PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D48

PROVIDER -
Spectrum Health-Kent Community Campus
Grand Rapids, Michigan

Provider No.: 23-2029

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC (n/k/a
National Government Services, LLC)

DATE OF HEARING -
December 5, 2006

Cost Reporting Period Ended -
December 31, 2001

CASE NO.: 05-0310

INDEX

ISSUE:

Whether the Intermediary and the Centers for Medicare & Medicaid Services erred in denying the Provider's rate adjustment request made under the Tax Equity and Fiscal Responsibility Act of 1982 TEFRA.

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. 42 U.S.C. §§1395-1395cc. 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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). 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. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

From the Medicare program's inception in 1966 until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 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 services efficiently or otherwise limit their costs. Congress first modified the law by enacting 42 U.S.C. §1395ww(a), which established limits on the 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.

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA), again

modifying the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. 42 U.S.C. §1395ww(b). TEFRA imposed a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. The TEFRA ceiling, 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-related 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 reimbursement for its reasonable costs plus an additional incentive payment.[1] Because the TEFRA target amount serves as a ceiling, a provider may generally not be reimbursed for its costs above its TEFRA target amount for a particular year. However, 42 U.S.C §1395ww(b)(4)(A) provides for exemptions, exceptions and adjustments to the limits stating, in part:

> (i) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services. . . that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. (Emphasis added)[2]

The Balanced Budget Act of 1997 (BBA 97)[3] amended the TEFRA legislation with respect to existing and new psychiatric hospitals and units, rehabilitation hospitals and units, and long-term acute care hospitals (LTACHs). With respect to existing hospitals, 42 U.S.C. §1395ww(b)(3)(H) was amended to "cap" TEFRA limits, stating in part:

> [i]n the case of a hospital or unit that is within a class of hospital described in clause (iv), for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii). (Emphasis added)

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[1] In 1983, Congress enacted the Social Security Amendments, P. L. No. 98-21, which created the Prospective Payment System (PPS) for hospital inpatient operating costs. After the implementation of PPS, only providers and units within providers exempt from PPS that continued to be paid under the reasonable cost system were subject to the TEFRA rate-of-increase limit.

[2] Program guidelines regarding exemptions from and adjustments to TEFRA target amounts are found in the Provider Reimbursement Manual, Part I (CMS Pub. 15-1) §§3003 through 3004.

[3] P.L. 105-33.

> (ii) [i]n the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996, as adjusted under clause (iii).

With respect to new psychiatric hospitals and units, rehabilitation hospitals and units, and LTACHs, 42 U.S.C. §1395ww(b)(7)(A) was enacted to "limit" program payments, stating:[4]

> [n]otwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—
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> (i) for each of the first 2 cost reporting periods for which the hospital has a settled cost report, the amount of the payment with respect to operating costs described in paragraph (1) under part A of this subchapter on a per discharge or per admission basis (as the case may be) is equal to the lesser of--
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> (I) the amount of [the hospital's] operating costs for such respective period, or
> (II) 110 percent of the national median . . . of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section. . . . (Emphasis added)

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Spectrum Health – Kent Community Campus (Provider) is a LTACH located in Grand Rapids, Michigan. The Provider was exempt from the prospective payment system (PPS) during its cost reporting period ended December 31, 2001 and was reimbursed on the basis of reasonable cost pursuant to TEFRA limitations. In addition, the Provider was a new hospital during this period and, therefore, was subject to the payment limitation of 42 U.S.C. §1395ww(b)(7)(A); where the Provider's program reimbursement would be based upon the lesser of its operating cost per discharge or 110 percent of the national median of target amounts for LTCAHs for cost reporting periods ending in 1996 trended forward.

[4] 42 C.F.R. §413.40(f) defines a "new" hospital as a provider of hospital inpatient services that has operated as the type of hospital for which CMS granted its approval to participate in the Medicare program, under present or previous ownership (or both) for less than 2 full years; and has provided the type of hospital inpatient services for which CMS granted it approval to participate in the Medicare program, for less than 2 years.

The Provider's fiscal year ended December 31, 2001 cost report showed that its actual operating cost per case significantly exceeded the 110 percent TEFRA limitation. The Provider concluded that the excessive costs were the result of intense patient care rendered in its ancillary units that had not been contemplated in the TEFRA limits and filed a timely request with United Government Services (Intermediary) for an exception to its limit. The Intermediary denied the Provider's exception request by letter dated October 9, 2004.

The Provider appealed the Intermediary's denial to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $518,517.[5]

The Provider was represented by Joel M. Hamme, Esq., of Powers Pyles Sutter & Verville PC. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Intermediary contends that the BBA 97 imposed a "hard" cap on the payments to both existing and new LTACHs reimbursed under TEFRA. Therefore, no law or regulation permits a LTACH to receive an exemption, an exception or an adjustment when its costs exceed the 75th percentile or the 110 percent limit, whichever is applicable.[6] The Intermediary argues that the statutory language regarding this matter is clear. With respect to existing hospitals the target amount "may not exceed the amount . . ." and regarding new hospitals, the amount of the payment "is equal to the lesser of . . . "

The Intermediary also refers to a letter issued by CMS on December 21, 2004 pertaining to the Provider's request in which CMS explains that program policy does not permit exceptions to be granted to hospitals, either new or existing, that are affected by the subject provisions of the BBA.[7] In part, CMS references the preamble of the final rule implementing the 1998 PPS rates as well as the BBA provisions (62 Fed. Reg. 46018 (August 1997)),[8] which states in pertinent part:

> [a] hospital that has a target amount that is capped at the 75th percentile would not be granted an exception payment as governed by §§413.40(a) and (i) based solely on a comparison of its costs or patient mix in its base year to its costs or patient mix in the payment year. Since the hospital's target amount would not be determined based on its own experience in a base year, any comparison of costs or patient mix in its base year to costs or patient mix in the payment year would be irrelevant.

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[5] See, Parties' Stipulation of Facts at 11.
[6] Intermediary's Supplemental Position Paper at 4.
[7] Intermediary's Supplemental Position Paper at 6. Exhibit I-3.
[8] Exhibit I-6.

The Provider contends that the statutory language governing exemptions, exceptions and adjustments to TEFRA limits does not bar an adjustment to the caps established by the BBA. 42 U.S.C. §1395ww(b)(4)(A)(i) states, in pertinent part, "[t]he Secretary shall provide for an exception and adjustment to . . . , the method under this subsection for determining the amount of payment to hospital . . . . The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate . . . ." (emphasis added). The Provider asserts that both the 75th percentile limit and the 110 percent limit imposed by the BBA are within the "payment method" prescribed by the relevant subsection, i.e., the TEFRA legislation.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes that the Intermediary/CMS properly denied the Provider's request for an adjustment to its TEFRA target limit.

The controlling authority in this case is 42 U.S.C. §1395ww(b)(4)(A). This statute requires the Secretary to provide for exceptions and adjustments to TEFRA limits when events or circumstances beyond a hospital's control create a distortion between its incurred costs and its target amount and gives the Secretary discretionary authority to provide for exemptions exceptions and adjustments to TEFRA limits in other instances.

It is undisputed that the discretionary portion of the statute is relevant in this case, since the Provider does not have an established TEFRA target amount as required by the statute's mandatory provision. As previously discussed, a TEFRA target amount is derived in part from a base period cost report which is generally a hospital's cost reporting period immediately preceding its first cost reporting period subject to TEFRA. The cost reporting period at issue in this case is the Provider's first cost reporting period as a participant in the Medicare program. The parties have stipulated that the Provider is a new LTACH exempt from TEFRA's rate of increase ceiling. The Provider is instead reimbursed pursuant to 42 U.S.C. §1395ww(b)(7)(A), which requires program payments for inpatient hospital services to be made based upon the lesser of the Provider's costs or 110 percent of the national median of target amounts for LTCAHs updated to the relevant period.[9]

With respect to the Secretary's implementation of the statute, a review of the pertinent regulations and program instructions shows that the Secretary chose only to address the statute's mandatory provision. Regulations at 42 C.F.R. §413.40ff, Ceiling on the rate of increase in hospital inpatient costs, and program instructions at CMS Pub.15-1 §3004ff, Adjustments to Rate of Increase Ceiling, only provide for the adjustment of a provider's target rate of increase ceiling, as indicated by their titles. There is no authority upon which to grant the relief sought by the Provider whose TEFRA payment limit is derived from a national base.

[9] See Parties' Stipulation of Facts at 3, 5, 6, and 7.

DECISION AND ORDER:

There is no statutory or regulatory authority upon which to grant an adjustment to the TEFRA cost limit imposed on a "new" provider reimbursed pursuant to 42 U.S.C. §1395ww(b)(7)(A). The Intermediary's denial of the Provider's request for an adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq.
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A
Anjali Mulchandani-West
Yvette C. Hayes

DATE: July 16, 2007

FOR THE BOARD:

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Chairperson