CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Community Care Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/ TriSpan Health Services** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: April 30, 1999** **Review of:** **PRRB Dec. No. 2005-D30** **Dated: April 8, 2005**

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)). Comments were received from the Intermediary and CMS' Center for Medicare Management (CMM) requesting reversal of the Board's decision. The parties were then notified of the Administrator's intention to review the Board's decision. Comments were received from the Provider requesting affirmation of the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary properly adjusted the method of reimbursing the Provider, a hospital-based skilled nursing facility (SNF), from cost-based reimbursement to the SNF prospective payment system (PPS).

The Board, reversing the Intermediary's adjustment, held that the SNF should have been reimbursed on a reasonable cost basis for the period under dispute. The Board noted that the statute provides for the implementation of the PPS for cost reporting periods beginning on, or after, July 1, 1998. The Board also noted that pursuant to

section 214.5 of the Provider Reimbursement Manual (PRM), a multi-facility complex which includes hospitals and hospital-based SNFs is required to submit one cost report. Further, section 102.1 of the PRM permits providers to file 13-month cost report. In this case, the Board found that the Provider chose its cost reporting period to conform to the requirements of the PRM. The Provider admitted its first Medicare patient on April 10, 1999; one month before the end of the cost reporting period April 1, 1998 through April 30, 1999. Thus, the Board concluded the SNF was not subject to SNF PPS for the cost period in dispute and should have been reimbursed on a cost basis.

COMMENTS

The Intermediary requested reversal of the Board's decision. The Intermediary argued that the Board's decision was incorrect and contrary to controlling regulation. The Intermediary noted that the Provider is a hospital-based SNF which was certified to participate in the program on April 1, 1999, and saw its first patient on April 10, 1999. However, the Intermediary pointed out that the SNF was included in the cost report filed by the hospital for the cost reporting period April 1, 1998 through April 30, 1999. Relying on correspondence of the Administrator of CMS, the Intermediary claimed that the Provider was advised that the initial cost reporting period of a provider is the date of certification, or the beginning of the month in which the first patient is seen. This requirement is applicable even in cases where the SNF is included in the cost report of an institutional complex. Thus, the Intermediary maintained that the first cost reporting period for this provider would begin in April 1999 and would be subject to SNF PPS.

CMM commented requesting that reversal of the Board's decision. CMM argued that the Board's decision is based on its flawed conclusion that the beginning date of the cost period selected by the hospital is the controlling factor when determining the start date for a SNF to be paid under SNF PPS. CMM pointed out that SNFs regardless of whether they are freestanding or hospital-based are paid under SNF PPS effective with their first cost period beginning on or after July 1, 1998. CMM noted that a SNF is a separate provider. The SNF may, for purposes of reimbursement, be included in the cost report of an institutional complex. However, in the case of a newly certified provider, the new provider's cost reporting year may not be the same as that of the hospital. CMM maintained that section 102.1 of the PRM identifies the initial cost reporting period of a provider as beginning on the date of certification or at the beginning of the month the provider first renders patient care services that could be covered under Medicare. In this case, the SNF was certified on April 8, 1999 and accepted its first patient on April 10, 1999. The SNF's cost reporting period is a Medicare “short cost reporting period” beginning on April 8, 1999, the

date it was certified and ended on April 30, 1999. Accordingly, CMM argued that the SNF was required to be paid under SNF PPS, not on a reasonable cost basis.

The Provider commented requesting affirmation the Board's decision. The Provider stated that the Board's decision was a correct interpretation of the law and was supported by the evidence. The Provider argued that a new hospital-based SNF that received its Medicare certification on, or after, July 1, 1998, should not be subject to PPS reimbursement if it is certified on, or after July 1, 1998, but is included in a hospital's cost report for a cost reporting period that begins prior to July 1, 1998. The Provider noted that section 2414.5 of the PRM states that pre-existing hospitals that have subproviders are required to submit one cost report for both entities. In addition, the Provider argued that, contrary to CMM, section 102 of the PRM does not apply. The Provider pointed out that the SNF PPS regulations do not require that a SNF will be subject to PPS if it was certified after July 1, 1998 or if it first saw patients after July 1, 1998. Thus, the Provider maintained that, since the cost reporting period began prior to July 1, 1998, the SNF is not subject to PPS for the cost period at issue.

DISCUSSION AND EVALUATION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments are included in the record and have been considered.

Prior to 1998, skilled nursing facility services provided under Part A of the Medicare program were paid under a retrospective reasonable cost- based system. Under the Medicare payment principles set forth in section 1861 of the Social Security Act and Part 413 of the Code of Federal Regulations, SNFs receive payment for three major categories of costs: routine costs, ancillary costs and capital-related costs. Routine costs (services included by the provider in a daily service charge) are paid on a reasonable cost basis subject to per diem limits. The reasonable costs of ancillary services (specialized services such as therapy and drugs and laboratory services that are directly identified to individual patients) and capital-related costs (the costs such as land, buildings, interest) are paid in full. In addition, sections 1861(v)(1) of the Act and 1888 of the Act authorize the Secretary to set limits on the allowable routine costs incurred by an SNF.

Section 4432 of the Balanced Budget Act of 1997 (Pub. Law 105-33) enacted on August 5, 1997, amended section 1888 of the Act by adding subsection (e). This subsection requires the implementation of a Medicare SNF prospective payment system for cost reporting periods beginning on or after July 1, 1998. Under the PPS,

SNFs are paid through a per diem prospective case-mix adjusted payment rate applicable to all covered services. Section 1888(e)(4) of the Act provides for the establishment of the per diem Federal payment rates applicable under the PPS and sets forth a formula for establishing the rates as well as the data on which they are based. The SNF PPS utilizes per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the system using costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in fiscal year 1995.

Beginning with a provider's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During the transition phrase, SNFs receive a rate comprised of a blend between the Federal rate and a facility specific-rate based on each facilities fiscal year 1995 cost report. The law provides that SNFs that receive their first payment from Medicare on or after October 1, 1995, are excluded from the transition period and payment is made in accordance to the Federal rates only.

The issue in this case involves the beginning date of the Provider's FYE April 30, 1999 cost report for purposes of determining whether that cost year is subject to SNF PPS. The Provider is a hospital-based skilled nursing facility (SNF) which was certified April 1, 1999.[1] Services that could be covered by Medicare were first rendered by the Provider on April 10, 1999. The Provider's costs were submitted on a multiple facility complex cost report. The multiple facility complex cost report at issue was not made part of the record.

The Provider cited the Provider Reimbursement Manual (PRM) at Section 2414.5 and stated "[p]re-existing hospitals such as [Community Care Hospital] that have a subprovider are required to submit one cost report for both entities [and that] [t]he SNF subprovider must take the hospital's cost reporting period."[2] Accordingly the

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[1] See Intermediary Exhibit 5 referring to an April 1, 1999 provider agreement date. While the Board decision refers to an April 8, 1999 certification date, it is undisputed that the date was well after the enactment of SNF PPS.

[2] Section 2414.5 of the Provider Reimbursement Manual states:

> Multiple-facility complex providers (hospitals, hospital-based SNF's, and hospital-based HHA's) will use the cost report designated for this type of facility which will provide adequate cost data. Institutions which have multiple facilities but only one provider number, or one provider number so subprovider numbers for its related cost entities, are required to submit one cost report under that particular provider number together with the subprovider numbers, if any.

Provider argues that, as the Hospital's cost reporting period began prior to July 1, 1998, the Provider qualifies for reasonable cost reimbursement even though it did not see its first patient until almost 10 months after the beginning of SNF PPS.[3]

Regarding cost reporting periods, Section 102 of the PRM explains that a provider may prepare a short period cost report for part of a year under the circumstances described in sections 102.1 and 102.3. Section 102.1 of the PRM explains that with respect to an initial cost reporting period, a provider may be permitted or required to file its first Medicare cost report covering less than or more than year. The ending date chosen by the provider for its initial reporting period is presumed to be the ending date the provider elects for its subsequent annual reporting periods. Section 102.1 further explains that

> In the case of a newly constructed provider that enters the Medicare program during its initial business year and in the case of providers that re-enter the Medicare program after a change of ownership, provider operations are considered to commence for cost reporting purposes when the first patient is admitted as an inpatient or received outpatient services (hospital or SNF)…. Therefore a provider's initial cost reporting period may not start before the beginning of the month in which it first renders patient care services which could be covered under the program.

Applying the provisions of the PRM to the facts in this case, the Administrator finds that the hospital-based SNF is a separate entity from the hospital under the Medicare program.[4] While a hospital-based SNF has the same cost reporting year end as the

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[3] The Intermediary adjusted the payment system identified for the Provider on Worksheet S-2. Worksheet S-2 sets forth the "Hospital and Hospital Health Care Complex Identification Data" including the provider numbers, certification dates and the payment system applicable to the hospital and its various components. Worksheet S-2 recognizes a distinct part SNF as a component that meets the requirements of Section 1819 of the Act, that is, as a separate provider entity from the hospital and as shown by the distinct provider numbers given to the Provider (provider number 19-5475) and the hospital (19-4056). The record in this case does not indicate that the provider is a subprovider of the hospital. Worksheet S-2 also requests the certification date of a hospital-based SNF in one column and the payment system in the next immediate column reflecting the nexus between the certification date and the payment system to be applied to a provider.

[4] A purpose of the multiple complex cost report is to ensure the appropriate allocation of costs between the various component for shared services and

hospital, the beginning of the cost reporting period can be different in the case of a newly certified SNF provider. In that instance, the start of the cost reporting period is necessarily controlled by when the Provider first rendered patient care services which could be covered by Medicare. In this case, the record shows that the hospital-based SNF did not render patient care services which could be covered by the Medicare program prior to July 1, 1998, but rather first rendered such services almost 10 months after the start of SNF PPS. Accordingly, the Provider's initial cost reporting period cannot be found to begin prior to July 1, 1998 and the Provider can only be reimbursed under SNF PPS.

DECISION

The decision of the PRRB is reversed.

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

Date: 6/7/05

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

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administrative costs of the hospital and any other related facility in the health complex. The costs stepped down to the hospital-based SNF pursuant to the multiple facility cost report would be consistent with its short cost reporting period and not reflect 13 months of costs.