediary Exhibit I-15 are consistent with 42 C.F.R. § 412.324(b)(3). The case before the Board falls under Illustration 3.a.ii.[77]

Provider Exhibit P-13 includes excerpts from the 2001 Final Rule. The Intermediary argues that the Provider acknowledged during the hearing that there were no regulatory changes based upon this rulemaking.[78] The Intermediary asserts that the excerpts in this exhibit simply explain how providers that were "new" during the transition period would be reimbursed after the ten-year transition period. Since the cost report at issue began after the end of the ten-year transition period, the Intermediary concludes that the excerpts in this exhibit are not applicable to the Provider.

The relevant Intermediary workpapers are in the record at Intermediary Exhibit I-14. The auditor refers to CMS instructions and internal work instructions to make changes to the Worksheet S-2 questions which required the Intermediary to change the answers to the Worksheet S-2 questions in order to complete Part 1 of Worksheet L as required by capital IPPS policy in place at the time.[79]

Prior to the December, 2008 revisions to the PRM 15-2 cost reporting instructions, there had been a discrepancy between these instructions and the regulations as noted by the Provider. The Intermediary contends that the December, 2008 revisions were only a clarification of existing CMS policy. Two of the revisions affect this case. First, Worksheet S-2, Line 33, was revised to recognize that the election to be reimbursed under 100 percent federal capital IPPS payments only applies to new providers with initial cost reporting periods on or after October 1, 2002. For the cost reporting period at issue, there was no provision for an election of this treatment. Second, Worksheet S-2, Line 36, was revised to clarify that only for initial (first operating year of a new hospital) cost reporting periods beginning on or after October 1, 2002 could providers elect to not be paid on a fully prospective basis. There is simply no option or election available for cost reporting periods beginning on or after October 1, 2001 but prior to October 1, 2002 and such cost reporting periods must be paid on a fully prospective basis.[80]

In conclusion, contrary to the Provider's assertions, there simply was not a regulation allowing new providers with an initial cost reporting period beginning on or after October 1, 2001 but prior to October 1, 2002 to receive special payments during such initial cost reporting period. While the PRM 15-2 cost reporting instructions available at the time of the cost report filing and the finalization did not agree with the capital IPPS regulations, these instructions were later revised in December 2008. Since these December 2008 revisions were applicable for cost reporting periods beginning on or after October 1, 2001, it is clear that these revisions merely clarify the intent of the manual provision.

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[76] Intermediary Exhibit I-15, Illustration 1.b.
[77] *See* Intermediary Post-Hearing Brief at 8.
[78] *See* Intermediary Post-Hearing Brief at 8 (citing to Tr. at 19, ln. 25).
[79] The Intermediary also notes that the auditor did not reference the PRM 15-2 as it existed at that time. The cost reporting instructions in Chapter 36 of PRM 15-2 were updated in December 2008 with Transmittal 19. *See* Intermediary Exhibit I-11. This is after the date that the auditor completed the workpaper in May 2006. *See* Intermediary Post Hearing Brief at 9.
[80] *See* Intermediary Post Hearing Brief at 9.

While the Intermediary acknowledges that the Provider's election of new hospital status and exemption from capital IPPS was made pursuant to the PRM 15-2 instructions available at the time the cost report was filed, the Intermediary contends that these PRM 15-2 instructions included a mistake that was finally corrected in December 2008. The Intermediary contends that 42 C.F.R. § 412.324(b)(1) does not apply to the Provider and that 42 C.F.R. § 412.304(c)(2) (2002) only extends "new hospital" eligibility to providers opening after October 1, 2002. As a result, the cost reporting period at issue, *i.e.*, Short FY 2003 period, falls into a regulatory "gap" and is ineligible for the new hospital payment methodology, even though the Provider met the definition of "new hospital" at 42 C.F.R. § 412.300 during that cost reporting period.[81]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, evidence presented in the record and the parties' contentions and stipulations, the Board finds and concludes that the Intermediary correctly reimbursed the Provider under the federal capital IPPS rate for FY 2003.

At the outset, it is important to recognize that the ten-year transition period is not required nor otherwise provided for by statute. Rather, as discussed above in the Medicare Statutory and Regulatory Background, the ten-year transition period is provided for solely by regulation as a result of CMS exercising the discretion granted to it under 42 U.S.C. § 1395ww(g).

Accordingly, the issue presented for the Board's evaluation requires an analysis of the regulatory environment in place at the time of the Provider's cost report filing for the Short FY 2003 period. The Provider began operations in 2002 and obtained Medicare certification on August 27, 2002. The Provider's first cost reporting period was Short FY 2003 period which began on August 21, 2002. The language at 42 C.F.R. § 412.304(c) in effect on August 21, 2002 stated:

> (c) *Cost reporting periods beginning on or after October 1, 2001.* For cost reporting periods beginning on or after October 1, 2001, the capital amount is based solely on the Federal rate determined under paragraphs (a) and (b) of §412.308 and updated under paragraph (c) of §412.308.[82]

Subsection (c) was subsequently modified to include a new paragraph (paragraph (c)(2)) addressing "new hospitals" with cost reporting periods beginning on or after October 1, 2002.[83] While the new provision became effective on August 1, 2002 which is prior to August 21, 2002 when Short FY 2003 period began, this provision expressly stated that it only pertained to "cost reporting periods beginning on or after October 1, 2002" and made no mention of cost reporting periods beginning in the interim between October 1, 2001 and October 1, 2002.

The Board is not persuaded by the Provider's argument that 42 C.F.R. § 412.324(b)(1) is applicable in this instance because this regulation is applicable only for new hospitals during the ten-year transition period that began on October 1, 1991 and ended October 1, 2001. The

[81] *See* Tr. at 44-49.
[82] 56 Fed Reg. at 43449.
[83] *See* 56 Fed. Reg. at 43449 as amended at 67 Fed. Reg. at 50113.

regulations governing capital IPPS are located in Subpart M of 42 C.F.R. Part 412 and a close reading and review of these regulations confirms that the application of § 412.304(b) is restricted to cost reporting periods that begin during this transition period.

During the time at issue, Subpart M of 42 C.F.R. Part 412 was broken up into four distinct sub-subparts:

1. "General Provisions" comprised of §§ 412.300-412.304;
2. "Basic Methodology for Determining the Federal Rate for Capital-Related Costs" comprised of §§ 412.308-412.322;
3. "Determination of Transition Period Payment Rates for Capital-Related Costs" comprised of §§ 412.324-412.52; and
4. "Special Rules for Puerto Rico Hospitals" comprised of §§ 412.370-412.374.

Significantly, § 412.324 is located in the sub-subpart that, per its title, pertains only to the transition period.

Further, the overall language of 42 C.F.R. § 412.324 (2001) supports the conclusion that subsection (b)(1) pertains only to new hospitals opening during the ten-year transition period. Examples include the following phrases in § 412.324 which necessarily refer to hospitals or new hospitals operating during the ten-year transition period:

1. § 412.324(a) – "*During* the ten-year transition period, payments to a hospital . . . ."[84]
2. § 412.324(b)(2) – "For the third year *through the remainder* of the transition period, the hospital . . . "[85]
3. § 412.324(b)(3) – "[T]he hold-harmless payment for old capital costs . . . *may continue beyond the first cost reporting period beginning on or after October 1, 2000.*"[86]

Finally, the "General Provisions" in the first sub-subpart of Part 412, Subpart M, confirm that § 412.324(b)(1) applies only during the transition period. In particular, § 412.304 (2001) addresses the "Implementation of the capital prospective payment system" and, in subsection (b), it restricts the application of § 412.324 to cost reporting periods that begin during the transition period. Specifically, § 412.304(b) (2001) states:

> *Cost reporting period beginning on or after October 1, 1991 and before October 1, 2001.* For cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, the capital payment amount is based either on a combination of payments for old capital costs and new capital costs or a fully prospective rate, as determined under § 412.324 through § 412.348.[87]

[84] (Emphasis added.)
[85] (Emphasis added.)
[86] (Emphasis added.)
[87] (Italics in original and underline emphasis added.)

There is no other cross reference to § 412.324 located in Subpart M (2001). Thus, contrary to the Provider's argument, the Board finds that the application of § 412.324(b) is limited to the transition period.[88] As a result, the only applicable section for new hospitals with cost reporting periods beginning between October 1, 2001 and October 1, 2002 as is the case with this Provider is § 412.304(c) which, during the time at issue, required payment under the federal capital IPPS rate.

The Board acknowledges that the preamble to the 2001 Final Rule states that: "For cost reporting periods beginning on or after October 1, 2001, payment for capital-related costs for all hospitals, except those defined as new hospitals *under § 412.324(b)*, will be determined based solely on the capital standard Federal rate."[89] This statement simply accounts for the fact that, pursuant to 42 C.F.R. § 412.324(b), a new hospital that began operations *prior to* the end of the ten-year transition period could be reimbursed at a rate other than the capital IPPS rate (*e.g.*, the hold-harmless payment which, pursuant to subsection (b)(3), "may continue beyond the first cost reporting period beginning on or after October 1, 2000").[90] The preamble discussion in the 2001 Final Rule confirms this several paragraphs later:

> Hospitals that are defined as "new" for the purposes of capital payments *during the transition period* (see § 412.300(b)) will continue to be paid according to the applicable payment methodology outlined in § 412.324.[91]

Thus, contrary to the Provider's contention, the Provider's citations to the 2001 Final Rule do not support its position that § 412.324(b)(1) applies to hospitals that began operations after the close of the ten-year transition period.[92]

The Board further acknowledges that the PRM 15-2 cost reporting instructions for Worksheet S-2, Lines 33 and 36, have been either ambiguous or in conflict with the capital IPPS regulations and discussion in the 2002 Final Rule. Specifically, the Board acknowledges that: (1) prior to June, 2003 these instructions had some ambiguity because they did not specifically state that the new hospital exemption from capital IPPS was limited to new hospitals that opened during the ten-year transition period; and (2) subsequent to June, 2003 these instructions suggest that any hospital opening before October 1, 2002 (including new hospitals such as the Provider that opened between October 1, 2001 and October 1, 2002) were exempt from capital IPPS for their first two years of operation. However, as discussed above, the language of the capital IPPS regulations are controlling and, pursuant to 42 C.F.R. § 405.1867, the Board is bound by and

[88] The Board notes that the Board's finding is consistent with CMS' interpretation of that regulation as discussed by in the preamble to the 2002 Final Rule. *See supra note* 26 and accompanying text.
[89] 56 Fed. Reg. at 39910 (emphasis added).
[90] The Board notes that the Provider's citations to rulemakings referencing the "normal transition period" are narrow in focus and simply discuss the fact that, pursuant to 42 C.F.R. § 412.324(b)(3), a hospital that began operations during the ten-year transition is eligible to receive hold-harmless payments for eight years even if that eight years extends beyond the close of the ten-year transition period.
[91] 56 Fed. Reg. at 39911.
[92] The Board further notes that the rejection of the Provider's proposed interpretation is further supported by the fact that it would result in two regulations (*i.e.*, § 412.304(c)(2) and 412.324(b)(1)) addressing the same reimbursement issue for new hospitals opening on or after October 1, 2002.

must enforce these regulations notwithstanding the fact these regulations create a gap in the application of CMS policy on special payment protections for new hospitals beyond the ten-year transition. Indeed, CMS recognized this regulatory gap in the 2002 Final Rule and determined that it could not fill in this gap because such an action would constitute a prohibited retroactive rulemaking.

Accordingly, the Board must conclude that the language of 42 C.F.R. § 412.304(c) (2001), which limited the capital payment amount to the federal capital IPPS rate for cost reporting periods beginning on or after October 1, 2001, is controlling for initial cost reporting periods beginning during the interim period of October 1, 2001 to October 1, 2002. That language limits the capital amount for the Provider during Short FY 2003 to the federal capital IPPS rate. Accordingly the Board affirms the Intermediary's adjustment for Short FY 2003.

DECISION AND ORDER:

The Board finds that the capital IPPS regulations at 42 C.F.R. Part 412, Subpart M that were in effect at the beginning of the Provider's initial short cost reporting period that began on August 21, 2002 limited capital amounts solely to the federal capital IPPS rate. Accordingly, the Board affirms the Intermediary's adjustment for the Provider's initial short cost reporting period.

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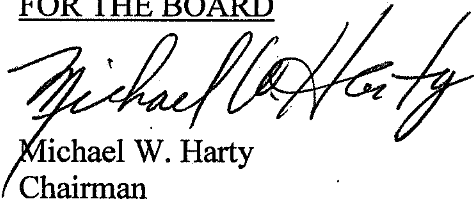

Michael W. Harty
Chairman

DATE: JUL 02 2013