PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D24

PROVIDER -
Southwest Ambulatory Behavioral Services, Inc.
Crowley, LA

Provider No.: 19-4650

vs.

INTERMEDIARY –
Novitas Solutions, Inc./
Blue Cross and Blue Shield Association

DATE OF HEARING -
June 13, 2013

Cost Reporting Periods Ended –
January 1, 2000 - December 31, 2000

CASE NO.: 08-0496

INDEX

ISSUE:

Was the Intermediary's adjustment to the allocation of the Provider's cost proper?

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 eligible individuals. Title XVIII of the Act was codified at 42 U.S.C., Chapter 7, Subchapter XVIII. The Centers for Medicare & 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 organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payment amounts due providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant period and the portion of those costs allocated to Medicare.[3] Each 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").[4]

A provider may appeal an intermediary's final determination of total reimbursement (*i.e.*, the NPR) with the Provider Reimbursement Review Board ("Board") provided it meets the following conditions: (1) the provider must be dissatisfied with that final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[5]

The Balanced Budget Act of 1997 ("BBA")[6] established a prospective payment system for outpatient department services, including community mental health centers that replaced the cost-based system.[7] On April 7, 2000, CMS adopted regulations implementing the hospital outpatient prospective payment system ("OPPS"). Although the BBA called for implementation by the beginning of 1999, OPPS was delayed until August 1, 2000, due to the scope of system

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20. 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.
[6] P.L. 105-33, § 4523, 111 Stat 251, 445-450 (1997).
[7] 42 C.F.R. §§ 419.21(a)-(c) (2000).

changes required to move from the prior cost-based system and address year 2000 issues related to claims processing.[8] OPPS was phased-in over a three-year transition period lasting until 2004.

On March 22, 2001, CMS issued Program Transmittal No. 4 for Chapter 18 of the Provider Reimbursement Manual, Part II, CMS Pub. No. 15-2 ("PRM 15-2")[9] revising the cost report instructions for Worksheet C in PRM 15-2 § 1802 to outline a computational methodology for allocating costs of outpatient rehabilitation providers on the cost report based on the August 1, 2000 effective date for OPPS. The computational methodology in § 1802, as revised, set forth a process to split/allocate costs by calculating a cost to charge ratio based upon the full cost reporting period, then applying that ratio to the Medicare charges for each of the short periods. These revised Worksheet C instructions will hereinafter be referred to as "the revised HCFA-2088-92 instructions for Worksheet C" and Transmittal No. 4 from PRM 15-2, Chapter 18 will hereinafter be referred to as "Transmittal No. 4."

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Southwest Ambulatory Behavioral Services, Inc. ("Provider"), is community mental health center ("CMHC") located in Crowley, Louisiana. Its fiscal year ("FY") ends on December 31st and the fiscal year at issue is FY 2000. Novitas Solutions, Inc. has assumed the responsibility for this Provider, which was previously serviced by TriSpan Health Services (collectively referred to as "Intermediary").

The Provider filed its FY 2000 cost report splitting costs for the two short periods (pre- and post-August 2000) pursuant to the methodology stated in the revised HCFA-2088-92 instructions for Worksheet C. However, the Provider protested the methodology use in Transmittal 4, utilizing the full fiscal year cost to charge ratios rather than its actual two separate cost to charge ratios, one for each pre and post August 2000. The Provider claimed $239,494 on Line 16.50 of Worksheet D for the additional cost not accounted for in that methodology.[10]

The Intermediary rejected the Provider's protest and declined to deviate from the revised HCFA-2088-92 instructions for Worksheet C. Accordingly, the Intermediary adjusted off the $239,494 claimed by the Provider.[11] On December 21, 2007, the Provider timely filed a request for hearing with the Board seeking the reversal of the Intermediary's adjustment.
The parties in this case have reached the following stipulations for use in this hearing:

> 1. Effective August 1, 2000, the reimbursement methodology for community mental health centers changed from the cost based reimbursement methodology to the prospective payment system.

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[8] 65 Fed. Reg. 18434, 18438 (Apr. 7, 2000); 65 Fed. Reg. 47670, 47671 (Aug. 3, 2000); 65 Fed. Reg. 67798, 67802 (Nov. 13, 2000); 65 Fed. Reg. 40535 (June 30, 2000).
[9] Copy included as Intermediary Exhibit I-3.
[10] For the period January 1-July 31, 2000, the actual costs were $1,018,897. *See* Provider's Letter dated June 21, 2013.
[11] *See* Intermediary Exhibit I-2 (copy of the Provider's FY 2000 CMS-2088-92 audit adjustment report showing Adjustment No. 6 in the amount of $239,494 "to remove protested items from the Provider's cost report").

2. As a result of this change in reimbursement methodology the Provider, a community mental health center (CHMC), was reimbursed for its FYE 12/31/2000 pursuant to two reimbursement methodologies; the cost based methodology from January 1, 2000 through July 31, 2000, and the prospective payment system from August 1, 2000 through December 31, 2000.

3. On March 22, 2001, HCFA (now known as CMS) issued Transmittal No. 4, which included revisions and instructions regarding Form HCFA-2088-92 that were applicable to the Provider's FYE 12/31/2000 cost report.

4. On or about June 17, 2002, the Provider submitted its FYE 12/31/2000 Medicare cost report to the then Intermediary (TriSpan Services). The cost report included a protested item in Worksheet D, Line 16.5, Column 1, seeking to add $239,494 to its reimbursement amount.

5. Following a desk review, on or about August 31, 2007, the Intermediary issued a final Notice of Program Reimbursement (NPR) to the Provider regarding the as-filed FYE 12/31/2000 cost report.

6. The NPR included minor standard adjustments of which Adjustment #6 is the only adjustment at issue in this appeal.

7. The protested item of $239,494 reflected the Provider's apportioned costs from January 1, 2000 through July 31, 2000, based on the Provider's Profit and Loss Statements from that period.

8. The Intermediary adjusted the protested item by following the applicable cost report instructions and forms, which allocated the Provider's costs before and after August 1, 2000 based on the percentage of Medicare revenues for the relevant time frames to total Medicare revenues for the year (as reflected on the PS&R report).

9. On December 21, 2007, the Provider timely filed its hearing request seeking the reversal of the Intermediary's Adjustment #6.[12]

[12] *See* Stipulation of Undisputed Facts and Law (May 29, 2014).

The Provider was represented by Christopher C. Johnston, Esq., of the Gachassin Law Firm. The MAC was represented by Robin Sanders, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends the Intermediary's application of the revised HCFA-2088-92 instructions for Worksheet D to its FY 2000 cost report was improper. According to the Provider, the Intermediary erred by following these instructions because they amounted to an "alternative" computational methodology that did not reflect the Provider's actual costs of services to Medicare beneficiaries. Further, the Provider asserts that this "alternative" computational methodology was not in compliance with the regulations and the PRM.[13]

In determining reasonable cost under the Medicare program, the Provider asserts that an "alternative" method may be used only when the actual costs cannot be determined and that the "actual costs" must be used when they are ascertainable. The fundamental principle of reporting actual costs is clearly stated in numerous Medicare regulations. The Provider contends that it apportioned costs based upon the actual costs incurred under its accrual-based accounting system and that such cost reporting methodology is compliant with, if not mandated by, Medicare regulations and the PRM.[14]

The Provider further asserts that its cost allocation methodology using actual costs meets the basic definition of "reasonable costs" set forth under 42 USC § 1395x(v)(1)(A) as "the costs actually incurred." The Provider contends further that its accrual-based system of accounting properly apportioned its actual costs which allowed it to know, in fact, its exact costs per short period. The "alternative" computational methodology set forth in the revised HCFA-2088-92 instructions for Worksheet C which were followed by the Intermediary does not properly reflect the Provider's actual cost for the two short periods at issue in FY 2000.[15] The Provider contends that its methodology using the actual costs for the cost reimbursed period of January 1, 2000 through July 31, 2000 when compared to the apportionment methodology utilized by the Intermediary recognized additional actual costs of $239,494. The Provider contends that these additional actual costs, reflected by a proper accounting method, are recognized by CMS regulations and should be accepted by the Intermediary.

The Provider further contends that the CMS cost report methodology as promulgated under Transmittal No. 4 improperly ignores the Provider's actual costs in violation of longstanding law and regulations because the law and regulations require the use of the actual costs if the Provider has the actual costs.[16]

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[13] *See* 42 C.F.R. §§ 413.9, 413.13, 413.24, 413.53, 413.60, 413.64; PRM 15-1 §§ 2100, 2102.1, 2300, 2302.1, 2302.7, 2304 and 2306.

[14] *See* 42 C.F.R. §§ 413.9, 413.13, 413.24, 413.53, 413.60, 413.64; PRM 15-1 §§ 2100, 2102.1, 2300, 2302.1, 2302.7, 2304 and 2306.

[15] *See* Provider's Post-Hearing Brief at 1.

[16] *See* Tr. at 27-30.

INTERMEDIARY'S CONTENTIONS:

The Intermediary asserts that it was simply following the revised HCFA-2088-92 instructions for Worksheet C, which clearly specified the reimbursement methodology to be used for purposes of the Provider's FY 2000 cost report. The Intermediary contends that the revised HCFA-2008-92 instructions for Worksheet C do not give the Intermediary discretion to disregard or modify the reimbursement methodology delineated in those instructions for any provider, including the Provider.[17]

The Intermediary further asserts that these instructions are consistent with applicable Medicare laws and regulations and that it acted correctly by disallowing the Provider's protested item.[18] The Intermediary contends that the regulatory provisions cited by the Provider do not mandate the "fundamental principle" that the Provider seeks to impose. Medicare regulations neither automatically require the use of ascertainable "actual costs" for purposes of reimbursement methodologies nor create an automatic link between "reasonable costs" and "actual costs" as implied by the Provider. The Intermediary contends that the regulatory and manual provisions cited by the Provider state the opposite and clarify that, while there is an undeniable connection between "reasonable costs" and "actual costs," it is only a provider's "reasonable costs" that may be subject to reimbursement under Medicare pursuant to cost apportionment methodologies approved by CMS.[19]

The Intermediary also contends that the regulations make clear that, contrary to the Provider's apparent position, a provider's actual costs may not be considered its *de facto* reasonable costs. The Intermediary cites to 42 C.F.R. § 413.9, which states that the connection between a provider's actual costs and its reasonable costs is "subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors." The Provider's arguments in this case ignore this significant regulatory limitation. The Intermediary asserts that, similarly, the cited PRM definition by the Provider for "reasonable costs" also recognizes that there are numerous methods for determining allowable costs under Medicare and that only reasonable costs – rather than actual costs – are subject to Medicare reimbursement.[20]

The Intermediary asserts that, since it is undisputed that CMS specifically identified the cost allocation methodology for the Intermediary to use when it processed the Provider's FY 2000 cost report and the Intermediary utilized this methodology when processing the Provider's disputed cost report, the Board should affirm the disallowance of the Provider's protested item and affirm its cost report adjustment.

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[17] *See* Intermediary's Position Paper at 7; Transmittal No. 4.
[18] Provider Exhibit P-8 at 8.8 (Letter from Darla B. Perry, dated June 21, 2013). *See* Worksheet D, Line 16.5, Column 1 for $239,494 (also reflected as cost report Adjustment #6, Intermediary's Exhibit P-2, at 3).
[19] *See* Intermediary's Post Hearing Brief at 4.
[20] *See* Intermediary's Post Hearing Brief at 4-5.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions, stipulations and the evidence presented in the record. Set forth below are the Board's findings and conclusions.

At the outset, the Board notes that, as stated in 42 C.F.R. § 413.9(c)(1) 2000, "it is the intent of Medicare that payments to the Provider of services should be fair to the providers, to the contributors, to the Medicare trust funds, and to other patients."[21] To this end, § 413.9(c)(2)-(3) goes on to state, in pertinent part, that:

> (2) The costs of providers' services vary from one provider to another and the variations reflect differences in scope of services and intensity of care. The provision in *Medicare for payment of reasonable cost of services is intended to meet the* ***actual*** *costs*, however widely they may vary from one institution to another. This is subject to a limitation if a particular institution's costs are found to be substantially out of line with other institutions in the same area that are similar in size, scope of services, utilization, and other relevant factors.
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> (3) The determination of reasonable costs of services must be based on cost related to the care of Medicare beneficiaries. . . . *The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the* ***actual*** *costs of providing quality care* ***however widely the actual costs may vary*** *from provider to provider and* ***from time to time for the same provider.***[22]

After looking at the parties' positions and listening to testimony of the witnesses it is clear to the Board that what is in dispute in this appeal is whether to calculate one cost to charge ratio on Worksheet C based on a full fiscal year or two separate cost to charge ratios, one for each short period. Reasonable cost is developed by calculating a ratio of total cost divided by total charges for each cost center. That ratio, i.e., "cost to charge ratio", is then multiplied by the total Medicare charges for each cost center to develop Medicare costs. The Board finds that by using the full fiscal year to calculate the cost to charge ratio, the cost allocations will be distorted. Instead, the cost to charge ratio should be calculated for each of the two short periods. (*i.e.*, January 1, 2000 through July 31, 2000 and August 1, 2000 through December 31, 2000) These periods are in essence short cost reporting periods and, the use of two cost to charge ratios is more accurate, fair and less arbitrary. Following the implementation of OPPS, a provider had a greater incentive to economize[23] and, as such, the Provider may have significantly different costs

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[21] 42 C.F.R. § 413.9(c)(1) (2000).

[22] (Emphasis added.) *See also* 413.13 (a) (defining "reasonable cost" as "cost actually incurred, to the extent that cost is necessary for the efficient delivery of the service, and subject to the exclusions specified in paragraph (d) of this section").

[23] *See* 65 Fed. Reg. at 18530 (stating "The *primary objective* of the hospital outpatient prospective payment system *is to* simplify the payment system and *encourage hospital efficiency in providing outpatient services*, while at the

between the pre- and post-OPPS implementation periods. Accordingly, the Board finds that the methodology set forth in the revised HCFA-2088-92 instructions for Worksheet C[24] is not the proper method to apportion the Provider's cost for the two short periods at issue in FY 2000 because by using two cost to charge ratios provides a more accurate and fair apportionment consistent with Medicare reasonable cost principles.

The Board further finds that the Provider mischaracterized the scope of the issue in this case by only accounting for the negative cost impact for the first seven months of the FY 2000 cost report due to the transition to the OPPS reimbursement methodology. As part of the Balanced Budget Refinement Act of 1999, Congress made available during the first three and half years of OPPS an additional payment known as "transitional outpatient payment" or "TOP" to certain qualifying providers to ease the transition from cost-based reimbursement to OPPS.[25] In asserting its claims, the Provider has failed to recognize the ripple effect created by the cost apportionment methodology in the TOP for the last five months of FY 2000 when OPPs was in effect. According to the cost report instructions, a TOP may be paid when the cost of Provider services for the short period of August 1, 2000 to December 31, 2000 is more than the OPPS.[26] Under the actual cost methodology of the Provider, the Provider may no longer qualify for TOP for the short period August 1, 2000 through December 31, 2000 because the OPPS payments for this period may be higher than the actual cost incurred for this period.

Accordingly, the Board finds that this case should be remanded to the Intermediary to apportion the FY 2000 costs across the two short periods. As part of this remand, the Board agrees with the Intermediary that the Intermediary should review the stated costs for FY 2000 to determine the reasonableness of these costs and adjust accordingly since this could impact the reimbursement (both pre- and post-August 1, 2000) if there were any audit adjustments.[27] To this end, the Intermediary also should calculate the impact of any adjustment to the costs on the TOP for the remaining portion of FY 2000 (*i.e.*, August 1, 2000 through December 31, 2000).

DECISION AND ORDER:

The Board remands this case to the Intermediary to review the stated costs for FY 2000 to determine the reasonableness of these costs and to apportion the Provider's FY 2000 costs across

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same time ensuring that payments are sufficient to compensate hospitals adequately for their legitimate costs." (Emphasis added)).

[24] *See* Transmittal No. 4 (includes revisions and instructions regarding Form CMS-2088-92 that were applicable to the Provider's FY 2000 cost report).

[25] Section 202 of the Balanced Budget Refinement Act of 1999 (Pub. L. No. 106-113, Appendix F, 113 Stat. 1501A-321, 1501A-342 (1999)) amended 42 U.S.C. § 1395l(t) by adding a new paragraph which provides for a transitional adjustment to limit payment reductions under OPPS. More specifically, from August 1, 2000 through December 31, 2003, a provider, including a CMHC, will receive an adjustment if its payment-to-cost ratio for outpatient services furnished during the relevant period is less than the estimate of what the provider would have been paid for that same period for the same services had OPPS not been in effect. *See* 65 Fed. Reg. at 67814-67815.

[26] *See* Transmittal No. 4 for instructions on calculating the transitional corridor payments. The as-filed cost report reflected an amount of $107,040 additional payments. The record does not reflect the submission of the complete copy of the Provider's finalized/audited cost report.

[27] *See* Intermediary Post Hearing Brief at 6 (stating that "[i]t is the FI's position that without specifically auditing the Provider's pre-and post-8/1/00 costs, it is not appropriate to automatically consider the Provider's actual costs as reasonable costs").

the two short periods of January 1, 2000 through July 31, 2000 and August 1, 2000 through December 31, 2000 based on a cost to charge ratio for each period. Based on this apportionment, the Intermediary should determine the amount of reasonable cost reimbursement due the Provider for the first short period and whether any adjustment should be made to the Provider's transitional corridor payment for the second short period.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

Michael W. Harty
Chairman

DATE: SEP 10 2014