CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
North Memorial Health Care	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: December 31, 2000**
Provider	
vs.	
Blue Cross Blue Shield Association / Noridian Administrative Services	**Review of: PRRB Dec. No. 2007-D27 Dated: April 20, 2007**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare Management (CMM) and the Intermediary, submitted timely comments, requesting partial reversal of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

North Memorial Health Care (the Provider) is a voluntary, non-profit, acute care hospital located in Minneapolis, Minnesota that also operates rehabilitation and psychiatric sub-providers, a home health agency, hospice and a hospital-based ambulance service. As part

of the final settlement of the Provider's FYE December 31, 2000 cost report, the Intermediary reduced capital-related costs for outpatient hospital services by 10 percent and outpatient operating costs by 5.8 percent. The Provider disagreed with the application of the reduction factors to its ambulance services (which were also subject to cost per trip limits) and filed a hearing request with the Board.

ISSUE AND BOARD'S DECISION

The issue is whether the Provider's fiscal year ending (FYE) 2000 ambulance cost per trip limits were improperly low because the Intermediary improperly applied the 5.8 percent outpatient operating cost reduction and the 10 percent outpatient capital cost reduction to base year costs utilized to calculate those limits.

The Board held that the Intermediary improperly applied the 5.8 percent outpatient operating cost reduction and 10 percent outpatient capital cost reduction to base year costs used to calculate the Provider's FYE 2000 ambulance cost per trip limits. The Board remanded the case to the Intermediary to recalculate the ambulance cost per trip limits accordingly and to modify its adjustments.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator overturn the Board's decision. Specifically, CMM requested reversal of portion of the Board's decision on the grounds that it would be contrary to consistent Medicare policy to reopen the base year for any adjustments or calculations. Across the Medicare program, and especially concerning the calculation of the base rate for ambulance services, CMM states that they have followed the procedure that, once the base year rates are determined, they are not altered as this would have ramifications for all subsequent cost years.

CMM agreed that the 5.8 and 10 percent reduction factors under Section 1861(v)(1)(S)(ii)(III) of the Act were properly applied by the Intermediary as ambulance services are considered to be outpatient hospital services. CMM stated that Medicare consistent policy is not to revise base year costs. Further, CMM stated that the Intermediary

properly applied the 5.8 and 10 percent reductions to the base year costs for the cost year in question.

The Intermediary submitted comments requesting reversal of the Board's decision. The Intermediary contended that the ambulance cost was subject to the 5.8 percent and 10 percent reductions because the ambulance service is an outpatient service subject to the cost reductions. The cost reductions were correctly computed in the base year, as the base year was to reflect reasonable cost. The Intermediary requested reversal of this part of the Board's decision.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments were received timely and are included in the record and have been considered. After a review of the record, applicable regulations and manual instructions, the Administrator finds that the Intermediary properly applied the 5.8 percent outpatient operating cost reduction and the 10 percent outpatient capital cost reduction to the base year costs used to calculate the Provider's FYE 2000 ambulance cost per trip limits.

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 CFR §413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

In response to rising costs, and realizing that the original structure of reasonable costs provided little incentive for providers to operate efficiently in delivering services, Congress authorized the Secretary to establish cost limits under Section 1861(v)(1)(A) of the Act.

Specifically, the Secretary has the authority to:

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

In addition, relevant to the reasonable cost principles above, existing Medicare law contains reduction factors for application to outpatient hospital services. Section 1886(v)(1)(s)(ii) of the Act states:

> (I) ... in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this subchapter ... by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1999 and until the first date that the prospective payment system under section 1833(t) of this title is implemented. (Emphasis added.)
>
> (II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and until the first date that the prospective payment system under section 1833(t) is implemented (emphasis added.)

As further evidence that the ambulance services at issue are outpatient hospital services, (although not covered under Outpatient PPS), Section 1833 of the Act states, in relevant part:

> (t) Prospective payment system for hospital outpatient department services --
>
> (1) Amount of payment ...
> (B) Definition of covered OPD services
> For purposes of this subsection, the term "covered OPD services" --...

> (iv) does not include ... ambulance services, for which payment is made under a fee schedule described in section 1834(k) of this title or section 1834(1) of this section ...
>
> (10) Special rule for ambulance services.
> The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1861(v)(1)(U) of this title, or, if applicable, the fee schedule established under 1833(1) of this title (emphasis added).

Furthermore, 42 CFR §419.22 states:

> Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.
>
> The following services are not paid for under the hospital outpatient prospective payment system:
>
> (i) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule under section 1834(1).

Accordingly, as the Board correctly determined, the ambulance services at issue are subject to the 5.8 percent and 10 percent reduction factors, as ambulance services are outpatient hospital services.

Regarding whether the costs recognized as reasonable in the base year should include the application of 5.8 percent and 10 percent reduction factors, the Administrator finds that the Intermediary properly applied the reduction factors to the Provider's base year costs. Pursuant to the Balanced Budget Act of 1997, Congress enacted Section 1861(v)(l)(U), which provided the following cost per trip limit to determine the payment for ambulance services:

> In determining the reasonable cost of ambulance services ... provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year ... increased by the percentage increase in the consumer price index for all urban consumers (U.S.

> city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point. (Emphasis added.)

Congress was concerned with escalating outpatient costs when it established the 10 percent and 5.8 percent reduction in costs for outpatient services and also the "cost per trip" limitation. The Secretary, in implementing the further cost containment measure reflected in the "cost per trip" provision, reasonably determined that the costs "recognized as reasonable" in the base year, should reflect the 10 percent and 5.8 percent reduction. That is, the base year costs, after application of the outpatient reductions are in fact the costs "recognized as reasonable" under the Medicare program.

The Administrator finds that the application of these reductions to the cost per trip base year is consistent with the statutory language of section 1861(v)(1)(U) and congressional concerns regarding escalating costs of outpatient and ambulance services. In addition, this policy is within the Secretary's authority under the reasonable cost provisions of section 1861(v)(1)(A) of the Act and the program. In light of the foregoing, the Administrator disagrees with the Board and finds that the Intermediary's application of the 5.8 percent outpatient operating cost reduction and 10 percent outpatient capital cost reduction to base year costs used to calculate the Provider's FYE 2000 ambulance cost per trip limits was appropriate. Application of the cost reduction factors to the base year produces costs that are reasonable as recognized by the Secretary and effectuates the intent of Congress to reduce and avoid excess cost per trip. Accordingly, the Board's decision is modified and the Intermediary's determination of the Provider's cost per trip for the cost year at issue is upheld.

DECISION

The decision of the Board is modified in accordance with the foregoing opinion. The Intermediary's determination of the Provider's cost per trip for the cost year at issue is upheld.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: 6/27/07

/s/

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services