PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D24

PROVIDER –
Summit Medical Center
Oakland, California

Provider No.: 05-0043

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, LLC - CA

DATE OF HEARING –
July 17, 2007

Cost Reporting Periods Ended –
February 28, 1998 and February 28, 1999

CASE NOs.: 01-0679 and 02-0244

INDEX

ISSUE:

Whether the TEFRA base year used by the fiscal intermediary to compute a target amount for the Provider's excluded psychiatric unit for the February 28, 1998 and February 28, 1999 cost years was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services, and the TEFRA base year used to establish that amount.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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. §1395x(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 the 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 cost plus an additional incentive payment.[1] If a provider's cost exceed its target amount, 42 C.F.R. §413.40(d)(3) provides for a relief payment under certain circumstances. The Balanced Budget Act of 1997 (BBA 97)[2] amended TEFRA legislation with respect to existing and new psychiatric hospitals and units, rehabilitation hospitals and units, and long-term acute care hospitals.

During the time period in question for this appeal, TEFRA limits applied to hospital-based psychiatric units that were excluded from the hospital inpatient prospective payment system (IPPS). The TEFRA ceiling is specific to the particular excluded unit. A target amount per discharge is derived from the unit's allowable net Medicare inpatient operating costs in the base year, and updated as noted above. The TEFRA ceiling is calculated by multiplying the updated target amount by the number of Medicare discharges within that period. See, 42 C.F.R. §413.40(a)(3) (defining "target amount" and "ceiling").

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This case relates to two appeals by Summit Medical Center (Provider; Summit) for its cost years ended February 28, 1998 (FYE 2/28/98) and February 28, 1999 (FYE 2/28/99). The issue in both appeals concerns the proper base year to be used to compute the TEFRA target amount for the Provider's PPS-excluded geriatric psychiatric unit. All other issues in the two appeals have been resolved through administrative resolutions.

The Provider is a 502-bed, not-for-profit acute care hospital located in Oakland, California. Summit was created in 1992 by the merger of Merritt Peralta Medical Center into Samuel Merritt Hospital. Both were not-for-profit corporations, and Merritt Peralta Medical Center was the sole corporate member of Samuel Merritt Hospital. The surviving corporation was Samuel Merritt Hospital. That corporation was renamed (eventually becoming Summit), and as part of the transaction, it purchased most of the assets of Providence Hospital, another not-for-profit corporation, which included an existing adult psychiatric unit. The transaction creating Summit was effective March 1, 1992. The psychiatric unit at the old Providence

[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] P.L. 105-33.

Hospital was closed by Summit by June 1992 as evidenced by the census reports showing no patients in that unit.[3]

After closure of the psychiatric unit in 1992, Summit requested that the State of California remove psychiatric services entirely from its hospital license.[4] On November 9, 1992, the California Department of Health Services Licensing and Certification Division formally removed psychiatric services from Summit's license.[5]

Summit did not offer or provide inpatient psychiatric services for almost five years (from June 1992 to February 1997) and was legally prohibited from offering those services without a special services permit from the State.[6] The Medicare cost reports after FY 1993, but before the establishment of the geriatric psychiatric (geri-psych) unit, show that Summit did not have a psychiatric subprovider.

In 1997, Summit opened an inpatient geri-psych unit. It applied for and received approval from the California Department of Health Services to provide this service, and the Provider's hospital license was amended to include 17 psychiatric inpatient beds. The Provider also applied for Medicare certification for the unit, which was granted effective March 1, 1997.

In filing its FYE 2/28/98 Medicare cost report, the Provider included the 17-bed inpatient geri-psych unit as a subprovider. On the as-filed cost report, the geri-psych unit was treated as a cost-based reimbursement subprovider with no TEFRA target rate limit applied.

The Intermediary applied a TEFRA limit, by taking the former Providence psychiatric unit's 1984 base year cost of $4,555.42 per discharge, updated it, and applied it to the newly certified geriatric unit for Summit's 2/28/98 cost year.[7] The resulting updated per-discharge target amount applied by the Intermediary was $7,434.31.[8] The actual Medicare cost per discharge at the Summit geri-psych unit was $16,108.41 for the 1998 cost year.[9] The application of the TEFRA target amount derived from the former psychiatric unit's costs in 1984 resulted in limiting the reimbursement per discharge to $8,177.74.[10] Multiplying the difference between these two figures by the number of discharges results in a reduction in reimbursement of $721,691.[11]

A similar approach was taken by the Intermediary for the FYE 2/28/99 cost year resulting in an updated TEFRA target amount per discharge of $7,434.31.[12] The Provider's actual cost per

---

[3] See, Exhibit P-8; Tr. at 58.
[4] Tr. at 58.
[5] See, Exhibit P-13; Tr. at 58-59.
[6] See, Exhibit P-4; Tr. at 60-63.
[7] See, Exhibit P-9, pp. 14-15; Tr. at 73.
[8] See, Exhibits P-9 and P-10 (Audit Adjustment Report excerpt, Adjustment 99); Tr. at 73.
[9] See, Exhibits P-1.
[10] See, Exhibit P-1, p-1; Tr. at 81.
[11] See, Exhibit P-1, p.1; Tr. at 82.
[12] See, Exhibits P-11, P-12; Tr. 78.

discharge in FYE 2/28/99 was $13,277.92. However, its cost was capped by a national 75th percentile limit of $10,534.[13]

The FYE 2/28/98 and FYE 2/28/99 cost reports disputing the Intermediary adjustments were timely appealed to the Board. The Provider was represented by Dan M. Peterson, Esquire, of Fulbright & Jaworski, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that 42 C.F.R. §413.40(b)(1)(i) is applicable to the Provider's factual situation. It states:

> (i) The target amount established under this provision remains applicable to a hospital or excluded hospital unit as described in §§412.25 through 412.30 of this chapter, despite intervening cost reporting reports during which the hospital or excluded hospital unit is not subject to the ceiling as a result of other provisions of the law or regulations, or nonparticipation in the Medicare program, unless the hospital or excluded hospital unit qualifies as a new hospital or excluded part hospital unit under the provisions of paragraph (f) of this section.

The Intermediary argues that the psychiatric unit had a target amount established for a psychiatric sub-provider and was not subject to a target limit during intervening cost reporting periods (1994-1997) because of its decision not to offer psychiatric services. The Intermediary observes that the regulations do not contemplate the opportunity for an ongoing acute care hospital to get a more favorable TEFRA target rate by closing a unit and reopening it at a later time. 42 C.F.R. §§412.25 and 412.27, the qualifying regulations for a PPS-exempt psychiatric unit, make no distinction between a given unit's choice of what type of patients it will serve. The Intermediary further contends that even under its application of 42 C.F.R. §413.40)(b)(l)(i), the Provider could have nevertheless obtained relief from the target and by applying for a exception to the TEFRA limits under 42 C.F.R. §413.40(e) and (g) but did not. Factors such as increased length of stay, more intense ancillary services, excess overhead and increased wages due to an emphasis on geriatric patients could have been pursued under the exception criteria.

PROVIDER'S CONTENTIONS:

The Provider contends that 42 C.F.R. §413.40(b)(1)(ii) applies. It provides that "[t]he base period for a newly established excluded unit is the first cost reporting period of at least 12-months following the unit's certification to participate in the Medicare program." Since the former psychiatric unit did not exist for nearly five years and had to have its license amended to open in 1997, it was a "newly established excluded unit," and its base year would, therefore, be its first full year of operation following its 1997 certification.

---

[13] See, Exhibits P-1, pp. 1, 11; Tr. at 77-80.

The Provider argues that 42 C.F.R. §413.40(b)(1)(i) is not applicable in this instance because it applies to excluded units that continue in existence, but are temporarily not subject to the TEFRA ceiling. In the Provider's case, the unit ceased to exist. 42 C.F.R. §413.40(f), New Hospitals And Units, used by the Intermediary to deny TEFRA exemption for the Provider's unit, does not apply because it can only apply when 42 C.F.R. §413.40(b)(1)(i) applies, and the Provider did not request a new provider exemption for its geriatric unit.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

After considering the Medicare law, regulations, program instructions, evidence presented and parties' contentions, the Board finds and concludes that the Intermediary properly used the inflation-adjusted 1984 base year rate and applied the FY 98 and FY 99 TEFRA limits to the Provider's psychiatric unit. It is undisputed that the Provider does not qualify for the new Provider exemption under 42 C.F.R. §413.40(f). Each party relies on §413.40(b)(1) to support its position.

The facts regarding the Provider's position are detailed in the Statement of the Case and Procedural History above. They are undisputed. The Board finds that these facts fit within the provisions of 42 C.F.R. §413.40(b)(1)(i). The Provider had a target amount established but then had intervening cost reporting periods during which it closed the psychiatric unit. As a result, it ceased participating in the program.

The Board observes that even though the psychiatric unit was closed for an extended period of time, and there is no evidence of intent to manipulate the base year rate, allowing the Provider's interpretation would have adverse policy implications. Any provider unhappy with its base year rate could simply close and reopen.

The Provider argues that the language of 42 C.F.R. §413.40(b)(1)(i) cannot apply because it assumes the Provider's excluded unit must be in existence during the intervening cost reporting periods in which the target amount did not apply. The Board finds that the regulatory language does not support that reading. On the contrary, the Board finds that not being subject to the ceiling or not participating in the Medicare program for the intervening cost reporting periods because the unit was closed, is equally reasonable and better serves the intent of the regulation.

The Board also finds that 42 C.F.R. §413.40(b)(1)(ii) applies only to hospital units that have never had a target amount established (and that do not qualify under 42 C.F.R. §413.40(f)). Therefore, 42 C.F.R. §413.40(b)(1)(ii) is not applicable in this situation. The Board also disagrees with the Provider's position that the unit was new in that it served only geriatric patients who had far more severe medical conditions and therefore more cost. The evidence shows that there is no distinction in certification for a geri-psych unit. The difference in the character of the psychiatric unit is therefore irrelevant. These differences would have been relevant if the Provider had pursued different remedies as the Intermediary suggests. Those issues are not before us.

DECISION AND ORDER:

The Intermediary's use of the inflation-adjusted 1984 base year TEFRA target rate for computing the target rate applicable to the Provider's psychiatric unit for the years in issue was correct. The Intermediary's adjustment are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, CPA
Yvette C. Hayes
Michael D. Richards, CPA

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: April 15, 2008