CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Mayo Clinic Hospital **Provider** **vs.** **Blue Cross /Blue Shield Association** **Noridian Administrative Services** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Periods Ending: 12/31/2000; 12/31/2001 and 12/31/2002** **Review of:** **PRRB Dec. No. 2009-D5** **Dated: December 22, 2008**

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. No comments were received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is a general acute care teaching hospital located in Phoenix, Arizona. The Provider entered the Medicare program on November 18, 1998.[1] The Provider's first cost report was for FYE December 31, 1999, and was filed on May 31, 2000.[2] The Notice of Program Reimbursement (NPR) for the FYE December 31, 1999 cost report was issued on September 26, 2005.[3]

---

[1] Provider's Revised Final Position Paper at 5.

[2] Id.

[3] The Administrator notes that FYE December 31, 1999, is not at issue in this case.

For the three fiscal periods in dispute, the Provider petitioned the Intermediary to authorize additional outlier payments. The Provider did not yet have a "settled" cost report since entering the Medicare program. The Intermediary applied the statewide cost-to-charge ratios to determine the Provider's outlier payments. The NPRs for the FYEs December 31, 2000 and 2001 were issued on September 29, 2005.[4] The NPR for FYE December 31, 2002 was issued on September 30, 2005.[5] Thus, the cost reports for the Provider's first four years under Medicare (three of which are at issue in this case) were all settled in September 2005.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary used the proper cost-to-charge ratios in calculating the Provider's outlier payments.

The Board held that the Intermediary did not use the proper cost-to-charge ratios to calculate the Provider's outlier payments. The Board held that the Intermediary should have used the cost-to-charge ratios determined from the Provider's "as filed" cost reports, instead of using the statewide cost-to-charge ratios. The Board concluded that the statute and enabling regulation did not permit the use of the statewide cost-to-charge ratios as a default methodology, when a settled cost report was not available. The Board found that the use of the statewide cost-to-charge ratios conflicted with the principles discussed in the preamble in that it placed reliance on averages that the Secretary discarded as being less accurate than the hospital's specific data.

Finally, the Board concluded that a recalculation of the Provider's outlier payments was not a retroactive adjustment and would not violate 42 C.F.R. § 412.116(e) because the required recalculations are based upon data contemporaneous to the subject cost reporting periods. At the time the Intermediary made its tentative settlement, the cost-to-charge ratios used to calculate the outlier payments should have been updated to the best data available, which the Board determined was the data from the Provider's "as submitted" cost reports. The Board ordered that the Intermediary was to base the Provider's outlier payments on data found in the Provider's tentatively settled cost reports.

---

[4] Intermediary's Final Position Paper Exhibit I-2.

[5] Intermediary's Final Position Paper Exhibit I-1.

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.

Title VI of the Social Security Amendments of 1983,[6] adding § 1886(d) to the Act, established the inpatient prospective payment system (IPPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries other than physician's services associated with each discharge. These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under IPPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. The purpose of IPPS was to reform the financial incentives hospitals face, promoting efficiency by rewarding costs effective hospital practices.[7]

Pursuant to § 1886(d)(5)(A) of the Act, Congress authorized the Secretary to make additional payments under IPPS for patient discharges that qualify as "outlier" cases, which involve unusually costly or lengthy patient treatments. To implement this additional payment provision, the Secretary promulgated regulations at 42 C.F.R § 412.80, et seq. (2000). The regulation at 42 C.F.R § 412.84(h) states with respect to cost outliers, that:

> The operating cost-to-charge ratio and, effective with cost reporting periods beginning on or after October 1, 1991, the capital cost-to-charge ratio used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital and charge data for that same time period as that covered by the cost report. Statewide cost-to-charge ratios are used in those instances in which a hospital's operating or capital cost-to-charge ratios fall outside reasonable parameters. CMS sets forth these parameters and the statewide cost-to-charge ratios in each year's annual notice of prospective payment rates published under §412.8(b). (Emphasis added.)

Thus, under the existing regulation for the fiscal periods in dispute, operating and capital cost-to-charge ratios were computed annually by the intermediary for each hospital based

---

[6] Pub. L. No. 98-21.

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

on the latest available settled cost report for that hospital.[8] Finally, if the intermediary is unable to compute a reasonable cost-to-charge ratio, CMS computes a statewide average cost-to-charge ratio to use in the cost outlier calculation.[9]

In the September 30, 1988 final rule with comments, the Secretary noted that outlier payments would be final and not subject to recalculation based on later data. The Secretary explained that:

> This policy was first set forth in the September 1, 1983 final rule (48 FR 39779) and at that time codified at § 405.454(m)(5). This section was subsequently redesignated as § 413.64(k)(1)(ii) in a final rule with comment period published on September 30, 1986 (51 FR 34790). However, in a final rule with comment period published on January 21, 1988 (53 FR 1621), when this section was further redesignated as § 412.116(e), we inadvertently deleted from that section the sentence that specified that outlier payments are based on submitted bills and represent final payment. As a part of this proposed rule, we corrected that paragraph to include the deleted sentence.[10]

Furthermore, the Secretary explained, in response to comments requesting that the latest filed cost report be used to compute the hospital-specific cost-to-charge ratios, as opposed to the latest settled cost report, that:

> *Comment*: A number of commenters expressed concern about the timeliness of the data we are using to compute the hospital-specific cost-to-charge ratios. Because the latest settled cost reports may be as much as three years old, commenters were concerned that there could be significant fluctuations in the ratios and that the data would not reflect current cost-to-charge ratios. Some commenters suggested that we use the latest filed cost report and others stated that we should update the ratios more than once a year.
> *Response*: We believe that the hospital-specific cost-to-charge ratios should be developed using the most current and accurate data available.

---

[8] 53 Fed. Reg. at 38503, (Sept. 30, 1988). Correspondingly, the regulation at 42 C.F.R. § 412.525(2002) states that, "[n]o retroactive adjustments will be made to the outlier payments upon cost report settlement to account for differences between the estimated cost-to-charge-ratios and the actual cost-to-charge ratio of the case." The regulation at 42 C.F.R. §412.116(e) also states that "[p]ayments for outlier cases… are not made on an interim basis…."

[9] 53 Fed. Reg. at 38503. (Sept. 30, 1988).

[10] 53 Fed. Reg. 38503. (Sept. 30, 1988).

> While the latest filed cost report represents the most current data, we have found that Medicare costs are generally overstated on the filed cost report and are subsequently reduced as a result of audit. Therefore, we believe the latest settled cost report represents the most accurate available data for computing the hospital-specific cost-to-charge ratios.[11] (Emphasis added.)

This particular case centers on whether the Intermediary properly calculated the Provider's outlier payments using the statewide cost-to-charge ratios to the Provider's covered charges, or as the Provider proposes, the Intermediary was required to use the Provider's cost-to-charge ratios determined from the "as filed" cost reports applied to covered charges. The Board held that the Intermediary incorrectly determined the Provider's outlier payments. The Board held that the Provider's outlier payments should be based on data found in the Provider's as submitted or as filed cost reports and, therefore, should be recalculated.[12]

The Administrator finds that the Intermediary properly used the statewide cost-to-charge ratios to determine the Provider's outlier payments in the absent of settled cost reports. While the latest filed cost report represents the most current data, the Administrator finds that the latest settled cost report, or when that is not available, the statewide average, generally represents the more accurate data for computing the hospital-specific cost-to-charge ratios. Thus, it is reasonable that, as a matter of policy, CMS prohibits the use of "as filed" cost reports to compute the ratio.[13] Consequently, the Administrator finds that a statewide average cost-to-charge ratio is appropriate to be used

---

[11] Id. at 38507. See also 68 Fed. Reg. 34494 (June 9, 2003) (Summary: "Under the existing outlier methodology, the cost-to-charge ratios from hospitals' latest settled cost reports are used in determining a fixed-lss amount cost outlier threshold.") Id. at 34494. ("Under our existing regulation at § 412.84(h), the operating cost-to-charge ration and, … the capital cost-to-charge ration used to adjust covered charges are computed annually by the intermediary for each hospital based on the latest available settled cost report for that hospital…") Id. at 34495. ("Currently, we use the most recent settled cost report when determining cost-to-charge ratios for IPPS hospitals.") Id. at 34497.

[12] While the Board discussion refers to "as submitted" cost reports, the Board's order requires the use of the tentatively settled cost reports. The Provider never requested use of such cost reports, nor does the record contain evidence of such cost reports, so it would appear that the reference to "tentatively" settled is an inadvertent error.

[13] CMS' policy is further supported as a prophylactic rule to prevent the manipulation of costs through the use of unaudited costs/cost reports, in light of the documented manipulation generally observed by CMS in the outlier payment arena.

when an intermediary is unable to compute a reasonable cost-to-charge ratio because there is no settled cost report.[14]

Further, while the Secretary made changes to allow for the use of settled or tentatively settled cost reports, effective after the periods involved in this case, the Secretary continued to have concerns about the accuracy of the latter data. Notably, the Secretary never proposed to use data from as-submitted cost reports. Accordingly, in allowing the use of tentatively settled cost reports, the Secretary made corresponding changes to require the reconciliation of outlier payments to account for difference between the cost-to-charge ratio (CCR) used to pay the claim at its original submission and the CCR determined at final settlement of the cost reporting period during which the discharge occurred. Consequently, the Administrator determine that, for the periods at issue in this case, neither "as-submitted" cost reports, nor tentatively settled cost reports, maybe used to calculate the cost to charge ratios.

Thus, applying the relevant law and program policy to the foregoing facts, the Administrator finds that the Intermediary properly applied the regulations at 42 C.F.R. § 412.84(h) by calculating the Provider's cost-to-charge ratios using the statewide average.

[14] With respect to the Board's determination that a recalculation of the Provider's outlier payments are not a retroactive adjustments, the CMS longstanding policy for the cost years in this case is that outlier payments are final and not subject to recalculation based on later data to account for differences between estimated cost-to-charge-ratios and the actual cost-to-charge-ratios of the 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: **2/24/09** **/s/**

Tim Hill
Acting Deputy Administrator
Centers for Medicare & Medicaid Services