CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Flagstaff Medical Center	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: June 30, 1997 through June 30, 2001**
Provider	
vs.	
Blue Cross Blue Shield Association / Noridian Administrative Services	**Review of: PRRB Dec. No. 2009-D4 Dated: December 18, 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 parties were notified of the Administrator's intention to review the Board's decision. The Intermediary submitted timely comments, requesting reversal of the Board's decision. The Provider also submitted timely comments, requesting affirmation of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

Flagstaff Medical Center (the Provider), is an acute care hospital located in Flagstaff, Arizona. During its cost reporting periods ending June 30, 1998, through June 30, 2001, the Provider furnished both ground and air ambulance services to Medicare beneficiaries. The Intermediary reviewed the Provider's cost reports and applied the interim cost limits of Section 4531 of the Balanced Budget Amendment (BBA) to the Provider's ambulance costs.

In doing so, the Intermediary applied a single limit to both the Provider's ground and air ambulance costs. In addition, based upon its interpretation of the BBA, the Intermediary determined the Provider's per trip limit for each affected cost reporting period based on the costs the Provider incurred in each of the immediately preceding cost reporting periods.[1] The Intermediary also applied the limit to the Provider's ambulance costs incurred after January 1, 2000, because CMS was unable to implement the required fee schedule payment methodology until April 1, 2002. The Provider appealed the Intermediary's calculation and application of the interim ambulance cost limits to the Board.

ISSUE AND BOARD'S DECISION

The Issue is whether the Intermediary properly calculated and applied the Provider's ambulance cost per trip limit.

The Board held that the Intermediary properly determined a single per trip ambulance cost limit applicable to both air ambulance service costs and ground ambulance service costs combined.

The Board also found that with the exception of the Provider's fiscal year 1999 cost report, the Intermediary properly applied a per trip ambulance cost limit determined from the Provider's costs in the immediately preceding cost report. The Board ruled, however, that the Intermediary must revise the Provider's fiscal year 1999 cost report to apply a per trip limit determined from the Provider's fiscal year 1998 costs. The Board stated that that the Intermediary improperly applied a per trip ambulance cost limit to Provider costs incurred on or after January 1, 2000, as no statutory or regulatory provision extended the cost per trip limits beyond January 1, 2000. Thus the Provider is entitled to be paid for ambulance services on the bases of reasonable cost reimbursement for that period.

[1] As noted by the Board, the Intermediary incorrectly calculated and applied a per trip ambulance cost limit derived from the Provider's 1997 cost report for the final settlement of the Provider's 1999 cost report. The Intermediary properly acknowledged this oversight in its Final Position Paper. The Board properly instructed the Intermediary to revise the final settlement by applying a per trip ambulance cost limit determined from the Provider's 1998 cost report to the Provider's 1999 costs.

SUMMARY OF COMMENTS

The Intermediary submitted comments requesting reversal of the Board's decision. The Intermediary contended that the ambulance costs are subject to the cost limits after January 1, 2000, even though the Secretary had not implemented the ambulance fee schedule until April 1, 2002.

The Provider submitted comments stating that the Board's decision should be affirmed. The Provider asserted that there is no statutory or regulatory provision that allows the Intermediary to apply cost limits after January 1, 2000. As such, the Intermediary should have applied reasonable cost for its June 30, 2001 cost report for ambulance costs.

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.

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. 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….

The Administrator agrees with the Board that the Intermediary properly determined a single trip ambulance cost limit applicable to both air ambulance service costs and ground ambulance service costs combined. However, the Administrator disagrees with that part of the Board's decision finding that the application of the per-trip ambulance cost limit to the Provider's costs incurred on or after January 1, 2000 was improper.

Section 1833(t) of the Act states that:

> (10) Special rule for ambulance services
>
> > The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1833(v)(1)(U) of this title, or, if applicable, the fee schedule established under 1833(1) of this title. (Emphasis added)

Pursuant to the Balanced Budget Act of 1997, Congress enacted Section 1861(v)(1)(U), pursuant to the following cost per trip limit to determine the reasonable cost of 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)

Regarding the application of the cost per trip limit after January 1, 2000, as promulgated in Section 4531(b)(4) of the BBA, which added section 1834(1)(3), the statutory provisions outlined in this section indicated that the fee schedule was to be effective for ambulance services on or after January 1, 2000. However, the Secretary was unable to implement the ambulance fee schedule until April 1, 2002, due to system changes and Y2k compliance. The Secretary clearly intended to implement the payment changes to ambulance services as instructed, but was forced to delay the implementation of a national fee schedule due to the difficulties that were experienced.

Congress, under the BBA, mandated the establishment of a national fee schedule to further remedy the problems experienced under the reasonable charge methodology and to provide a consistency in payments for ambulance related services. There is no specific provision or instruction to support that ambulance services should revert back to pre-BBA cost reimbursement for the period after January 1, 2000 until the implementation of the fee schedule. The congressional intent is clearly to move ambulance services to a national fee schedule and to provide a consistency in payments to control material variation in costs.

In establishing the fee schedules, Congress continued to require the Secretary to establish mechanisms to control increases in expenditures for ambulance services under Part B of the Medicare program (Section 1834(l)(2)(A) of the Act). Section 1833(t)(10) instructs that payment is to be made under Section 1861(v)(1)(U) (the cost per trip limit) or the fee schedule under section 1833(1) and does not contemplate a reversion to pre-BBA methodology. Congress also required the Secretary to ensure that aggregate payment amounts made in the first year under the fee schedule not exceed the aggregate amount of payment that would have been made for such services had the cost per trip limitation applied. Section 1834(l)(2)(C)). Therefore, it is inconsistent with the statutory scheme for ambulance services to allow payment without application of the cost per trip limitation for periods after January 1, 2000 involved in this case.

DECISION

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

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

Date: **2/24/09**

/s/
Tim Hill
Acting Deputy Administrator
Centers for Medicare & Medicaid Services