CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Wayne County Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/ United Government Services, LLC-WI** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 08/13/84** **Review of:** **PRRB Dec. No. 2004-D44** **Dated: September 24, 2004**

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 Section 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. The Intermediary submitted comments, requesting reversal of the Board's decision. The Provider submitted comments, requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether the Intermediary properly recognized all termination costs as relating to the period ending 8/13/84 rather than allocating costs to prior years and recognizing the additional Medicare reimbursement as a below the line adjustment on the final 8/13/84 cost report.

The Board found the benefit costs at issue were a function of the duration of employment and, as such, should be allocated to other years, in addition to the termination year. The Board found that the "cost allocation and reimbursement method" produced the most accurate determination of costs of providing services to Medicare beneficiaries. The Board concluded that the "cost allocation and reimbursement method" should be used

because the costs at issue related to multiple cost report years prior to 1984 and also because of a lack of a specific rule to deal with the present situation. The Board noted that §2305 of the Provider Reimbursement Manual (PRM) did not address this situation because liability cannot be determined until a future event occurs.

BACKGROUND

The Provider terminated its operations and participation in the Medicare program on August 13, 1984. The Provider subsequently filed a final cost report covering the period from 12/1/83—8/13/84. On September 28, 1989, a Notice of Program Reimbursement (NPR) was issued for the Provider's final cost reporting period. The Provider appealed several of the adjustments including the disallowance of certain pension costs and retirees' health and life insurance costs. An Administrative Resolution was reached, and on September 17, 1993, a Notice of Correction for the period ending August 13, 1984 was issued.

When the settlement was implemented, the Intermediary treated all the costs as if they were attributable only to 1984. The Provider filed a Board appeal to protest the corrected NPR. The Provider contended that, since a significant portion of these costs related to cost report years prior to 1984, these costs should be allocated to the prior years based on the Provider's Medicare utilization in those years, and, reimbursed as a below-the-line impact adjustment on the 1984 final cost report.

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Board's decision be reversed. The Intermediary asserted that the Board exceeded its authority and manufactured a remedy where none existed. The Intermediary asserted that the PRM §§2305 and 2176.2 have relevance in this case. In addition, under regulation at 42 C.F.R. §412.112, employee costs for inpatient care were paid as inpatient operating costs under the prospective payment system (PPS) and there is no exception to pay the termination costs as “pass-through.”

The Provider commented, requesting that the Administrator affirm the Board's decision. The Provider disagreed with the Intermediary's assertion that the Board was treating costs as “pass-through.” The Provider contended that there was no “pass-through” because, under the Board's decision, the Provider did not receive additional Part A Medicare reimbursement for fiscal year ending (FYE) 1984. The Provider agreed with the Board that PRM §§2305 and 2176.2 do not apply in this case and that there was no Medicare rule or program instruction that specifically dealt with the situation in this case.

As such, the Provider argued that the Board correctly ruled that the fundamental principles of Medicare reimbursement dictated that the Provider must be reimbursed for undisputed costs incurred while its employees were providing services to Medicare beneficiaries. When reimbursement produced by the methods of determining costs proves to be either inadequate or excessive, the Medicare statute requires the Secretary provide suitable retroactive corrective adjustments. The reimbursement for the 1976 through 1984 cost years was clearly inadequate because it did not reflect all of the pension and retirees' health and life insurance costs incurred while providing patient care to Medicare beneficiaries. Therefore, according to the Provider, retroactive corrective adjustment was required and must be accomplished by adjustment to the 1984 cost report through the "cost allocation and reimbursement methodology."

The Provider also noted that the Board's decision was supported by prior decisions of the Board, the Administrator and the Courts. The Board ruled that the costs at issue should be allocated to prior periods and reimbursed to the Provider under the agreed-upon "cost allocation and reimbursement methodology." This concept is not without precedent in the Medicare rules. When a depreciable asset is sold for a significant gain, the gain is recognized in the period in which it occurs. Calculation of the reimbursement impact, however, reflects the Medicare utilization rate in each of the cost reporting periods in which the asset was held, not simply the cost reporting period in which the gain is recognized. 42 C.F.R. §413.134(f)(2)(iii).

Finally, the Provider argued that it is not seeking additional reimbursement for the 1984 cost year. Instead, a significant portion of the costs allowed by the Intermediary in the corrected NPR related to services rendered to Medicare beneficiaries in years prior to 1984. Thus, these costs are no longer subject to the rules governing PPS since they have been excluded from the determination of reasonable costs for purposes of the lower cost of charges (LCC) limitation and it is not necessary to reopen prior cost reports in order to calculate the Medicare reimbursement due the Provider. At least two district courts have held that this is the appropriate method for determining and reimbursing the costs of terminating providers.

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.

From its inception in 1966, until October 1983, Medicare paid for covered inpatient hospital services on the basis of "reasonable cost." Section 1861(v)(1)(A) of the Act defines the term, "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…." In addition, while section 1861(v)(1)(A) does not prescribe specific procedures for calculating reasonable cost, it authorizes the Secretary to promulgate regulations setting forth the methods to determine reasonable cost and the items to be included in reimbursable services.

In 1983, §1886(d) to the Act, was amended to establish the prospective payment system, otherwise referred to as "IPPS," for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries other than physicians' services associated with each discharge.[1] These a mendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under the inpatient prospective payment system (IPPS), hospitals and other health care providers are reimburse their inpatient operating costs on the basis of prospectively determined national regional rates for each discharge rather than reasonable operating costs. The purpose of IPPS was to reform the financial incentive hospitals face, promoting efficiency by rewarding cost-effective hospital practices.[2]

While Congress was anxious to restrain costs, it recognized that a sudden break from the "reasonable cost" method of reimbursement could pose financial hardship for many healthcare providers. Thus, to minimize disruption that might otherwise occur because of sudden changes in reimbursement levels, Congress chose to phase-in IPPS over a three-year transition period, which was subsequently extended for an additional year.[3] Section 1886(d) of the Act describes how the IPPS rates are to be determined for the transition period from the earlier cost-base reimbursement system to the IPPS. During the transition period, a gradually increasing portion is based on a regional or national Federal rate per discharge, or both,[4] and a declining portion of the total prospective payment rate is based on a hospital's historical costs in a given base year. The hospital's historic cost portion is referred to as the hospital-specific portion or HSP. During the year at issue in this case, the Provider's HSP constituted seventy-five percent of the total IPPS rate, while the prospective rate (Federal rate) equaled 25 percent.

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[1] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

[2] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272). See Also 51 Fed. Reg. 16772, 16773-16776 (1986).

[3] See §9102 of Pub. L. 99-2782, the Consolidated Omnibus Reconciliation Act (COBRA) of 1985.

[4] The "Federal portion" is a percentage of the product determined by multiplying the weighting for the applicable diagnosis related group (DRG) by the appropriate standardized amount, which is based on the historical average costs of all hospitals in a designated grouping, i.e., throughout the nation, within a particular census division and within designated urban or rural areas.

Section 1886(d)(5) of the Act, sets forth various exceptions to the reimbursement rates prescribed under IPPS. In addition, this section endows the Secretary with general authority to "provide by regulation for such … exceptions and adjustments to … payments amounts under this subsection as the Secretary deems appropriate."[5] However, consistent with the Act, the regulations at 42 C.F.R. §412.110 further explain that:

> Under the prospective payment system, Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the payments listed in §§412.112 through 412.115, reduced by the amount specified in §412.120.

Relevant to the facts in this case §2305 of the Provider Reimbursement Manual (PRM) states:

> Where the liability (1) is not liquidated within the 1-year time limit or (2) does not qualify under the exceptions specified in §§2305.1 and 2305.2 …, the cost incurred …, is not allowable in the cost reporting period when the liability is incurred, but is allowable in the cost reporting period when the liquidation of the liability occurs.

Finally §2305.1 states:

> Exception to 1-year Time Limit.—If the provider presents to the intermediary sufficient written justification based upon documented evidence for the nonpayment of a short term liability within the 1-year time limit, the cost associated with the liability may continue to be allowed. This exception must not extend beyond 3 years after the end of the cost reporting period in which the liability was incurred….

After reviewing the record and applying the above provisions to the facts of this case, the Administrator disagrees with the Board's determination that the benefits at issue in this case should be allocated to other years in addition to the termination year and paid outside of IPPS. The Administrator finds that there is no exception in Medicare policy, either under the cash basis of accounting or under the accrual basis of accounting, to recognize costs as though incurred in earlier periods when, in fact, they are incurred in later periods. Thus, the costs at issue in this case are properly reported as allowable for the terminating cost reporting period.[6]

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[5] Section 1886(d)(5)(I) of the Act.

[6] The costs were liquidated in 1985, 1986 and 1987, within the three year period specified in §2305.1.

The Administrator finds that the statute and regulations require that the IPPS payment serve as total Medicare payment for inpatient operating costs for all items and services furnished, other than those exceptions listed in the Act and the regulations, for the terminating cost reporting period. Accordingly, the Administrator reverses the Board's decision in this case.

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: 11/24/04

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers For Medicare & Medicaid Services