CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Innovis Health	**Determination for Cost Reporting Period Ending: December 31, 2000**
Provider	
vs.	
Blue Cross Blue Shield Association / Noridian Administrative Services	**Review of: PRRB Dec. No. 2007-D56 Dated: August 2, 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 Intermediary submitted comments requesting reversal of the Board's decision. The Provider submitted comments requesting that the Administrator affirm the Board's decision. The CMS' Center for Medicare Management (CMM) submitted comments, requesting reversal of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is a 60-bed, general short-term hospital located in Fargo, North Dakota. The Provider began operations in November 14, 2000 and submitted its first Medicare cost report for the short period ended December 31, 2000. The Provider claimed as a protested amount, the Transitional Outpatient Payments (TOPs) because it filed a cost report prior to the

January 1, 2001 date that would be used to establish its base payment-to-cost ratio pursuant to 42 C.F.R. §419.70(f)(2). The Intermediary disallowed the claim, however, as it stated that a full 12-month cost report is required to establish a base payment-to-cost ratio and to comply with the intended purpose of TOPs.

ISSUE AND BOARD'S DECISION

The issue is whether the Provider is entitled to Transitional Outpatient Payments (TOPs).

The Board found that the Provider is entitled to TOPs in accordance with 42 C.F.R. §419.70 and reversed the Intermediary's disallowance. The Board found that the Provider met the regulatory criteria for a TOP. Because the Provider had a cost report before January 1, 2001, a base payment to cost ratio may be calculated and hence, it is eligible for a TOP. The Board did not find any evidence that the purpose of the TOP was to ease the transition to the outpatient prospective payment system (OPPS). The Board concluded that since the inception of Medicare's OPPS, CMS has had ample opportunities and numerous rule promulgations to alter the regulations and the TOPs qualification rule but has chosen not to make any changes. The regulation was unambiguous, easily administered and as rational a policy decision as any other rule for determining TOPs eligibility.

SUMMARY OF COMMENTS

The Provider commented, stating that the Board's decision on this issue should be affirmed. The Provider asserted that there are no grounds for reviewing the final decision of the Board in this matter. The Provider disagreed with the Intermediary's comments regarding the need for additional clarification on the methodology for determining a TOPs amount applicable to the Provider.

The Intermediary commented, stating that the Board's decision on this issue should be reversed. The Intermediary stated that the Board's decision was based on an erroneous interpretation of the regulation. The Intermediary argued that granting TOPs relief to the Provider under the facts of this case is a logical impossibility given the Provider's less than two month duration of Medicare operations for the cost year at issue. Alternatively, the Intermediary stated that should the Administrator agree with the basic premise of the Board's decision, then clarification is needed as to how the calculation should be conducted.

CMM submitted comments requesting that the Administrator reverse the Board's decision. CMM stated that they have consistently informed both Intermediaries and Providers that hospitals must have a full cost report ending before January 1, 2001 in order to calculate a payment-to-cost ratio, which determines eligibility for TOPs and that a partial year cost report ending before January 1, 2001 is insufficient for qualification for the TOPs.

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 Board's decision should be reversed.

Section 1861(v)(1)(A) of the Social Security Act (the 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.

Effective with cost reporting periods beginning on or after October 1, 1983, short-term acute care hospitals became subject to Medicare's Prospective Payment System (PPS). Under this system, Medicare's payment for hospital inpatient Part A operating costs is made on prospectively determined rates and applied on a per discharge basis. Medicare discharges are classified into diagnostic related groups (DRGs), and a hospital-specific payment rate is assigned to each DRG with respect to resource use or intensity. Hospital inpatient operating costs include general routine service costs, ancillary service costs, and intensive care-type unit service costs, but exclude certain other costs such as the costs of medical education training programs and organ acquisition expenses.

The Balanced Budget Act of 1997 (BBA), enacted on August 5, 1997, amended section 1833 of the Act by adding subsection (t), which provides for the implementation of a hospital outpatient PPS (OPPS) effective for services furnished on or after July 1, 2000. Under OPPS, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Healthcare Common Procedure Coding System (HCPCS).

On November 29, 1999, the Balanced Budget Refinement Act of 1999 (BBRA), P.L. 106-113, was enacted. Section 202 of the BBRA amended section 1833(t) of the Act by re-designating paragraphs (7) through (11) as paragraphs (8) through (12), and adding a new paragraph (7) which provides for a transitional adjustment to limit payment reductions under the hospital 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).

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 is entitled "Transitional adjustment to limit decline in payments." The regulation at 42 C.F.R §419.70(a) states in part that:

> for covered hospital outpatient services furnished before January 1, 2002, for which the prospective payment system amount … is –
>
> > (1) At least 90 percent, but less than 100 percent, of the pre-BBA amount … the amount of payment under this part is increased by 80 percent of the amount of this difference.

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….

However, the definition at 42 C.F.R. §419.70(f)(2) was revised retroactively to August 1, 2000, in accordance with section 403 of the Benefits Improvement Act of 2000 (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 payment for these services through cost-sharing described in paragraph (e) of this section:
>
> (A) The cost reporting period ending in 1996: or
>
> (B) <u>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</u>; and
>
> (ii) The reasonable costs of these services for the same cost reporting period. (Emphasis added).

CMS policy as referenced in the Internet-Only Manual, Pub 100-4, Chapter 4, Section 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 <u>full year cost reporting period</u>, 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, section 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. The Internet-Only Manual, Pub 100-4, Chapter 4, Section 80.1 states:

> For most hospitals and CMHCs, the base year cost report used to calculate the payment-to-cost ratio is the cost report ended during calendar year 1996. However, if a hospital or CMHC did not file a cost report that ended in calendar year 1996, the payment-to-cost ratio will be calculated using the provider's first cost report that ended after calendar year 1996 and before calendar year 2001.

In this case, the Provider began operations in November 14, 2000, and submitted its first Medicare cost report for the short period ended December 31, 2000. Since the Provider started its operations after the implementation of OPPS and does not have a full year cost report, the Administrator finds that the Provider is not eligible for TOPs. Contrary to the Board's finding, it is not the intent of the law to allocate an extra payment for this Provider, where it has not experienced a "decline" in its payments under OPPS.

As stated in the Internet-Only Manual, Pub 100-4, Chapter 4, Section 80.1:

> The purpose of the TOP is to restore some of the decrease in the payment that a provider may experience under the OPPS … The pre-BBA amount is an estimate of what the provider would have been paid during the calendar year for the same services under the system that was in effect prior to OPPS.

In light of the foregoing, the Administrator finds that the Board's decision is incorrect. The Provider is ineligible for TOPs since it did not have a full year cost report before January 1, 2001. As further evident in CMS' published policies and procedures which clarifies and adds further interpretation of the rationale and intent of 42 C.F.R. §419.70(f)(2), the underlying purpose of TOPs is to restore some of the decrease in the payment that a provider may have experienced under the OPPS due to Pre-BBA estimate amounts. The Administrator finds that, as the Provider never operated under a system other than the OPPS, and does not have a full year cost reporting period, the Provider is not eligible for TOPs.

DECISION

In accordance with the foregoing opinion, the decision of the Board is reversed.

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

Date: **9/27/07**

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