CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
HealthEast Woodwinds Hospital	**Provider Cost Reimbursement/ Payment Determination for Cost Reporting Periods Ending: 08/31/03 and 08/31/04**
Provider	
Blue Cross Blue Shield Association/ AdminaStar Federal, Inc.,	**Review of:**
	PRRB Dec. No. 2008-D20 Dated: March 04, 2008
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 Intermediary and the CMS' Center for Medicare Management (CMM) commented, requesting reversal of of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Provider submitted comments, requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's refusal to reimburse the Provider for capital-related costs under the hold-harmless methodology was proper.

The Board held that the Intermediary's refusal to reimburse the Provider for capital-related costs under the hold-harmless methodology for the cost years at issue was improper. Based upon the Provider's status as a new provider during the transition period and the fact that the Provider's hospital-specific rate (HSR) for the periods in dispute exceed the Federal rate, the Board ruled that the Provider was entitled to payment under the hold-harmless methodology outlined at 42 C.F.R. § 412.324(b)

for up to eight years even though the hold-harmless payments may extend beyond the end of the transition period. The Board stated that it could find no support in the statute, or regulation, for the Intermediary's contention that a provider must be paid under the hold-harmless methodology prior to the end of the 1991-2001 transition period to continue to receive such treatment after 2001.[1] Accordingly, the Board remanded the case to the Intermediary to recalculate the Provider's HSR for the fiscal years at issue. The Board also instructed the Intermediary to amend, if necessary, the Provider's fiscal years ending (FYs) 2003 and 2004 cost reports to reflect its election of the hold-harmless methodology.

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Administrator review and reverse the Board's decision. The Intermediary argued that the Provider was not entitled to the hold-harmless methodology outlined at 42 C.F.R. § 412.324(b)(3), because the Provider was never paid under the hold-harmless methodology during the transition period. The Intermediary argued that payment under the hold-harmless methodology was a pre-requisite to continuing the methodology after the close of the ten-year transition period. In this case the Provider's third cost reporting period (September 1, 2002) began after the close of the ten-year transition period (October 1, 1991 through October 1, 2001); therefore, since the Provider never received hold-harmless treatment during the transition period, the Provider was not entitled to receive hold-harmless payments for up to eight years and beyond the first cost reporting period beginning on, or after, October 1, 2000.

CMM commented requesting that the Administrator reverse the Board's decision. CMM agreed with the Intermediary's position that the Provider was never paid under the hold-harmless methodology, therefore, the Provider could not continue to be paid under the hold-harmless methodology after the end of the transition period. CMM noted that the regulations at 42 C.F.R. § 412.324 are titled "Determination of Transition Period Payment Rates for Capital-Related Costs" which dictate payment during the capital PPS transition period for cost reporting periods beginning on or after October 1, 1991 to cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on, or after, October 1, 2001, CMM noted that 42 C.F.R. § 412.304(c)(1) applied and, as such, capital payment amounts were based solely on the Federal rate.

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider argued that CMS created three separate schemes to deal with the implementation of the capital prospective payment system: (1) a transition

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[1] Id.

methodology for hospitals already in existence at the beginning of the transition period in 1991, governed by 42 C.F.R. § 412.304(b) and (c); (2) a transition methodology for "new hospitals" created during the transition period, governed by 42 C.F.R. §412.324(b); (3) and a payment methodology for "new hospitals" created after the ten-year transition period ended. The Provider contends that it was a "new hospital" created during the ten-year transition period. Thus, it is entitled to the hold-harmless provision of 42 C.F.R. 412.324, since its HSR exceeded the Federal rate. To support its position, the Provider relied on the following language that stated: "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… If the hold-harmless methodology is applicable, the hospital will receive hold-harmless payment for assets in use during the base period for 8 years, which may extend beyond the 10-year transition period.[2]

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 received timely are included in the record and have been considered.

Section 1861(v)(1)(A) of the Social Security Act (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 therefrom 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 C.F.R. § 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.

Reasonable costs include capital-related costs. Consistent with the Secretary's rulemaking authority, the Secretary promulgated the regulation at 42 C.F.R. § 413.130, which lists capital-related costs that are reimbursable under Medicare. Capital-related costs under Medicare include depreciation, interest, taxes, insurance, and similar expenses (defined further in 42 C.F.R. § 413.130) for plant and fixed equipment, and for movable equipment.

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[2] 66 Fed. Reg. At 39,911 (Aug. 1, 2001).

Title VI of the Social Security Amendments of 1983[3] added §1886(d) to the Act and established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital services provided to Medicare beneficiaries. Under this system, hospitals are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge according to a list of diagnosis-related groups. Reimbursement under the prospective payment rate is limited to inpatient operating costs. The Social Security Amendments of 1983[4] amended subsection (a)(4) of §1886 of the Act to add a last sentence which specifies that the term "operating costs of inpatient hospital services" does not include "capital-related costs (as defined by the Secretary for periods before October 1, 1986)...." That provision was subsequently amended until finally, §4006(b) of Omnibus Budget Reconciliation Act (OBRA) 1987 revised §1886(g)(1) of the Act to require the Secretary to establish a prospective payment system for the capital-related costs of IPPS hospitals for cost reporting periods beginning in Federal fiscal year (FFY) 1992. Under the statute, the Secretary was granted broad authority in establishing and implementing the capital prospective payment system. To ease the transition of hospitals from cost reimbursement to the inclusion of capital payments under the inpatient prospective payment system, the Secretary promulgated regulations which established a ten-year transition period (that is, cost reporting periods beginning on, or after, October 1, 1991 and before October 1, 2001) to allow these hospital to adjust to the new system.[5]

During the ten-year transition period, hospitals were paid under one of two different payment methodologies. Hospitals with a hospital specific rate or "HSR" below the Federal rate were paid a blended percentage of their own capital cost and the Federal prospective rate for each year during the transition period.[6] Hospitals with a base period HSR greater than the Federal rate were paid under the hold-harmless methodology.[7] Hospitals paid under the hold-harmless methodology received the higher of: (1) a blended payment of 85 percent of reasonable cost for old capital plus an amount for new capital based on a portion of the Federal rate; or (2) a payment based on 100 percent of the adjusted Federal rate.[8] At the end of the ten-year period, hospitals would be paid solely on the Federal prospective rate.[9]

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[3] Pub. L. 98-21.

[4] Section 601(a) (2) of Pub. L. 98-21.

[5] 56 Fed. Reg. at 43,358 (Aug. 30, 1991). See also 42 C.F.R. § 412.304.

[6] 56 Fed. Reg. at 43,359-60 (Aug. 30, 1991). See also 42 C.F.R. § 412.324.

[7] 56 Fed. Reg. at 43,359-60 (Aug. 30, 1991). See also 42 C.F.R. § 412.344.

[8] 66 Fed. Reg. 39,910, 39,911 (Aug. 1, 2001). See also 42 C.F.R. § 412.344.

[9] Id.

During the ten-year transition period, the regulation at 42 C.F.R. § 412.324(b) provided an exemption from the capital prospective payment system for the first two years in the case of a new hospital.[10] The regulation explained that:

> (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.
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> (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).
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> (3) If the hospital is paid under the hold-harmless methodology described in §412.344, the hold-harmless payment for old capital costs described in §412.344(a)(1) is payable for up to and including 8 years and may continue beyond the first cost reporting period beginning on or after October 1, 2000. (Emphasis added).

The exemption was provided because the Secretary recognized certain difficulties new hospitals may face. In particular, the Secretary states that:

> This payment provision 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. For instance, hospitals newly participating in the Medicare program may not initially have adequate Medicare utilization. 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' capital prospective payment system payment to finance capital projects.[11]

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[10] The term "new hospital" is defined as "a hospital that has operated under previous or present ownership) for less than 2 year. See 42 C.F.R. § 412.300(b).

[11] 67 Fed. Reg. 49982 (Aug. 1, 2002).

The Secretary reiterated this policy in 2001 at the end of the transition period.[12] The Secretary explained, with respect to the treatment of "new hospitals", that:

> 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. During the transition period, new hospitals are exempt from the prospective payment system for their first 2 years of operation and are paid 85 percent of their reasonable capital-related costs during that period. The hospital's first 12 month cost reporting period…beginning at least 1 year after the hospital accepts its first patient, serves as the hospital's base period. Those base year costs qualify as old capital and are used to establish its hospital-specific rate used to determine its payment methodology under the capital prospective payment system. Effective with the third year of operation and through the reminder of the transition period, the hospital will be paid under either the fully prospective methodology or the hold-harmless methodology. If the fully prospective methodology is applicable, the hospital is paid using the appropriate transition blend of its hospital-specific rate and the Federal rate for that fiscal year until the conclusion of the transition period, at which time the hospital will be paid based on 100 percent of the Federal rate. If the hold-harmless methodology is applicable, the hospital will receive hold-harmless payment for assets in use during the base period for 8 years, which may extend beyond the 10-year transition period.

For cost reporting periods beginning on, or after, the transition period (October 1, 2001), capital PPS payments were based solely on the Federal rate for the vast majority of hospitals. The regulations at 42 C.F.R. § 412.304(c)(1), stated that:

> Except as provided in paragraph (c)(2) of this section, for cost reporting periods beginning on or after October 1, 2001, the capital payment amount is based solely on the Federal rate determined under §§ 412.308(a)(b) and updated under § 412.308(b).

Recognizing that there was no provision for "new hospitals" that began operation after the close of the ten-year transition period (October 1, 2001), the Secretary promulgated a new regulation extending the two-year exemption from capital PPS for new providers for cost reporting periods beginning on or after October 1, 2002.[13]

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[12] 66 Fed. Reg. 39,910, 39,911 (Aug. 1, 2001).

[13] 67 Fed. Reg. 50,100-50,101 (Aug. 1, 2002); See also 42 C.F.R. 412.304(c)(2).

Under 42 C.F.R. 412.304(c)(2), Secretary proposed to pay "new hospitals" 85 percent of their reasonable cost during their first two-years of operation, unless they elected to received payment based on 100 percent of the Federal rate. However, effective with their third year of operation, the new hospital would be paid based on the Federal rate.[14]

In this case, the record shows that the Provider began operations in August of 2000, within the initial ten-year transition period under 42 C.F.R. § 412.304(b). The record shows that the Provider qualified as a "new hospital" pursuant to 42 C.F.R. § 412.300(b) and was treated as a "new hospital" for purposes of capital-related payment during the Provider's first two cost reporting periods ending August 31, 2001, and 2002.[15] For the Provider's first two cost reporting periods, the Provider was paid 85 percent of its capital-related cost.[16] For the subsequent third and fourth cost reporting periods, the Provider requested to be reimbursed under the hold-harmless methodology outlined at 42 C.F.R. §§ 412.324 and 412.344 respectively.[17] However, the Intermediary notified the Provider that, effective with its cost report period beginning September 1, 2002, the Provider would be paid 100 percent of the Federal rate for capital-related cost under PPS, rather than the hold-harmless methodology. The Intermediary explained that the Provider was still a "new hospital" and had never been paid under the hold-harmless methodology prior to the end of the transition period.[18] As a result, the Provider appealed.

Based upon the Provider's status as a "new hospital" during the transition period and the fact that the Provider's HSR for the periods in dispute exceed the Federal rate, the Board ruled that the Provider was entitled to payment under the hold-harmless methodology outlined at 42 C.F.R. § 412.324(b) for up to eight years even though the hold-harmless payments may extend beyond the end of the transition period.

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Applying the foregoing provisions to the facts of this case, the Administrator finds that the Provider is not entitled to the hold-harmless provision described at 42 C.F.R. § 412.324(b)(3). The Administrator finds that 42 C.F.R. § 412.324(b)(3), requires that a hospital must have been paid during the transition period under the hold-harmless methodology in order to receive that benefit at the close of the transition period for up to eight years and beyond the end of the transition period. 42 C.F.R. § 412.324(b) states:

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[14] Id.
[15] Transcript of Oral Hearing (Tr.) at 55, 169, 197, and 201.
[16] Id.
[17] Tr. at 163-64, 170-72, and 203.
[18] Provider's Exhibit 11; Tr. at 73-74.

> (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 costs described in §412.344(a)(1) is payable for up to and including 8 years and may continue beyond the first cost reporting period beginning on or after October 1, 2000. (Emphasis added.)

In this case, the Administrator finds that the Provider was determined to be a new hospital and paid 85 percent of its capital costs for its first two cost reporting periods beginning September 1, 2000 through August 31, 2001, and September 1, 2001 through August 31, 2002, consistent with the rules applicable for new hospitals.[19] The record further shows that the Provider's third cost reporting period (beginning September 1, 2002 through August 31, 2003), began after the close of the ten-year transition period (i.e., for cost reporting periods beginning October 1, 1991 through October 1, 2001). The Administrator finds that the Provider was never paid under the hold harmless provision during the ten-year transition period. Consequently, because the Provider was never paid during the transition period (October 1, 1991 through October 1, 2001) under the hold-harmless methodology, the Administrator finds that the Provider is not entitled to receive hold0harmless payments with its cost years beginning September 1, 2002 through August 31, 2003 and September 1, 2003 through August 31, 2004.

[19] Tr. at 55, 169, 197 and 201.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: **5/5/08** **/s/**

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