

HEALTH INDUSTRY ALERT

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CENTERS FOR MEDICARE & MEDICAID SERVICES ACQUIESCES ON THE APPLICATION OF THE 5.8 PERCENT COST REDUCTION FACTOR TO INPATIENT ANCILLARY SERVICES

Over the past decade, Congress has mandated a 5.8 percent reduction in the reasonable cost of hospital outpatient services (other than capital-related costs) attributable to portions of cost reporting periods occurring between October 1, 1990 and August 1, 2000 (the advent of the outpatient prospective payment system). See 42 U.S.C. § 1395x(v)(1)(S)(ii); 42 C.F.R. § 413.124(a). In our *Health Industry Alert: Inpatient Reimbursement Implications Related to the Hospital Outpatient Cost "Haircut"* (Sept. 17, 1998) (available online at <http://www.akingump.com/health/>), we called to your attention the fact that the Medicare cost reporting instructions improperly apply this 5.8 percent cost reduction to all Part B services, including Part B *inpatient* ancillary services. Since the statute and regulations clearly state that the 5.8 percent reduction is only to be applied to *outpatient* services, we suggested in our 1998 *Alert* that hospitals might wish to consider including this issue in Medicare appeals before the Provider Reimbursement Review Board (PRRB).

Significantly, in Program Memorandum (PM) A-01-125 (Sept. 28, 2001) (attached), the Centers for Medicare & Medicaid Services (CMS) has now conceded that the 5.8 percent cost reduction "should not be applied when

computing reimbursement for inpatient ancillary services." The PM is effective for portions of hospital cost reporting periods between October 1, 1990 and August 1, 2000, which are awaiting final settlement by the intermediary (*i.e.*, before the issuance of a Notice of Program Reimbursement (NPR)), or where the issue is pending as part of a jurisdictionally valid PRRB appeal or civil court action.

In light of this recent development, we thought it would be appropriate to again suggest that hospitals may wish to consider adding this issue (if they have not done so already) to their pending PRRB appeals for fiscal years 1990–2000. Once this issue is included in a pending appeal, according to the PM, the issue should be resolvable through an Administrative Resolution without further PRRB proceedings.

The new policy provides that cost reports not already appealed should not be reopened to reflect the PM. Nonetheless, it would appear that even if a hospital's appeal period for a given fiscal year has passed, there may be enforceable rights under the PM based upon a timely reopening request (*i.e.*, a reopening request within three years of the NPR for the affected year). Notably, the PM does not explicitly prohibit intermediaries from reopening cost reports to correct this error.

In that regard, you may recall Ruling No. 97-2, in which CMS acquiesced in the counting of "Medicaid-eligible" days

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in the calculation of the Medicare disproportionate share hospital (DSH) adjustment. In that ruling, CMS expressly directed intermediaries not to reopen cost reports to reflect the new DSH policy. However, in *Monmouth Medical Center v. Thompson*, 257 F.3d 807 (D.C. Cir. 2001), the United States Court of Appeals for the District of Columbia Circuit held that where CMS issues a ruling that essentially concedes that a prior policy was unlawful, “a clear duty on intermediaries to reopen” cost reports is created. A similar argument may

conceivably be made that as a result of CMS’ new policy determination in PM A-01-125, intermediaries have a duty to reopen hospital cost reports to correct the improper application of the 5.8 percent cost reduction to inpatient ancillary services.

Although the Medicare impact of this issue in any given fiscal year tends to be relatively small, the cumulative effect may be significant where multiple years are eligible for corrective payments.

IF YOU HAVE ANY QUESTIONS OR COMMENTS ABOUT THE FOREGOING, PLEASE CONTACT:

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