CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Decatur County General Hospital	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: June 30, 2000 and June 30, 2001**
Provider	
vs.	
Blue Cross Blue Shield Association / Riverbend Government Benefits Administrators	**Review of: PRRB Dec. No. 2007-D28 Dated: April 20, 2007**
Intermediary	

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 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. CMS' Center for Medicare Management (CMM) submitted timely comments, requesting reversal of the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

Decatur County General Hospital, (the Provider), is a governmental acute care hospital chartered by the State of Tennessee. The Provider operates swing beds, a home health agency and a hospital-based emergency medical ambulance service for Decatur County. For the fiscal years at issue, the Provider reported the cost of ambulance services on the cost

reports and the Medicare charges for ambulance services on Worksheet D, Part V of the cost reports. As part of the final settlement of Provider's FYE 6/30/2000 and 6/30/2001 cost reports, the Intermediary reduced capital-related costs for outpatient hospital services by 10 percent and outpatient operating costs by 5.8 percent. The Provider disagreed with the application of the reduction factors to its ambulance services (which were also subjected to cost per trip limits) and filed a timely hearing request with the Board.

ISSUE AND BOARD'S DECISION

The Issue is whether the Provider's fiscal years ending (FYEs) 6/30/00 and 6/30/01 ambulance cost per trip limits were improperly low because the Intermediary improperly applied the 5.8 percent outpatient operating cost reduction and the 10 percent outpatient capital cost reduction to base year costs utilized to calculate those limits.

The Board held that the Intermediary improperly applied 5.8 percent outpatient operating cost reduction and 10 percent outpatient capital cost reduction to base year costs used to calculate the Provider's FY 2000 ambulance cost per trip limits. The Board found that the Provider is entitled to costs reimbursement for ambulance services provided during FYE 6/30/01 (subject to the 5.8 percent and 10 percent reductions). No ambulance cost per trip limits are to be applied. The Board remanded the case to the Intermediary to recalculate the ambulance cost per trip limits accordingly and to modify its adjustments.

SUMMARY OF COMMENTS

CMM submitted comments requesting that the Administrator overturn the Board's decision. Specifically, CMM requested reversal in part of the Board's decision on grounds that it would be contrary to consistent Medicare policy to reopen the base year for any adjustments or calculations. Across the Medicare program, and especially concerning the calculation of the base rate for ambulance services, CMM stated that they have followed the procedure that, once the base year rates are determined, they are not altered as this would have ramifications for all subsequent cost years.

CMM agreed that the 5.8 and 10 percent reduction factors were properly applied by the Intermediary as they were considered to be outpatient hospital services under Section 1861(v)(1)(S)(ii)(III) of the Act. CMM agreed that the 5.8 and 10 percent reductions should be applied to the ambulance services for the base year.

CMM disagreed with the Board's finding that payments for ambulance services were not subject to the cost per trip limit as of January 1, 2000. CMM stated that Congress' intent was to have the ambulance fee schedule implemented by January 1, 2000, which would have negated the need for the cost per trip limit if there had also been no transition period to the full ambulance fee schedule payment. In fact, the ambulance fee schedule was not implemented until April 1, 2002, and, even at that point, it was implemented with a 5-year transition period. This meant that all the provisions of the reasonable cost payment method had to remain in place as established by the Balanced Budget Act (BBA) of 1997 so that Congressional intent to limit the cost of ambulance services would not be undermined until the full implementation of the ambulance fee schedule was accomplished.

The Intermediary submitted comments requesting reversal in part of the Board's decision. The Intermediary contended that the ambulance cost was subject to the 5.8 percent and 10 percent reductions because the ambulance service is an outpatient service subject to the cost reductions. The cost reductions were correctly computed in the base year, as the base year was to reflect reasonable cost.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments were received timely and are included in the record and have been considered. After a review of the record, applicable regulations and manual instructions, the Administrator finds that the Intermediary properly applied the 5.8 percent outpatient operating cost reduction and the 10 percent outpatient capital cost reduction to the base year costs used to calculate the Provider's FY 2000 ambulance cost per trip limits.

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. Consistent with the statute, the regulation at 42 CFR §413.9 states

that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

In response to rising costs, and realizing that the original structure of reasonable costs provided little incentive for providers to operate efficiently in delivering services, Congress authorized the Secretary to establish cost limits under Section 1861(v)(1)(A) of the Act.

Specifically, the Secretary has the authority to:

> [p]rovide for the establishment of limits on the direct or indirect overall incurred costs… based on estimates of the costs necessary in the efficient delivery of needed health services….

In addition, relevant to the reasonable cost principals above, existing Medicare law contains reduction factors for application to outpatient hospital services. Section 1861(v)(1)(S)(ii) of the Act states:

> (I) … in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this subchapter… by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1999 and until the first date that the prospective payment system under section 1833(t) of this title is implemented. (Emphasis added.)
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> (II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 through 1999 and until the first date that the prospective payment system under section 1833(t) is implemented (emphasis added.)

As further evidence that the ambulance services at issue are outpatient hospital services, (although not covered under Outpatient PPS), Section 1833 of the Act states, in relevant part:

…(t) Prospective payment system for hospital outpatient department services–

(1) Amount of payment …

(B) Definition of covered OPD services

For purposes of this subsection, the term "covered OPD services"--…

(iv) does not include … ambulance services, for which payment is made under a fee schedule described in section 1834(k) of this title or section 1834(l) of this section…

(10) Special rule for ambulance services

The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in section 1833(v)(1)(U) of this title, or, if applicable, the fee schedule established under 1833(l) of this title (emphasis added).

Furthermore, 42 CFR §419.22 states:

Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

(i) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule under section 1834(1).

Accordingly, as the Board correctly determined, the ambulance services at issue are subject to the 5.8 percent and 10 percent reduction factors, as ambulance services are outpatient hospital services.

Regarding whether the costs recognized as reasonable in the base year should include the application of 5.8 percent and 10 percent reduction factors, the Administrator finds that the Intermediary properly applied the reduction factors to the Provider's base year costs. Pursuant to the Balanced Budget Act of 1997, Congress enacted Section 1861(v)(1)(U), which provided the following cost per trip limit to determine the payment for ambulance services:

> In determining the reasonable cost of ambulance services… provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year … increased by the percentage increase in the consumer price index for all urban consumer (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point. (Emphasis added).

Congress was concerned with escalating outpatient costs when it established the 10 percent and 5.8 percent reduction of costs for outpatient services and also the "cost per trip" limitation. The Secretary, in implementing the further cost containment measure reflected in the "cost per trip" provision, reasonably determined that the costs "recognized as reasonable" in the base year, should reflect the 10 percent and 5.8 percent reduction. That is, the base year costs, after application of the outpatient reductions, are in fact the costs "recognized as reasonable" under the Medicare program.

The Administrator finds that the application of these reductions to the cost per trip base year is consistent with the statutory language of section 1861(v)(1)(U) and congressional concerns regarding escalating costs of outpatient and ambulance services. In addition, this policy is within the Secretary's authority under the reasonable cost provisions of section 1861(v)(1)(A) of the Act and the program. In light of the foregoing, the Adminstrator disagrees with the Board and finds that the Intermediary's application of the 5.8 percent outpatient operating cost reduction and 10 percent outpatient capital cost reduction to base year costs used to calculate the Provider's FYEs 2000 and 2001 ambulance cost per trip limits was appropriate. Application of the cost reduction factors to the base year produces costs that are reasonable as recognized by the Secretary and effectuates the intent of Congresses to reduce and avoid excess costs per trip. Accordingly, the Board's decision is modified and the Intermediary's determination of the Provider's cost per trip for the cost years at issue is upheld.

Further, regarding the application of the cost per trip limit after January 1, 2000, Section 4531(b)(4) of the BBA, which added section 1834(1)(3), sets forth the statutory provisions indicating that the fee schedule was to be effective for ambulance services on or after January 1, 2000. The Secretary was unable to implement the ambulance fee schedule until April 1, 2002, due to system changes and Y2k compliance, payment for ambulance services should not revert back to pre-BBA cost reimbursement. The Secretary clearly intended to

implement the reimbursement changes to ambulance services as instructed, but was forced to delay the implementation of a national fee schedule due to the difficulties it experienced.

Congress, under the BBA, mandated the establishment of a national fee schedule to remedy the problems experienced under the reasonable charge methodology, to provide consistency in payments and continue cost containment for ambulance related services. Under the fee schedule methodology, Congress was continuing to require the Secretary to establish mechanisms to control increases in expenditures for ambulance services under Part B of the Medicare program. Congress was also requiring the Secretary to ensure that aggregate payment amounts made in the first year under the fee schedule not exceed the aggregate amount of payment that would have been made for such services had the cost per trip limitation applied. Thus, there is no statutory provision to support a finding that payment for ambulance services would revert back to pre-BBA cost reimbursement without its cost per trip cost containment measure, if the ambulance fee schedule was not implemented by January 1, 2000. A policy to allow payments for the period after January 1, 2000 until the implementation of the fee schedule without application of the cost per trip limitation, would be inconsistent with, and undermine, the overall statutory scheme for ambulance services. Such a policy would also be inconsistent with the Secretary's determination of the reasonable cost of ambulance services under the Medicare program.

Thus, the Provider is not entitled to cost reimbursement for ambulance services for FYE June 30, 2001 without application of the cost per trip limits. The Administrator finds that the Intermediary's application of the cost per trip limitation for the Provider's fiscal years at issue was proper.

DECISION

The decision of the Board is modified in accordance with the foregoing opinion. The Intermediary's calculation and application of the Provider's cost per trip limitation for the cost years at issue is upheld.

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

Date: 6/27/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services