PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D21

PROVIDER –
McCamey Hospital and Convalescent Center
McCamey, TX

Provider No.: 45-0728

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Trailblazer Health Enterprises, LLC

DATE OF HEARING –
December 15, 2009

Cost Reporting Periods Ended –
September 30, 1998 and
September 30, 1999

CASE NOs.: 04-0327 and 04-0328

INDEX

ISSUE:

Whether the Provider is entitled to payment of "fair compensation" pursuant to 42 C.F.R. § 413.13.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. § 1395 *et seq*. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FI) and Medicare administrative contractors (MAC). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20 and .24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. *See* 42 C.F.R. § 413.20. The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). *See* 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Prior to 1984, the Medicare statute required that providers be reimbursed the "reasonable cost" of providing services to Medicare beneficiaries, including hospital inpatients. Congress defined "reasonable cost," in part, as follows:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services[.] […] Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be

[1] FIs and MACs are hereinafter referred to as intermediaries.

> borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs[.]

42 U.S.C. § 1395x(v)(1)(A).

Under the reasonable cost reimbursement methodology, payment for both Part A and Part B services furnished by most providers was based on the lesser of the reasonable cost of the services, as determined under section 1861(v) of the Act, or the provider's customary charges for the services. This reimbursement method is generally known as the "lesser of costs or charges (LCC) principle," and is set forth fully in regulations at 42 C.F.R. § 413.13.[2] The LCC principle was established to ensure that the program would not pay more for services than the provider charged to the general public. *See* 53 Fed. Reg. 10077 (1988).

On October 1, 1983, Congress amended the Social Security Act and adopted a new payment system known as the Prospective Payment System (PPS) for the operating costs of inpatient hospital services. *See* 42 U.S.C. § 1395ww(d)(l)-(5). Under PPS, with few exceptions, acute care hospitals are no longer reimbursed for inpatient care provided to Medicare beneficiaries on the basis of reasonable costs incurred; instead, they are paid a predetermined, standardized amount for each discharge, depending on the "diagnosis related group" (DRG) into which the patient's diagnosis and treatment is classified. *Id.*

As a result of the change to the PPS payment methodology, CMS revised the regulations specific to the LCC provisions as follows:

> Section 405.455 was revised to provide that the lower of cost or charges (LCC) provision will not apply to the determination of payment for Part A Medicare inpatient hospital services under either the rate of increase or the prospective payment system. … With respect to the prospective payment system, payment for inpatient operating costs is made on the basis of a fixed amount per discharge rather than on the basis of LCC. In order to prevent imposing significant new recordkeeping burdens on hospitals if we were to apply the LCC provisions to costs other than inpatient operating costs (by which we mean capital-related costs, and costs allocated by a hospital to approved medical education programs), we decided to discontinue application of the LCC provision with respect to all Part A Medicare inpatient hospital services furnished in cost reporting periods beginning on or after October 1, 1982. The LCC provisions will still be applicable to all Medicare Part B services.

Prospective Payment for Medicare Inpatient Hospital Services, 49 Fed. Reg. 297 (1984).[3]

---

[2] Former Regulation 42 C.F.R. § 405.455 was redesignated as 42 C.F.R. § 413.13 at 51 Fed. Reg. 34790 (Sept. 30, 1986, effective Oct. 1, 1986). *See* Exhibit I-6.

[3] Exhibit I-5; *See also* footnote 2.

The controlling regulation for the cost reporting periods at issue states:

Sec. 413.13, Amount of payment if customary charges for services furnished are less than reasonable costs

(a) *Definitions*. As used in this section --

Fair compensation means, for the purpose of providers that meet the nominal charge provisions in paragraph (f) of this section, the reasonable cost of covered services furnished to beneficiaries.

New provider means a provider that has operated as the type of facility for which it has been approved for participation in the Medicare program (for example, as a SNF or an HHA) under present and previous ownership for less than three full years.

Provider with a significant portion of low-income patients means a nonpublic provider whose charges are 60 percent or less of the reasonable cost represented by the charges, and that demonstrates, as required under paragraph (c)(1)(iii) of this section, that its charges are less than costs because its customary practice is to charge patients based on their ability to pay.

Public provider means a provider operated by a Federal, State, county, city, or other local government agency or instrumentality.

(b) *Application of the principle of lesser of costs or charges* --

(1) *General rule*. Except as provided in paragraph (c) of this section, effective with cost reporting periods beginning on or after January 1, 1974, hospitals, SNFs, HHAs, OPTs, and CMHCs but only for purposes of providing partial hospitalization services, are paid the lesser of the reasonable cost (as described in paragraph (d) of this section) of covered services furnished to beneficiaries or the customary charges (as defined in paragraph (e) of this section) made by the provider for the same services. The carryover of unreimbursed reasonable costs from previous cost reporting periods is recognized, in accordance with the provisions of paragraph (h) of this section.

(2) *Example*. A provider's reasonable cost for covered services furnished to Medicare beneficiaries during a cost reporting period is $125,000. The customary charges to those beneficiaries for these services is $110,000. The provider is to be reimbursed $110,000 less deductible and coinsurance amounts that the beneficiaries are charged.

> (c) *Providers and services not subject to the principle* --
>
> (1) *Providers* --
>
> (i) *CORFs*. Payment to CORFs is based on the reasonable cost of the services.
>
> (ii) *Public providers*. Public providers furnishing services free of charge or at a nominal charge (as specified in paragraph (f) of this section) are paid fair compensation for services furnished to beneficiaries.
>
> (iii) *Providers furnishing services to a significant portion of low-income patients*. Effective with cost reporting periods beginning on or after October 1, 1984, a provider furnishing services at a nominal charge (as specified in paragraph (f) of this section) is paid fair compensation, upon request, for services furnished to beneficiaries if the provider can demonstrate to its intermediary that a significant portion of its patients are low income and that its charges are less than costs because its customary practice is to charge patients based on their ability to pay.
>
> (2) *Services* --
>
> (i) *Part A inpatient hospital services*. The lesser of costs or charges principle does not apply to Part A inpatient hospital services subject to--
>
> (A) The rate-of-increase limits under Sec. 413.40, effective with cost reporting periods beginning on or after October 1, 1982; or
>
> (B) The prospective payment system under Part 412 of this chapter, effective with cost reporting periods beginning on or after October 1, 1983.

42 C.F.R. § 413.13 (1997).[4]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

McCamey Hospital and Convalescent Center (Provider) is a 16-bed non-proprietary, general, short-term, Medicare-certified hospital located in McCamey, Texas. Trailblazer Health Enterprises, LLC (Intermediary) is the Provider's Medicare fiscal intermediary.

[4] For 1998, the only change to section 413.13 was the addition of a new paragraph (c)(2)(iv) to list Critical Access Hospital services as an exclusion to the principle of LCC. *See* 63 Fed. Reg. 26317, 26357 (May 12, 1998, effective June 11, 1998).

In its Medicare cost reports for the fiscal years ended September 30, 1998, and September 30, 1999, the Intermediary adjusted the identification data on the Medicare cost report to indicate that the Provider qualified for an exception to the application of LCC as provided in 42 C.F.R. § 413.13. The Provider disputes the level of reimbursement it received pursuant to this exception and appealed the Intermediary's determinations to the Board. The Intermediary challenged the Board's jurisdiction to hear the nominal rate adjustment issue, arguing that that Provider is challenging its PPS reimbursement and is prohibited from appealing issues involving DRG classifications. The Board concluded that it does have jurisdiction over the nominal rate adjustment issue under 42 C.F.R. §§405.1835 – .1841.

The Provider was represented by Creed J. Pearson, Hospital Reimbursement Consultant. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it should have been reimbursed its actual inpatient cost as a tax district, nominal rate provider. The Provider cites 42 C.F.R. § 413.13(c)(1)(ii) – (iii), arguing that this provision directs CMS to pay fair compensation to public providers that furnish services free of charge or at a nominal charge, or to any other providers that furnish services to a significant portion of low-income patients and can demonstrate that charges are less than costs because the customary practice is to charge patients based on their ability to pay. Countering the Intermediary's arguments, the Provider asserts that 42 C.F.R. § 413.13(c)(2)(i) simply stated that the LCC principle did not apply to PPS hospitals, but argues that this section did not prohibit PPS hospitals from receiving an additional payment adjustment if they qualified as nominal charge providers.

The Provider contends that the "public provider" section remained in the regulations after the implementation of PPS to allow for public, nominal rate hospitals to obtain relief and survive without undue shifting of cost from the Medicare program to taxpayers. The Provider argues that current Critical Access Hospital (CAH) provisions demonstrate the recognition by Congress that small rural hospitals were bearing too large of a financial burden to provide healthcare services to Medicare beneficiaries.

The Provider contends that the Intermediary recognized the hospital as a nominal rate provider because the Intermediary proposed adjustments to the cost report indicating that the Provider qualified for an exception to the LCC provisions.[5] However, the Provider maintains that it was denied any benefit because the Intermediary did not make any further adjustments to the Medicare cost report to properly reimburse the Provider its "fair compensation" as defined at 42 C.F.R. § 413.13(a). Specifically, the Provider claims the Intermediary did not adjust the Medicare reimbursement settlement[6] to reflect actual Medicare program costs incurred.[7]

---

[5] *See*, Exhibit P-4 (1998), Adjustment No. 40, and Exhibit P-4 (1999), Adjustment No. 40, modifying Provider identification data on Worksheet S-2, line 47, of the Medicare cost report.

[6] Provider references "Total [Calculation of Reimbursement Settlement]" per Worksheet E, Part A, line 16, on the Medicare cost report; *see* Exhibit P-5 and CMS Pub. 15-2 § 3630.

[7] Provider references "Total Program Inpatient Costs" per Worksheet D-1, Part II, line 49, on the Medicare cost report; *see* Exhibit P-5 and CMS Pub. 15-2 § 3622.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider is subject to PPS and, as such, is reimbursed for inpatient services on the basis of prospectively determined rates applied on a per discharge basis. The Intermediary cites 42 C.F.R. § 413.13(c)(2), and argues that this regulation specifically states that the LCC principle does not apply to Part A inpatient hospital services subject to PPS under Part 412 of this chapter. The Intermediary argues that actual costs or charges have no bearing on payments due to the Provider for inpatient services and therefore, there can be no application of the LCC principle to this payment determination.

The Intermediary contends that the Provider is confusing the exception to the LCC principle (which is available to PPS-exempt specialty hospitals, excluded units, outpatient services, etc.) with the inpatient payment determination based on PPS laws and regulations. The Intermediary contends that the language cited by the Provider in 42 C.F.R. § 413.13(c), must be read in the context of the regulatory provision, and that context is specific to facilities subject to cost-based reimbursement. The Intermediary maintains that there is nothing in this regulatory section that exempts hospitals from the PPS system. Rather, the Intermediary notes that 42 C.F.R. § 412.23 specifies the classifications and requirements for hospitals to be excluded under PPS, and contends that the Provider is not eligible for relief since it has not requested an exclusion from PPS in accordance with that regulation.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare regulations and program instructions, the evidence presented, and the parties' contentions, the Board finds and concludes that the Provider is not entitled to be reimbursed based on the reasonable cost of Part A inpatient covered services furnished to beneficiaries.

The Provider requested reimbursement as a nominal rate provider pursuant to 42 C.F.R. § 413.13(c)(1)(ii). The Intermediary did not dispute that the Provider qualified as a nominal charge provider and indicated that it did permit an exception to the application of the LCC principle for Part B outpatient services because these services were still being reimbursed on a cost basis for the cost reporting periods at issue.[8] However, the Board finds that this recognition of the Provider's nominal charge status, while relevant to the Part B reimbursement determination, has no bearing on the payment for covered Part A services at issue in this appeal.

The LCC principle was established to ensure that the Medicare program would not pay more for services than a provider charged to the general public. Congress provided an exception to this limitation for providers that furnish services free of charge or at nominal charge to the public.[9] However, with the enactment of the rate-of-increase limits (section 1886(b) of the Act) and the prospective payment system (section 1886(d) of the Act), most Part A inpatient hospital services are no longer subject to the LCC principle.[10] Payment for these services is no longer based on

[8] Tr. at 36.
[9] *See* 42 U.S.C. § 1395f(b)(2); 42 C.F.R. § 413.13(c)(1)(ii) (1997); See also H.R. Rep. No. 92-231 (1971), reprinted in 1972 U.S.C.C.A.N. 4989, 5087-88.
[10] *See* 49 Fed. Reg. 234, 297 (1984); 42 C.F.R. § 413.13(c)(2)(i) (1997).

reasonable costs incurred, and therefore is not subject to any limitation based on the Provider's charge structure.

The Board finds that the provision at 42 C.F.R. § 413.13(c)(1)(ii) is an exception to the LCC principle, not to the PPS payment methodology as a whole. Although the Provider is a small county hospital whose PPS reimbursement is not fully covering its costs, the Provider's financial situation does not establish a valid basis for an exception to the PPS reimbursement methodology.[11] Further, the Board finds it does not have the authority to award the Provider equitable relief. In addition, while the establishment of the CAH status and its alternative reimbursement methodology may demonstrate Congress' intent to provide relief to small rural hospitals, such discussion of subsequent legal and regulatory changes is moot for the cost reporting periods within this appeal.

DECISION AND ORDER:

The Provider is not entitled to payment of "fair compensation" pursuant to the LCC exception at 42 C.F.R. § 413.13. The Intermediary properly reimbursed the Provider under the PPS methodology pursuant to 42 U.S.C. § 1395ww(d)(l) – (5). The Intermediary's determination is affirmed.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: March 17, 2011

[11] *See* 42 U.S.C. § 1395ww(d)(l)(B) and 42 C.F.R. Subpart B for the definition of hospital services subject to and excluded from PPS.