PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D31

PROVIDER -
Olive View Medical Center
Sylmar, CA

Provider No.: 05-0040

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC--CA

DATE OF HEARING -
January 13, 2006

Cost Reporting Period Ended -
June 30, 1990

CASE NOs.: 93-1227+ & 93-1227C

INDEX

ISSUE:

Whether the Provider is entitled to the benefit of the previously granted change in the TEFRA base period, from fiscal year ending (FYE) June 30, 1985 to FYE June 30, 1988, for the purpose of applying the TEFRA limit for the Provider's FYE June 30, 1990.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Olive View Medical Center (the Provider) is a general acute care hospital owned and operated by the County of Los Angeles (County). The Provider has a psychiatric unit that is exempt from reimbursement under the Prospective Payment System (PPS) and is instead reimbursed under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) target rate limits. The Provider's fiscal intermediary changed from Blue Cross of California to United Government Services of CA, Inc. (Intermediary).

As a result of the Provider's appeal of its FYE 6/30/92 and 6/30/93 TEFRA rates, the Provider Reimbursement Review Board (Board) granted the Provider's request for a new TEFRA base period. See Olive View Medial Center v. Blue Cross Blue Shield Association/United Government Services, PRRB Dec. No. 2002-D14, March 20, 2002, Medicare & Medicaid Guide (CCH) ¶ 80,801 (Olive View). The Board changed the Provider's TEFRA base year from FYE 6/30/85 to FYE 6/30/1988. The Board also directed the Intermediary to recalculate and apply the appropriate new TEFRA target amounts to each of the Provider's Medicare cost reporting periods following FYE 6/30/91 that were still subject to reopening. Id. The CMS Administrator upheld the Board's decision to grant a new base year with regard to the Provider's request for a Board hearing of its fiscal years ending June 30,1992 and June 30,1993, but vacated for lack of jurisdiction the portion of the Board's decision that applied the rebasing to other years. See Olive View, CMS Administrator's Decision, May 24, 2002, Medicare & Medicaid Guide (CCH) ¶ 80,865.

This case concerns the Provider's FYE 6/30/90 cost report.[1] The Provider filed timely appeals of both its notice of program reimbursement (NPR) and its notice of final hospital specific rate. The dispute in this case is whether the new base year granted the Provider in Olive View should be used in setting the Provider's FYE 6/30/90 TEFRA rate.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

From the Medicare program's inception in 1965 until 1983, hospitals were reimbursed the lesser of their reasonable costs or customary charges for health care services provided to Medicare beneficiaries. 42 U.S.C. §1395f(b)(1); see generally Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993). The statute at 42 U.S.C. §l395x(v)(1)(A) defines reasonable costs as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . . " Congress ultimately amended the reasonable cost payment system because it was concerned that, while being reimbursed the reasonable costs of covered services, providers had no incentive to provide

[1] By joint stipulation dated March 5, 2003, the parties agreed that all issues in these cases had been administratively resolved except for the TEFRA loss issue.

services efficiently or otherwise limit their costs. Congress first modified the law by enacting 42 U.S.C. §1395ww(a), which established limits on operating costs of inpatient hospital services and authorized the Secretary of the Department of Health and Human Services (Secretary) to promulgate regulations to establish prospective limits on the costs recognized as reasonable in furnishing patient care. One of the regulations the Secretary promulgated to provide such limits on cost reimbursement was 42 C.F.R. §413.30.

In 1982, Congress enacted TEFRA, which again modified the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. TEFRA imposed a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. The TEFRA ceiling amount, or target amount, is calculated based upon the allowable Medicare operating costs in a hospital's base year (net of certain other expenses including capital and medical education costs) divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually based on an inflation factor. If a provider incurs costs below the applicable TEFRA target amount in a given cost reporting year, it is entitled to be reimbursed its reasonable costs plus an additional incentive payment. Because the TEFRA target amount serves as a ceiling, a provider may not be reimbursed for its costs above the applicable TEFRA target amount for a particular year. The regulation implementing TEFRA, 42 C.F.R. §413.40, established the procedures and criteria for providers to make requests to CMS for exemptions and adjustments to the TEFRA target amount.

In 1983 Congress enacted the Social Security Amendments, P.L. No. 98-21, which created PPS for hospital inpatient operating costs. After the implementation of PPS, only providers and units exempt from PPS that continued to be paid under the reasonable cost system were subject to the TEFRA rate-of-increase limit. In this case, the Provider's inpatient psychiatric unit, exempt from PPS, continues to be subject to TEFRA and its rate-of-increase limit.

Congress, in 42 U.S.C. §1395ww(b)(4)(A), authorized the Secretary, at its discretion, to assign a hospital a new base period for TEFRA purposes when a new base period would be ". . . more representative . . . of the reasonable and necessary cost of inpatient services . . . ." Pursuant to that statute, the Secretary promulgated a regulatory process at 42 C.F.R. §413.40(i) for assigning a new base period for cost reporting periods beginning on or after April 1, 1990. In determining whether to award a new TEFRA base period under 42 C.F.R. §413.40(i), CMS must determine whether the proposed new base period is "more representative of the reasonable and necessary cost of furnishing inpatient services" than the existing base period. In making this determination, all of the following conditions must be satisfied: 1) the actual allowable inpatient costs of the hospital in the cost reporting period that would be affected by the revised ceiling exceed the established TEFRA target amount; 2) the hospital documents that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base period; and 3) the TEFRA adjustment process as outlined under 42 C.F.R. §413.40(g) and (h) would not result in the recognition of the reasonable and necessary cost of providing inpatient services. Id. In evaluating whether a provider has established that the higher costs are the result of substantial and permanent changes, CMS may consider, among other things: i) changes in the services provided by the hospital; ii) changes in applicable technologies and medical practices; and iii) differences in the severity of illness among patients or types of patients served. Id.

If a provider is awarded a new TEFRA base period, the new base period is the first cost reporting period that is 12 months or longer that reflects the substantial and permanent change in the provider's operations. 42 C.F.R. §413.40(i)(2). The revised TEFRA limit will be based on the necessary and proper costs incurred during this new base period. Id.

The issue in this case is whether the Provider is entitled to the benefit of a previously granted change in its TEFRA base period for purposes of applying the TEFRA limit for the Provider's fiscal year ended June 30, 1990.

The Provider was represented by Jon P. Neustadter, Esquire, of Hooper, Lundy & Bookman. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS

The Provider states that the statute and regulation authorizing the assignment of a new base period were effective for cost reporting periods beginning on or after April 1, 1990. The Provider acknowledges that it could not have sought relief under the statute or regulation until its FYE 6/30/91 cost reporting period or later, and that it did so. See Olive View, supra. The Provider asserts, however, that once it was granted a new base period, the new base period would apply to any open fiscal years that postdate the new base period; that it would make no sense to use an improper base period for any year that is open, appealable, and therefore correctable.

The Provider points out that Congress may have indicated when a change in base period could be assigned, but not when it could be applied. The Provider indicates that Congress may have set this limit for administrative convenience and likely did not want CMS to need to consider new or amended TEFRA exception/adjustment requests for current or past years. The Provider notes, however, that nothing in the legislation impacts the actual base period chosen or to what fiscal years the new, more representative base year should be applied. For its FYE 6/30/90, the Provider contends that its proper TEFRA base period is FYE 6/30/88; the new one previously granted by the Board and upheld by the Administrator.

The Provider also points out that in Edgemont Hospital v. Mutual of Omaha Insurance Co., PRRB Dec No. 95-D34, April 6, 1995, Medicare & Medicaid Guide (CCH) ¶43,264, declined review, CMS Administrator, May 5, 1995 (Edgemont), a provider's TEFRA base year costs that had been established in 1983 were revised through a reopening, and the intermediary sought to reopen subsequent cost reports to correct the TEFRA target rate to reflect the adjusted base year costs. However, the provider objected, contending that the years at issue (1984 and 1985) were final and could not be reopened. The provider argued that under the TEFRA statute, the intermediary was required to use the preceding year to update the TEFRA limits; thus, the intermediary had to use the 1984 limit updated for 1985, and then the 1985 limit updated for 1986. The Board rejected this argument and stated that because the base year rate serves as the foundation for future years, it must be as correct as possible, and that there must be a mechanism to correct erroneous base year costs and apply the corrected cost information to future years. The Provider indicates that if the same

reasoning is used in this case, the Intermediary must apply the 1988 base period to all subsequent years that are open and can be corrected.

The Intermediary points to the language of the regulation which specifically states that changing a base period is an option for fiscal years beginning on or after April 1, 1990. The Intermediary observes that the Provider's FYE 6/30/1990 cost reporting period began before April 1, 1990; therefore, it cannot be assigned a new base year period.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, finds and concludes as follows:

The Board finds that the statute and regulation clearly mandate that the rebasing of TEFRA rates only applies to cost reporting periods beginning on or after April 1, 1990. The language of the statute uses the phrase "effective with," which the Board views as synonymous with "applicable from." Therefore, the Board finds that TEFRA rate relief only applies to cost reports beginning with the effective date of the regulation. This comports with the Board's previous decision, which applied the rebasing to all open cost reporting periods beginning on or after April 1, 1990. See Olive View, supra.

The Provider's argument, based on Edgemont, supra, is logical; if the base year is adjusted, it makes sense to recalculate and apply the new base year to all subsequent years that are subject to reopening. The Board finds, however, that the language of the statute and regulation applicable to this case only permits relief effective with cost reporting periods beginning on or after April 1, 1990.

DECISION AND ORDER:

The Board finds that the statute and regulation regarding rebasing apply to cost reporting periods beginning on or after April 1, 1990. The Intermediary's denial of rebasing for the Provider's FYE 6/30/90 was proper.

Board Members Participating:
Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: June 16, 2006

Suzanne Cochran
Chairperson