CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Southwest Ambulatory Behavioral Services, Inc.	**Provider Cost Reimbursement Determination for Cost Year Ending: December 31, 2000**
Provider	
vs.	**Review of:**
Novitas Solutions, Inc./Blue Cross and Blue Shield Association	**PRRB Dec. No. 2014-D24**
Intermediary	**Dated: September 10, 2014**

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 mandated 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. The Center for Medicare (CM) submitted comments, recommending reversal of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE

The issue was whether the Intermediary's[1] adjustment to the allocation of the Provider's cost was proper.

BOARD'S DECISION

The Board remanded the case to the Intermediary to review the stated costs for FY 2000 to determine the reasonableness of these costs and to apportion the Provider's

[1] Formerly known as Fiscal Intermediaries (FIs), CMS's payment and audit functions under the Medicare program are now contracted to organizations known as Medicare Administrative Contractors (MACs). However, for the cost year at issue in this case, the term "Intermediary" will be used.

FY 2000 costs across the two short periods of January 1, 2000 through July 31, 2000 and August 1, 2000 through December 31, 2000 based on a cost to charge ratio for each period. Based on this apportionment, the Board directed that the Intermediary should determine the amount of reasonable cost reimbursement due the Provider for the first short period and whether any adjustment should be made to the Provider's transitional corridor payment for the second short period.

The Board stated that the matter in dispute in this appeal was whether to calculate one cost to charge ratio on Worksheet C based on a full fiscal year, or two separate cost to charge ratios, one for each short period. The Board found that, by using the full fiscal year to calculate the cost to charge ratio, the cost allocations are distorted. Instead, the cost to charge ratio should be calculated for each of the two short periods (i.e., January 1, 2000 through July 31, 2000 and August 1, 2000 through December 31, 2000). The Board noted that in essence, these periods are short cost reporting periods, and thus the use of two costs to charge ratios is more accurate, fair, and less arbitrary. The Board found that following the implementation of the Outpatient Prospective Payment System (OPPS), a provider had a greater incentive to economize, and thus, the Provider may have significantly different costs during the pre- and post-OPPS implementation periods. Thus, the Board found that the methodology set forth in the revised HCFA-2088-92 instructions for Worksheet C is not the proper method to apportion the Provider's cost for the two short periods at issue in FY 2000 because by using two cost to charge ratios, it provides a more accurate and fair apportionment consistent with Medicare reasonable cost principles.

The Board further found that the Provider mischaracterized the scope of the issue in this case by only accounting for the negative cost impact for the first seven months of the FY 2000 cost report due to the transition to the OPPS reimbursement methodology. As part of the Balanced Budget Refinement Act of 1999, Congress made available during the first three and a half years of OPPS an additional payment known as "transitional outpatient payment" or "TOP" to certain qualifying providers to ease the transition from cost-based reimbursement to OPPS. The Board noted that in asserting its claims, the Provider failed to recognize the ripple effect created by the cost apportionment methodology in the TOP for the last five months of FY 2000 when OPPS was in effect. According to the cost report instructions, a TOP may be paid when the cost of Provider services for the short period of August 1, 2000 to December 31, 2000 is more than the OPPS. Under the actual cost methodology of the Provider, the Provider may no longer qualify for TOP for the short period August 1, 2000 through December 31, 2000 because the OPPS payments for this period may be higher than the actual cost incurred for this period.

Thus, the Board held that the case should be remanded to the Intermediary to apportion the FY 2000 costs across the two short periods. As part of this remand, the

Board agreed with the Intermediary that the Intermediary should review the stated costs for FY 2000 to determine the reasonableness of these costs and adjust accordingly since this could impact the reimbursement (both pre- and post-August 1, 2000) if there were any audit adjustments. To this end, the Board noted, the Intermediary should also calculate the impact of any adjustment to the costs on the TOP for the remaining portion of FY 2000 (i.e., August 1, 2000 through December 31, 2000).

SUMMARY OF COMMENTS

The Center for Medicare (CM) commented, recommending that the Board's decision be reversed.[2] CM noted that the Provider is subject to the outpatient prospective payment system (OPPS) reimbursement methodology which became effective August 1, 2000, and is required to allocate costs using one cost to charge ratio and identify the charges for pre and post August 1, 2000. CM stated that this OPPS reimbursement methodology was communicated to providers in Transmittal No. 4. Additionally, under the regulations at 42 C.F.R. 419.70, community mental health centers may be eligible to receive a transitional outpatient payment (TOP). The purpose of the TOP, CM claimed, is to restore some of the decreased payment the provider may experience under the new OPPS reimbursement methodology. The final TOP payment is calculated on the Medicare cost report based upon the difference between what the provider was paid under the new OPPS, and the provider's pre-BBA amount (the estimated amount that the provider would have received under the former cost-based reimbursement methodology during the calendar year for the same services). CM noted that pursuant to the regulations, if the pre-BBA amount exceeded the actual OPPS payments, the provider received a portion of the difference as a TOP. In order to establish the pre-BBA amount and determine the amount the provider would have received under cost reimbursement, one cost to charge ratio must be used.

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[2] The Provider challenged the timeliness of CM's comments. Notices of Review, on own motion, were sent by the Administrator on September 23, 2014. According to the regulation at 42 C.F.R. §405.1875(c)(4)(i), comments are due within 15 days of the date the parties received the Administrator's notice. Pursuant to the regulation at 42 C.F.R. §405.1801(a)(1)(iii), the "date of receipt" is presumed to be 5 days after the issuance of the notice. Thus, the 20 day deadline for comments (15 days plus the 5 days presumed for receipt) in this case was October 13, 2014. However, the regulation at 42 C.F.R. §405.1801(d) "Calculating time periods and deadlines" explains that if the last day is a Saturday, Sunday, or Federal legal holiday, then the deadline becomes the next day. Thus, since October 13, 2014 was a Federal legal holiday (Columbus Day), the deadline was the next day, October 14, 2014. Hence, comments submitted by CM on October 14, 2014 were timely.

CM stated that in this case, the Intermediary correctly applied a single cost to charge ratio for the full fiscal year. The methodology the Provider sought to use was contrary to Medicare payment policy and Medicare cost reporting instructions, and does not reflect the proper costs under the former cost-based reimbursement methodology. CM summarized, by noting that the correct application of CMS policy would not allow a provider to ignore Medicare rules or utilize an incorrect Medicare reimbursement methodology, and as such, the Board's remand decision should be reversed.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely submitted have been taken into consideration.

When the Medicare program was first implemented, it paid for hospital services (inpatient and outpatient) based on hospital-specific reasonable costs attributable to serving Medicare beneficiaries.[3] Later, the law was amended to limit payment to the lesser of a hospital's reasonable costs or its customary charges. In 1983, § 601 of the Social Security Amendments of 1983 completely revised the cost-based payment system for most hospital inpatient services by enacting § 1886(d) of the Social Security Act (the Act). This section provided for a prospective payment system (PPS) for acute hospital inpatient stays, effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although payment for most inpatient services became subject to the PPS, Medicare hospital outpatient services continued to be paid based on hospital-specific costs, which provided little incentive for hospitals to furnish outpatient services efficiently. At the same time, advances in medical technology and changes in practice patterns

[3] Section 1861(v)(1)(A) of the Social Security Act states that "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…" Likewise, the regulation at 42 C.F.R. §413.9(c)(3) notes, "The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider."

were bringing about a shift in the site of medical care from the inpatient to the outpatient setting. During the 1980s, Congress took steps to control the escalating costs of providing outpatient care by amending the statute to implement across-the-board reductions of 5.8 percent and 10 percent to the amounts otherwise payable by Medicare for hospital operating costs and capital costs, respectively. Congress also enacted a number of different payment methods for specific types of hospital outpatient services. These methods included fee schedules for clinical diagnostic laboratory tests, orthotics, prosthetics, and durable medical equipment (DME); composite rate payment for dialysis for persons with end-stage renal disease (ESRD); and payments based on blends of hospital costs and the rates paid in other ambulatory settings such as separately certified ambulatory surgical centers (ASCs) or physician offices for certain surgery, radiology, and other diagnostic procedures. However, Medicare payment for services performed in the hospital outpatient setting remained largely cost-based. As part of determining the outpatient reimbursable costs for a Community Mental Health Center (CMHC), Medicare requires the apportionment of patient service costs between Medicare and non-Medicare patients. This is done through the determination of the gross amount of charges for each reimbursable cost center and gross total patient charges for each reimbursable cost center to determine the total cost to total charges to Medicare program charges.

Section 4523 of the Balanced Budget Act of 1997[4] (BBA), enacted on August 5, amended § 1833 of the Act by adding subsection (t), which provided for implementation of a PPS for outpatient services. Section 4523(d) of the BBA made a conforming amendment to § 1833(a)(2)(B) of the Act to provide for payment under the hospital outpatient PPS for some services described in § 1832(a)(2) that were previously paid on a cost basis and furnished by providers of services, such as comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), hospices, and community mental health centers (CMHCs).[5] This amendment provided that partial hospitalization services furnished by CMHCs be paid under a PPS. The OPPS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 C.F.R. parts 410 and 419.

On November 29, 1999, the Balanced Budget Refinement Act of 1999[6] (BBRA) was enacted. Section 202 of the BBRA amended § 1833(t) of the Act by re-designating paragraphs (7) through (11) as paragraphs (8) through (12), and adding a new

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[4] Pub. L. 105-33.

[5] Section 1866(a)(2) of the Act provides that a CMHC is a provider of services only with respect to the furnishing of partial hospitalization services.

[6] Pub. L. 106-113.

paragraph (7) which provides for a transitional adjustment to limit payment reductions under the OPPS, i.e., Transitional Corridors, also known as TOPs.

In general, for the years 2000 through 2003, a provider will receive an adjustment if its payment-to-cost ratio for outpatient services furnished during the year is less than a set percentage of its payment-to-cost ratio for those services in its cost reporting period ending in 1996 (the base year).

On April 7, 2000, CMS published a final rule[7] with comment period to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000.

CMS promulgated regulations to implement Medicare's hospital OPPS. The regulation at 42 C.F.R. § 419.70 specifically implements the transitional adjustment payments enacted by the BBRA. In general, this regulation explains that a provider will receive a transitional adjustment when its OPPS payments are less than its pre-BBA amount. The regulation at 42 C.F.R § 419.70, entitled "Transitional adjustment to limit decline in payments" states in part that:

> (a) Before 2002. Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished before January 1, 2002, for which the prospective payment system amount (as defined in paragraph (e) of this section) is—
>
> (1) At least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in paragraph (f) of this section), the amount of payment under this part is increased by 80 percent of the amount of this difference;
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> (2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.71 and the pre-BBA amount exceeds the product of 0.70 and the prospective payment system amount;
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> (3) At least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.63 and the pre-BBA amount, exceeds the product of 0.60 and the PPS amount; or

[7] 65 Fed. Reg. 18,434.

> (4) Less than 70 percent of the pre-BBA amount, the amount of payment under this part shall be increased by 21 percent of the pre-BBA amount.

The regulation at 42 C.F.R. §419.70(f) defines the "pre-BBA amount" as:

> (1) General Rule. In this paragraph, the "pre-BBA amount" means, with respect to covered hospital outpatient services furnished by a hospital or a community mental health center (CMHC) in a year, an amount equal to the product of the reasonable cost of the provider for these services for the portions of the provider's cost reporting period (or periods) occurring in the year and the base provider outpatient payment-to-cost ratio for the provider (as defined in paragraph (f)(2) of this section).

Initially, 42 C.F.R. §419.70(f)(2) defined the "base payment-to-cost-ratio" as the ratio of:

> (i) [t]he provider's payment under this part for covered outpatient services furnished during the cost reporting period ending in 1996, including any payment for these services through cost-sharing described in paragraph (e) of this section; and
>
> (ii) The *reasonable cost* of these services for this period…(Emphasis added.)

At the time the OPPS was implemented, § 1833(t)(7)(F)(ii) of the Act defined the payment-to-cost ratio (PCR) used to calculate the "pre-BBA amount" for purposes of calculating the transitional corridor payments to be determined using the reasonable costs of services furnished during the provider's cost reporting period ending in calendar year 1996. The Benefits and Improvement Protection Act (BIPA)[8], enacted December 21, 2000, revised that requirement. Section 403 of BIPA amended § 1833(t)(7)(F)(ii) of the Act to allow transitional corridor payments to hospitals subject to OPPS that did not have a 1996 cost report by authorizing use of the first available cost reporting period ending after 1996 and before 2001 in calculating a provider PCR. The definition at 42 C.F.R. §419.70(f)(2) was in accordance with § 403 of the BIPA, to state that the "base payment-to-cost ratio" means the ratio of:

> (i) [t]he provider's payment under this part for covered outpatient services furnished during one of the following periods, including any

[8] Pub. L. 106-554.

> payment for these services through cost-sharing described in paragraph (e) of this section:
>
> > (A) The cost reporting period ending in 1996: or
> >
> > (B) If the provider does not have a cost reporting period ending in 1996, the first cost reporting period ending on or after January 1, 1997 and *before January 1, 2001*; and
>
> (ii) The reasonable costs of these services for the *same cost reporting period*. (Emphasis added.)

Moreover, under OPPS, cost to charge ratios based on full cost reporting periods continue to be used for determining CMHC outlier payments, payments for pass-through services, and monthly interim transitional corridor payments.[9] CMS policy as referenced in the Internet-Only Manual, Pub 100-4, Chapter 4, § 10.13.1 states:

> Fiscal Intermediaries (FIs) must calculate overall cost to charge ratios (CCRs) for hospitals paid under OPPS and for CMHCs using the provider's most recent *full year cost reporting period*, whether tentatively settled or final settled, in accordance with the instructions in §10.13.7, §10.13.8 or §10.13.9 as applicable. The FIs must calculate a provider overall CCR whenever a more recent full year cost report becomes available. (Emphasis added).

In addition, § 10.13.5 states:

> The FIs must calculate a hospital CCR using the *most recent full-year* cost report if a hospital or community mental health center has a short period cost report. The FIs must use the Statewide CCR for all inclusive rate hospitals paid under OPPS, or when a new provider does not have a full year's cost report and has no cost report history. Similarly, under the OPPS, *CMS policy requires a full year cost report to calculate a payment-to-cost ratio since a partial year cost report is unlikely to be representative of a hospital's true yearly costs.* (Emphasis added.)

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[9] *See*, *e.g.*, Program Memorandum Transmittal A-03-004 ("Calculating Provider-Specific Medicare Outpatient Cost-to-Charge Ratios (CCRs) and Instructions on Cost Report Treatment of Hospital Outpatient Services Paid on a Reasonable Cost Basis.").

On March 22, 2001, HCFA (now CMS) issued Provider Reimbursement Manual, Part 2, Chapter 18, HCFA Publication 15-2 Transmittal No. 4 (Transmittal No. 4), regarding Revisions to Form HCFA-2088-92, the Outpatient Rehabilitation Provider Cost Reporting Form. The Transmittal noted that Worksheet S, Parts I-III, Worksheet C, and Worksheet D were being revised effective for services rendered on or after August 1, 2000. CMS set forth instructions at §1809 (Transmittal No. 4) for [CMS] Form-2088-92 for Worksheet C— Apportionment of Patient Services Costs. Specific for CMHCs are lines 29 through 39 with respect to determining the Medicare cost for services rendered on or after August 1, 2000 and determining the Medicare pre-August 1, 2000 costs.

In this case, the Provider is a CMHC located in Crowley, Louisiana. Effective August 1, 2000, the reimbursement methodology for community mental health centers changed from the cost based reimbursement methodology to the prospective payment system. As a result of this change in reimbursement methodology, the Provider, was reimbursed for its FY 2000 cost year pursuant to two reimbursement methodologies: the cost based methodology from January 1, 2000 through July 31, 2000, and the prospective payment system from August 1, 2000 through December 31, 2000.

On or about June 17, 2002, the Provider filed its FY 2000 cost report (pre- and post-August 1, 2000) pursuant to the two methodologies stated in the revised HCFA-2088-92 instructions for Worksheet C. However, the Provider protested the methodology used in Transmittal 4, utilizing the full fiscal year cost to charge ratios rather than its actual two separate cost to charge ratios, one for each pre and post August 2000 in determining its pre-August 1, 2000 Medicare costs.

The cost report included a protested item in Worksheet D, Line 16.5, Column 1, seeking to add $239,494 to its reimbursement amount. The costs for the partial cost reporting period January 1, 2000 through July 31, 2000 were $1,018,897. The methodology implemented on the Cost Report calculated by apportionment came to $779,404.00. The difference of $239,493.97 the Provider protested was due to the fact that the Provider's calculated costs were higher for that period under the Provider's methodology that used a cost to charge ratio based on data from January 1, 2000 through July 31, 2000.[10] Following a desk review, the Intermediary issued a final Notice of Program Reimbursement (NPR) to the Provider regarding the as-filed FY 2000 cost report. The NPR included minor standard adjustments, of which Adjustment #6 is the only adjustment at issue in this appeal. The protested item of $239,494 reflected the Provider's apportioned costs from January 1, 2000 through July 31, 2000 based on the Provider's Profit and Loss Statements from that period.

[10] *See* Provider's letter dated June 21, 2013.

The Intermediary adjusted the protested item by following the applicable cost report instructions and forms, which allocated the Provider's costs before and after August 1, 2000 in accordance with Transmittal No. 4. On December 21, 2007, the Provider timely filed its hearing request seeking the reversal of the Intermediary's Adjustment No. 6.

The Provider argued that the computational methodology in Transmittal No. 4 "set forth a process to split/allocate the calendar year costs according to the percentage of revenue for the periods 'prior to 8/1/2000' and 'post 8/1/2000'" and that this "computational/statistical allocation of costs based upon the revenues by period is undisputedly an 'alternative' method of cost allocation".[11] The Provider submitted that this "alternative" method "may be used only when the actual costs cannot be determined and that the 'actual costs' must be used when they are ascertainable".[12] The Provider contended that its accrual based system of accounting properly allocated its actual costs which "allowed it to know, in fact, its exact costs per period", and that actual costs are to be used when ascertainable.[13] The Provider noted that the alternative computational methodology advocated by the Intermediary, even if set forth in the instructional forms, does not properly reflect the Provider's actual cost for the two periods at issue in FY 2000, noting that the actual costs for the cost reimbursed period of January 1, 2000 thru July 31, 2000 when compared to the allocation by computational methodology advocated by the Intermediary (and as set forth in the instructions) recognized additional actual costs of $239,494.[14] Therefore, the Provider argued that its claimed "actual costs" should be accepted by the Intermediary for the Provider's reportable costs. Further, the Provider noted that Transmittal No. 4 improperly ignores the Provider's actual costs in violation of longstanding law and regulations because the law and regulations require the use of the actual costs if the Provider has the actual costs.[15]

The Intermediary asserted that it was following the Transmittal No. 4 instructions for Worksheet C, and that it did not have the discretion to disregard or modify the reimbursement methodology in those instructions.[16] The Intermediary stated that the Provider's numerous cites to Medicare regulations and PRM section for what it describes as a "fundamental principle" of Medicare reimbursement—that the "actual costs" must be used when they are ascertainable—do not pertain to the specific

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[11] *See* Provider's Post Hearing Brief at 1.
[12] *See Id.* at 2.
[13] *See Id.* at 4. The Provider cited to 42 C.F.R. §§ 413.9, 413.13, 413.24, 413.53, 413.60, 413.64; PRM 15-1 §§ 2100, 2102.1, 2300, 2302.1, 2302.7, 2304, and 2306.
[14] Id. at 4.
[15] *See* Transcript of Proceedings, June 13, 2013, p. 33.
[16] *See* Intermediary's Post-Hearing Brief at 4-5.

circumstances at issue here where CMS specifically identified the reimbursement methodology to be used for the Provider's disputed cost report.[17] The Intermediary noted that the regulations also make clear that, a provider's actual costs may not be considered its *de facto* reasonable costs as set forth and evident under § 1861(v)(1)(a) of the Act.[18]

The Board found that by using the full fiscal year to calculate the cost to charge ratio, the cost allocations will be distorted, and that instead, the cost to charge ratio should be calculated for each of the two short periods for purposes of determining the cost reimbursement due for the period January 1, 2000-July 30, 2000. The Board found that doing this would allow for a result that was more accurate, fair, and less arbitrary, and would reimburse the Provider for its "actual costs." The Board noted that following the implementation of OPPS, providers had a greater incentive to economize, and thus, a provider may have significantly different costs during the pre- and post-OPPS implementation period. Thus, the Board found that the methodology set forth in Transmittal No. 4 regarding the instructions for Worksheet C was not the proper method to apportion the Provider's cost.

The Administrator disagrees with the Board's finding. Transmittal No. 4 specified the manner in which all intermediaries were to calculate the cost to charge ratio for CMHCs across the United States for purposes of determining Medicare's share of the costs under reasonable cost reimbursement. CMS has historically used a 12 month cost reporting period to determine any cost to charge ratios for purposes of allocating costs for reasonable cost payment or for use in other payment methodologies, and to the extent applicable, for purposes of determining base year amounts.

The Provider argued that the reimbursement methodology incorporated therein was optional if the Provider chose to rely on its purported actual costs. The Administrator notes that had the instructions been optional, Transmittal No. 4 would have said as much. Instead, it specifically instructs intermediaries as to the manner in which a CMHCs payment was to be calculated for its pre-August 1, 2000 and post-August 1, 2000 time periods. According to longstanding Medicare principles, providers cannot be treated in a disparate manner. Regarding the Provider's argument that actual costs should be used where they are known, the Administrator notes that reasonable costs are not synonymous with actual costs, as reasonable cost always requires some cost allocation and cost finding statistics to differentiate costs of Medicare and non-Medicare patients. Because of this, CMS specifically does not use short cost reporting periods for either cost to charge ratios or for base calculations at they may distort costs.

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[17] *See Id.* at 4.
[18] *See Id.* at 4-5.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion. The Intermediary's adjustment to the allocation of the Provider's cost was proper.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 11/5/14

/s/
Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services