PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D69

PROVIDER -
Memorial Hospital of Rhode Island
Pawtucket, Rhode Island

Provider No. 41-0001

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Rhode Island

DATES OF HEARING-
October 11, 1996 and
December 19, 1996

Cost Reporting Period Ended -
September 30, 1988

CASE NO. 90-0989

INDEX

ISSUE:

Was the Health Care Financing Administration's ("HCFA") denial of the Provider's request for reconsideration of the TEFRA exception request proper?[1]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Memorial Hospital of Rhode Island ("Provider") is a 322 bed, nonprofit hospital located in Pawtucket, Rhode Island. During the fiscal year at issue, the Provider operated a 16-bed rehabilitation unit ("Unit") which was subject to the TEFRA[2] target rate ceilings prescribed by 42 U.S.C. § 1395ww(b) and the regulatory provisions of 42 C.F.R. § 413.40. Pursuant to 42 U.S.C. § 1395ww(b), Medicare payments for inpatient operating costs relating to the Provider's unit were based on the relationship between its actual costs and a ceiling determined by a target rate of increase in operating costs per case. The initial target amount was determined by multiplying the distinct part unit's allowable Medicare inpatient operating cost per discharge incurred in the base year by the applicable target rate percentage.[3] The target rate percentage consists of the rate-of-increase in the hospital wage and price index (the Market Basket Index), plus one percentage point. After the first year, a hospital's target amount is calculated by increasing the previous year's target amount by the current year's target rate percentage increase. If a provider's actual Medicare operating costs fall below the target amount, it receives reimbursement for its actual reasonable cost plus a share of the savings, known as the incentive payment. However, if its cost exceeds the target amount, the Provider does not receive full reimbursement for its incurred costs.

If a provider's cost exceeds the target rate ceiling, the statutory provisions at 42 U.S.C. § 1395ww(b)(4)(A) authorize the Secretary to grant an exemption from, or an adjustment or exception to a provider's rate of increase ceiling where events beyond the hospital's control or extraordinary circumstances create a distortion in the increase in costs for a cost reporting period. The Secretary's regulations at 42 C.F.R. § 413.40(g) and (h) implement the statutory provisions by providing for modifications to a hospital's target amounts. Those sections read, in pertinent part:

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[1] Except for the above-stated issue, all other issues previously appealed by the Provider have been administratively resolved or withdrawn from this case. With respect to the remaining issue, the Provider withdrew its appeal for additional amounts based on the relief granted for length of stay. The sole matter remaining for the TEFRA exception request relates to the three-hour rule for therapy services. (See Tr. (Oct. 11, 1996), at 105-106.

[2] The Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") (Pub. L. 97-248).

[3] The Provider's base year in the instant case was FYE September 30, 1985.

> (g) Exceptions-- (1) General procedure. HCFA may adjust a hospital's operating costs (as described in paragraph (b)(1) of this section) upward or downward, as appropriate, under circumstances as specified in paragraphs (g)(2) and (3) of this section. HCFA makes an adjustment only to extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, separately identified by the hospital, and verified by the intermediary. HCFA may grant an exception only if a hospital's operating costs exceed the rate of increase ceiling imposed under this section.
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> (2) Extraordinary circumstances. The hospital can show that it incurred unusual costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects.
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> . . .
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> (h) Adjustments-- (1) Comparability of cost reporting periods. (i) HCFA may adjust the amount of the operating costs considered in establishing cost per case for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, to take into account factors that could result in a significant distortion in the operating costs of inpatient hospital services. The adjustments include, but are not limited to, adjustments of the base period costs to include explicitly FICA taxes (if the hospital did not incur costs for FICA taxes in its base period), and services billed under Part B of Medicare during the base period, but paid under Part A during the subject cost reporting period.

42 C.F.R. § 413.40(g) and (h).

In May of 1989, the Provider submitted an application for TEFRA relief[4] for fiscal year 1988 citing the following contributory factors:

> Increased severity of patient disability and underlying medical conditions which resulted in both:
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> - Increased therapy and medical treatment each day, and
> - Longer length of stay.

On August 9, 1989, HCFA forwarded to Blue Cross and Blue Shield of Rhode Island

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[4] Provider Exhibit 4/Intermediary Exhibit 17.

("Intermediary") its decision regarding the Provider's request, granting partial relief in the amount of $182,533.[5] HCFA's response, which was forwarded to the Provider on August 17, 1989,[6] addressed two factors in the Provider's request for TEFRA relief. One factor concerned the "Three-Hour Rule" which HCFA initiated during fiscal year 1985. This rule established a medical standard for rehabilitation patients that required rehabilitation units to furnish three hours of physical and/or occupational therapy to Medicare patient during each day of a rehabilitation stay. The effect of this standard would be to increase both the volume of therapy services and the related costs of such services. In its response to the Provider's request, HCFA recognized the potential problem that would result from the implementation of this standard. Accordingly, HCFA recognized the fiscal year's impact in the target rate limitation as opposed to forcing the hospital to request an adjustment each year because of the impact of the three-hour rule. As such, HCFA adjusted the fiscal 1985 cost per discharge for the three-hour rule and granted a target rate of $6,344.76 for fiscal year 1988. HCFA further advised that the $6,344.76 per discharge would be adjusted by future updates in subsequent cost reporting periods, and that this methodology would eliminate any aberrant increases in costs resulting from increases over the allowable rate of increase percentage recognized for each fiscal year.[7]

On February 8, 1990, the Provider submitted correspondence to the Intermediary requesting a reconsideration of its request for a TEFRA target rate adjustment.[8] In its reconsideration request, the Provider stated that HCFA's three-hour rule calculation disregarded the exceptional increase in physical therapy costs between fiscal years 1987 and 1988 when it adjusted the target rate per discharge to $6,344.76. In order to obtain the full reimbursement to which it was entitled under 42 C.F.R. § 413.40(h), the Provider believed its target rate should be adjusted to $7,144.58 and, thus, was due an additional award of $61,889. On July 30, 1990, HCFA responded to the Provider's reconsideration request, and cited several reasons for denying an increase in the TEFRA target rate.[9] HCFA advised that the Provider had received full relief in the initial determination, and that the Provider was presenting the same arguments as those set forth in its prior year request for fiscal year 1987. In granting the Provider relief for fiscal year 1987, HCFA recognized the impact of the three-hour rule on the

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5 Intermediary Exhibit 18.

6 Provider Exhibit 5/Intermediary Exhibit 19.

7 HCFA also commented on the increase in length of stay for rehabilitation patients, and recalculated cost on a per diem basis and awarded the Provider an adjustment in the amount of $182,533. As stated previously, the Provider is no longer pursuing additional amounts for this portion of its reconsideration request.

8 Provider Exhibit 6/Intermediary Exhibit 20.

9 Provider Exhibit 7/Intermediary Exhibit 22.

target rate and provided a permanent adjustment to the target rate. With respect to the Provider's request for relief due to increased salaries in the physical therapy area, HCFA stated that the regulation cited by the Provider [42 C.F.R. § 413.30(f)(8)] does not pertain to the ceiling on the rate of hospital inpatient cost increases, and that the percentage increase applied to the target rate takes into account salary and other cost increases. The Provider was expected to initiate cost containment measures if the actual rate of increase for expense items was above the allowable rate of increase.

The Provider appealed HCFA's denial of its reconsideration request to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and has met all jurisdictional requirements of those regulations. The Provider was represented by Thomas S. Crane, Esquire, from the law firm of Hinckley, Allen & Snyder. The Intermediary's representative was Michael F. Berkey, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it has met all the regulatory requirements for TEFRA relief under the three-hour rule, and that its target rate should be adjusted to $7,187.87, based on additional relief of $70,470.[10] The Provider argues that it has demonstrated that its costs are reasonable and directly related to compliance with the three-hour rule, and that HCFA's refusal to grant relief is contrary to Medicare law and HCFA's own prior practice. Given HCFA's permanent adjustment for fiscal year 1987 costs, the Provider believes that a permanent adjustment for fiscal year 1988 costs is equally warranted.

The Provider points out that the relief it is seeking relates exclusively to its compliance with the Medicare program's three-hour rule in carrying out a rehabilitation program. The Medicare Part A Intermediary Manual ("HCFA Pub. 13-3 Part 3")[11] at § 3101,11D.3 states that "[t]he general threshold for establishing the need for inpatient hospital rehabilitation services is that the patient must require and receive at least 3 hours a day of physical and/or occupational therapy." To grant relief under the three-hour rule, HCFA must find that the unit experienced a cost distortion effect, with costs that are separately identifiable, related to compliance with the three-hour rule, and reasonable. The Provider contends that the data it provided in its application for TEFRA relief for fiscal year 1988 presented a compelling case for relief because the unit experienced a change in case mix that required increased levels of

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[10] The adjusted target rate of $7,187.87 and additional relief of $70,470 were presented to the Board for the first time during the opening statement of the Provider's representative [Tr. (Oct. 11, 1996) at 17-18.] The Provider's reconsideration request to HCFA reflected an adjusted target rate of $7,144.58 and additional relief of $61,889 (Provider Exhibit 6/Intermediary Exhibit 20.)

[11] Attachment B - Provider's Post-Hearing Brief.

treatment in order to comply with the three-hour rule. Since the regulation at 42 C.F.R. § 413.40(h) requires an examination of the overall operating costs of furnishing inpatient hospital services, the best measure of resources utilized is total patient days. From 1985 to 1988, not only did total patient days and stroke patient days increase substantially in the unit, but stroke represented a greater proportion of the days by increasing from 70.5 percent in 1985 to 75.3 percent in 1988. Consequently, intensity of care increased along with the resources necessary to furnish this level of care.

The Provider asserts that significant evidence was presented demonstrating that more complex patients require more hours of therapy services. The factors of caring for functionally more dependent patients with more co-morbid illnesses, where stroke was a more predominant diagnosis, meant that the rehabilitation of these patients was more complex and labor intensive, requiring more time to be spent with each patient and with resultant slower improvements. As a natural and direct result, the number of therapy hours per day increased from 1985 to 1988, reaching 3.44 hours per day in 1988. As to the reasonableness of the level of therapy rendered, the Provider cites a district court decision in Idaho Elks Rehabilitation Hospital v. Shalala, 1995 WL 864079, (D. Idaho) ("Idaho Elks").[12] In that case, the provider appealed partial TEFRA relief granted by HCFA based on its efforts to comply with the three-hour rule, and demonstrated that its rehabilitation unit was facing a change in case mix resulting from a greater percentage of stroke patients. Like the Provider in the instant case, the hospital in Idaho Elks was below three therapy hours per day for certain years, and above that amount in the years under appeal (3.65 hours in 1987 and 4.04 hours in 1988). In its decision, the court in Idaho Elks referred to the rule's requirement for three hours of therapy as an "average" or a "minimum" requirement or "guideline," and characterized the 1987-1988 utilization as "slightly increasing the minimum" requirements under the three-hour rule. The court held: "the costs so closely approximate the Secretary's own bare minimum requirement, they are presumptively reasonable." (Emphasis added.) Id. at 12.

The Provider contends its evidence overwhelmingly demonstrates that its costs were reasonable and directly related to compliance with the three-hour rule. The two categories of expenses in question are salary expenses and overhead for treating inpatients. Although the total increase in salary expense between 1987 and 1988 of 32.92 percent may seem large, the Provider asserts that the reasonableness of these costs must be examined based on the two components: staffing or FTEs and wages. The Intermediary's data (Intermediary's Position Paper at 9) shows that FTE increases in the physical therapy cost center between 1987 and 1988 was 16.7 percent, virtually identical to the 16.6 percent increase in physical therapy rendered in 1988. The Provider contends that wage increases were similarly reasonable, with an increase of only 8.68 percent for physical therapists, 7.12 percent for speech pathologists, and 11.2 percent for assistants. The reasonableness of these increases can be seen in the Provider's method of setting wages. The Provider determined wages using comparative data

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[12] Attachment C - Provider's Post-Hearing Brief.

from the Hospital Association of Rhode Island, and found its salaries in these areas to be reasonable. Moreover, these costs must be considered presumptively reasonable given the fact that the Intermediary's witness has "no idea" whether it challenged the Provider's 1988 salary expense costs.[13] With respect to the reasonableness of the allocation of indirect overhead expenses, the Provider contends that the allocation statistics provided by the Intermediary are an accurate reflection of the indirect costs allocated to the physical therapy cost center related to the hospital's compliance with the three-hour rule.[14] These allocation statistics are not only normal and reasonable, they were also not challenged by the Intermediary in fiscal year 1988.

The Provider notes that the Intermediary has presented three arguments as to why the Provider's costs are unreasonable: productivity, increase in beds, and overhead allocation statistics including the expansion of the physical therapy department. However, in each case, the Intermediary has presented no credible evidence challenging the appropriateness of full relief under the three-hour rule. Even though HCFA found that the Provider's data supported relief under the three-hour rule, the Intermediary questioned the Provider's productivity. One of the Intermediary's arguments is that a test is a test, and that if tests are merely added up, a finding can be made that there was little change in the number of tests. The Provider argues that such an approach does not withstand close scrutiny, and fails to address the more labor intensive rehabilitation furnished by the unit because of the need for the therapy to be broken into separate, smaller blocks of time. Given the virtual match between the increases in therapy hours and FTE increases between 1987 and 1988 (16.6 and 16.7 percent, respectively), the Provider believes there is no better indicator of the reasonableness of the Provider's physical therapy utilization and costs. As to the Intermediary's unsubstantiated productivity argument that physical therapy cost increases must be driven by outpatient costs, the Provider notes that the record clearly demonstrates that it is not seeking relief for outpatient costs. Even if the Intermediary is correct that the Provider had experienced a substantial increase in outpatient therapy tests, such a result could in no way impact the relief the Provider is seeking. This is because the allocation of costs between inpatients and outpatients is made on the basis of the cost-to-charge ratio. Consequently, if outpatient tests had increased, charges would increase concurrently, with the result that the ratio of outpatient charges would yield more costs diverted to the outpatient side of the ledger. In addition, an increase in outpatient volume would merely spread the costs over a larger base, thereby lowering the unit costs, not raising them as the Intermediary alleges.

In response to the Intermediary's allegation that the Provider's increase in the size of the unit does not justify an increase in nursing salary expenses, the Provider points out that both the nursing staff expenses and depreciation and interest for the increase in the number of beds are not part of the Provider's request and, therefore, are irrelevant. Moreover, the Provider

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[13] Tr. (Oct. 11, 1996), at 201-202.

[14] Intermediary Exhibit 30.

contends that the increase in bed capacity was reasonable. In 1987, the occupancy of its 12-bed unit was 95.87 percent, which is an unreasonably high utilization for this size unit. In 1988, the Provider's utilization of beds was 12 or more on 141 days. Accordingly, if the Provider had not expanded the unit to 16 beds, the utilization on those days would have been 100 percent or more. The Provider argues that queuing theory demonstrates that if a provider desires to assure that a bed is available with a certain level of confidence, a small size unit must operate at a much lower utilization rate than 90 to 95 percent. While the Intermediary challenges the Provider's overhead statistics principally on the grounds that the physical therapy department should not have been expanded, the Provider contends that this argument is grounded in the Intermediary's unfounded bias that the patients should have been receiving their therapy as medical surgical patients in the non-exempt PPS unit. The Provider believes that it has presented sufficient reasoning to render such an argument baseless.

The Provider contends that HCFA's refusal to consider its fiscal year 1988 costs is contrary to law and prior administrative action. In contrast to the relief granted to the Provider for fiscal year 1987 costs, HCFA only granted the Provider relief for its fiscal year 1988 costs with an update factor. Thus, as conceded by HCFA, none of the Provider's actual costs incurred in attempting to comply with the three-hour rule was adjusted even though HCFA determined that the Provider had met the regulatory threshold requirement for relief. The Provider notes that HCFA took this approach without being able to point to any single category of fiscal year 1988 costs that it found unreasonable. At the hearing, the HCFA witness merely stated that all of the Provider's costs in excess of the 1987 updated costs were found unreasonable.[15] This response, however, doesn't square with HCFA's own rationale given in its August 9, 1989 determination letter.[16] HCFA did not even hint that it determined certain of the Provider's costs were excessive; rather HCFA merely stated that it was providing the relief in the manner it was doing to avoid "requiring hospitals to request an adjustment each year to ameliorate the impact of the 3-hour rule. . ." Thus, the Provider's reading of HCFA's determination letter was that the Provider met all the regulatory requirements for relief under the three-hour rule, including the requirement that its costs were reasonable.

The Provider contends that HCFA's approach is directly contrary to HCFA's own regulatory scheme. Subsections (g) and (h) of 42 C.F.R. § 413.40 specifically require HCFA to "adjust a hospital's operating costs" or "adjust the amount of the operating costs. . . ." In contrast, other parts of the regulation require annualized changes in reimbursement to be determined according to a preset statutory inflation factor called the "applicable target rate percentage." 42 C.F.R. § 413.40(c)(5). Nowhere in the statutory and regulatory history of TEFRA can HCFA find authority to use an arbitrary inflation adjustment to provide relief under 42 C.F.R.

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15 Tr. (Dec. 19, 1996), at 38, 88-101.

16 Provider Exhibit 5.

§ 413.40(g) and (h). The Provider notes that the court in Idaho Elks[17] rejected HCFA's approach of not considering a provider's actual costs in a given year that are associated with three-hour rule compliance. In Idaho Elks, the provider received a permanent adjustment for fiscal year 1985 costs attributable to the three-hour rule. In 1989, the provider again sought relief, inter alia, for its physical therapy costs associated with three-hour rule compliance for fiscal years 1987 and 1988. HCFA rejected relief for these years arguing, as it argues now in the instant case:

> The previous adjustments granted. . .more than compensate the services provided to Medicare beneficiaries. Permanent adjustments were made to [the] target rate for increased services and physical and occupational therapy due to the three-hour rule requirement.[18]

Although the Idaho Elks court did not address the issue of an inflation update, the court found: "the 1984 and 1985 adjustments did not take into account any future increases that [the hospital] would need to make to attain and exceed by a small amount the three-hour minimum." Id. The court then held in favor of the provider's requested relief for 1987 and 1988 costs incurred in compliance with the three-hour rule.[19]

The Provider asserts that the primary reason that its fiscal year 1988 costs were not examined is because HCFA believes it is legally barred from giving relief for a provider's salary expenses incurred in complying with the three-hour rule. The HCFA witness stated that the Provider only received wage relief through the update factor, and that this update factor includes relief for both wages and staffing increases.[20] In response, the Provider contends that this argument does not withstand scrutiny, and notes that it is universally known that more than half of hospital costs are wages. Notwithstanding Congress' intent to moderate the impact of cost distortions through the TEFRA exception process, the Intermediary argues that wages, by far the largest category of hospital costs, must be disregarded in this process. This argument is based upon extremely oblique negative implications of a subsequently enacted statute which deals with a different subject matter. The Provider contends that common sense suggests that if Congress intended to ravage the regulatory scheme it had previously mandated, it would have sent a very clear signal that it was doing so. The signal that the Intermediary claims to read falls far short of the mark. During the cost year in question, the regulations that governed exception requests said nothing at all about wages. (See 42 C.F.R. § 413.40(g) and (h)). Nothing therein suggests that any category of costs (much less the

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17 Attachment C - Provider's Post-Hearing Brief.

18 Id. at 5.

19 Id. at 11-12, 18.

20 Tr. (Dec. 19, 1996), at 31-35.

largest component of costs) would not be considered as part of the overall mix of cost distortions.

The Provider argues that the regulations at 42 C.F.R. § 413.40(g) and (h) were promulgated pursuant to the TEFRA legislation and authorize HCFA to review wages as a component of operating costs. The statutory provisions of 42 U.S.C. § 1395ww(b)(1) reference the definition of "operating costs" as set forth in 42 U.S.C. § 1395ww(a)(4). The definition is broad and includes ". . . all routine operating costs, ancillary service operating costs, and special care unit operating costs. . ." Id. Wages are unquestionably among these costs. Expressly excluded are "capital" costs, proving that Congress was clearly able to exclude a category of costs when it intended to do so. Moreover, the Provider contends that the provision of law that underlies the Intermediary's claim of negative implication does not even relate to TEFRA exception requests. The Intermediary's argument is apparently based on section 4005(c)(2) of OBRA 1990, which was codified at 42 U.S.C. § 1395ww(b)(4)(B). This provision explicitly addresses the assignment of a new base period to a TEFRA provider. This is a different form of relief designed to change a provider's base year from one year to another, rather than provide for adjustments to a provider's specific base year costs.

The Provider contends that the argument that HCFA is statutorily barred from giving wage relief is also inconsistent with its own practices. In its determination of this Provider's very same fiscal year 1988 application, HCFA found the Provider's fiscal year 1987 wages in the physical therapy cost center allowable and gave a permanent adjustment for fiscal year 1987 costs that included wages. Yet somehow in the same determination, HCFA argues that it is legally barred from giving wage relief for 1988 costs. In further support of its position, the Provider cites the Board's decision in Idaho Elks Rehabilitation Hospital v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Oregon, PRRB Decision No. 93-D97, September 23, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,744. In that decision, the Board specifically considered the provider's request for increased staff salaries in order to retain qualified staff for compliance with the three-hour rule. The Board found that under HCFA's adjustment methodology, the provider does not receive any adjustment due to increases in salary costs as those costs are factored out by the adjustment methodology. The Board then held for the provider for the relief it was requesting. In summary, the Provider contends that wage costs comprise the bulk of hospital costs, and that a regulatory scheme that disregards wages flies in the face of a Congressional mandate to moderate cost distortions. Moreover, HCFA has granted exception requests based on wages, and courts have found wages an appropriate subject matter for exception requests. To view a subsequently enacted statute addressing a different form of relief as retroactively implying to the contrary would be an irrelevant application of the fact, the law, and relevant policy applications.

The Provider concludes that it qualifies for a permanent adjustment in its TEFRA base year costs based on its fiscal year 1988 costs. While HCFA granted the Provider a permanent adjustment for its 1987 costs, the only rationale provided by HCFA for the different posture

for 1988 costs was that it believes it was legally barred from providing wage relief. By stating that providers should not be forced to make repetitive annual applications, HCFA has, in essence, understood the need to provide permanent relief. A year-by-year approach forces HCFA to engage in a series of microscopic comparisons between a provider's annual utilization and costs. The irrationality of this approach is readily apparent. With respect to fiscal year 1987, the Provider sought and received TEFRA relief, although not permanent relief. Had the Provider not requested this relief, but instead filed its first exception request as to fiscal year 1988, HCFA and the Intermediary would have had no basis for focusing its inquiry on comparisons between 1987 and 1988. Rather, 1988 costs and other statistics would have been compared with those of the base year. Presumably, HCFA would have then applied the same methodology as it in fact devised to calculate relief due the Provider pursuant to the Provider's 1987 request. The result would have been that the Provider would have received the full amount of relief requested for 1988. This approach would have resulted in an appropriate resolution of the Provider's 1988 TEFRA request, but would have required the Provider to forego the relief to which it was legally entitled in fiscal 1987. A methodology that compels a provider to elect which year's legal rights should be sacrificed could not possibly reflect Congressional intent.

INTERMEDIARY'S CONTENTIONS:

It is the Intermediary's position that the relief granted to the Provider by HCFA through its adjustment to the TEFRA target rate for fiscal year 1988 is adequate and even generous. Between the fiscal years 1987 and 1988, rehabilitation beds at the Provider's exempt unit were increased from 12 to 16 beds. This increase in beds, along with the resulting incremental increases in cost allocation statistics, caused the cost for the unit to increase dramatically.[21] In addition, total patient days in the unit increased from 3,696 to 3,978 between the two fiscal years (7.63 percent increase), while Medicare days declined from 2,899 to 2,285 (a drop of 21.18 percent). As a result of these statistics, the routine cost per day for the unit increased from $195.03 to $215.19, a 10.75 percent increase. The Intermediary notes that it is the Provider's dramatic decline in Medicare utilization which is the major source of its problem with the TEFRA target rate of increase.

While the Provider claims that the implementation of Medicare's three-hour rule for therapy services caused unavoidable increased costs, the Intermediary argues that this declaration is not valid. Contrary to the Provider's assertion that a greater number of physical therapy tests needed to be performed than in previous years, a review of physical therapy activity between 1987 and 1988 indicates that inpatient tests only increased from 19,420 to 20,126, an increase of 3.63 percent. During the same time period, total therapy tests have gone from 46,559 to 49,880, an increase of 3,321 or 7.13 percent. This data includes physical, occupational and

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[21] See Intermediary Exhibits 24 and 25.

speech therapy, and is based on data submitted to the Intermediary by the Provider.[22] Based on a review of the cost allocation statistics between fiscal 1987 and 1988, gross salaries in the therapy cost centers increased by $230,714, from $478,592 to $709,306, representing an increase of 48.21 percent. During this same time period, the number of full time equivalents in the therapy department increased from 22.89 to 26.72, which resulted in a productivity drop in the number of tests per full time equivalent from 2,034.0 in fiscal 1987 to 1,866.6 in fiscal 1988.

In light of the above data, the Intermediary avers that the three-hour rule clearly had no negative impact on the Provider since the number of inpatient tests performed only increased by 3.63 percent during the period under consideration. Moreover, it is apparent that the Provider inappropriately increased the staffing level in the physical therapy department in the face of a static number of therapy tests. As stated by HCFA in its correspondence dated July 30, 1990,[23] when the costs of salaries or other expenses increase above the allowable rate of increase percentage, hospitals are expected to initiate cost containment measures with respect to other costs. The Provider failed to take action to reduce cost in the physical therapy areas which, in turn, would have reduced the cost in the rehabilitation unit in fiscal year 1988. The Intermediary maintains that the increase in full time equivalent personnel and associated costs was a direct result of the rise in outpatient therapy tests of 2,615 between the two fiscal years, and is unrelated to any inpatient rehabilitation activity.

The Intermediary further argues that the increase in rehabilitation beds from 12 to 16 was unnecessary, and that this factor is also an issue in increasing the cost of the unit. During fiscal year 1987, the Provider was certified for 12 rehabilitation beds making 4,380 bed days available. For 1987, the total patient days for the unit equaled 3,696 for an overall utilization of 84.38 percent and an average utilization of 10.13 beds per day. For fiscal 1988, the Provider expanded the rehabilitation unit to 16 operating beds which increased available bed days to 5,856. The total patient days for fiscal 1988 equaled 3,978 for an overall utilization of 67.93 percent and an average utilization of 10.86 beds per day. Given the level of 3,978 total patient days in 1988 and the availability of 4,380 bed days in 1987, the Intermediary insists that there was no need in the community to expand the rehabilitation unit by four beds. The Intermediary points out that overall utilization in 1988 would have been 90.82 percent had the additional beds not been opened, and there would have been lower cost for the unit. With a lower per diem cost, the Provider would not have experienced a TEFRA target rate problem in 1988. Accordingly, the Intermediary surmises that the Provider's expansion of its rehabilitation unit by 33 percent was not a fiscally prudent action.

Coupled with the increase in staff and related cost allocation statistics in fiscal 1988, the Intermediary notes that the Provider also materially increased the majority of the cost

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22 See Intermediary Exhibits 26, 27 and 28.

23 See Intermediary Exhibit 22.

allocation statistics in physical therapy over fiscal 1987.[24] This, in turn, caused the overhead costs flowing to the physical therapy cost center to rise dramatically despite the fact that the increase in tests performed remained fairly constant.[25] The overhead costs flowing to physical therapy increased in one year from $422,156 to $610,749, an increase of 44.67 percent. Since a portion of the therapy costs flow to the rehabilitation unit via the cost finding process, this also impacted on the ratio of cost to charges for physical therapy. Due to the significant increase in cost and the small increase in tests performed, the ratio of costs to charges for physical therapy increased by 17.31 percent. This factor further guaranteed an increase in therapy costs flowing to the rehabilitation unit unrelated to any increase in physical therapy services provided to patients.

At the hearing before the Board, the Intermediary advanced additional arguments for HCFA's denial of the Provider's reconsideration request for a TEFRA target rate adjustment. First, the Intermediary raised a motion to dismiss a portion of relief being sought by the Provider on the grounds that the amount being sought was approximately $9,000 greater than the amount claimed in the original reconsideration request which was denied by HCFA.[26] The Intermediary argues that neither the Provider nor the Board has the power to enlarge the scope of a TEFRA adjustment appeal under the governing regulatory provisions of 42 C.F.R. § 413.40(g) and (h). As a regulatory appeal, the scope of the Board's review is limited to the request made and the exception denied to that request, or the partial granting of that exception request under HCFA's review process.

As to the merits of the Provider's reconsideration request, the Intermediary contends that the Provider ignored one of the most important requirements under 42 C.F.R. § 413.40(g) which states that "HCFA makes an adjustment only to the extent that the hospital's operating costs are
. . . attributable to the circumstances specified . . . .[27] Whereas the Provider experience a 16.6 percent increase in therapy hours from 1987 to 1988, the Intermediary determined from its review of Provider's Exhibits 5 and 6 that the Provider wants approval of over a 300 percent increase in cost. The Intermediary believes that this is where the nexus fails in this case, and that the Provider has not explained or justified this substantial increase in cost to support this nominal growth in therapy hours.[28]

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[24] See Intermediary Exhibit 29.

[25] See Intermediary Exhibit 30.

[26] See Tr. (Oct. 11, 1996) at 19-20/Tr. (Dec. 19, 1996) at 136-137.

[27] Tr. (Dec. 19, 1996) at 137-138.

[28] Tr. (Dec. 19, 1996) at 138-139.

With respect to the three-hour rule requirement, the Intermediary points out that if the Provider had an average of 2.95 hours of therapy services per day for all of fiscal year 1987, then the Provider must have met the three-hour rule by the end of fiscal 1987. That is why HCFA granted the Provider additional cost in response to its application for TEFRA relief for fiscal year 1987 and, effectively, rebased the Provider with respect to the three-hour rule. It would not have been fair to the Provider to impose a rule in 1987 that had not been imposed in 1985 for the Provider's base year. However, with respect to the Provider's application for TEFRA relief for fiscal year 1988, the Provider has not shown why it had to go higher than the three-hour requirement to a level of 3.44 hours by the end of fiscal 1988. Moreover, the Provider hasn't even shown that increasing therapy hours to 3.44 was the reason the rehabilitation unit incurred the additional costs.[29]

While the Provider attempted to show that the additional cost incurred in fiscal year 1988 was due to additional wages or wage increases, the Intermediary advises that HCFA is not allowed to give the Provider an exception for this type of cost, and that the inflation factor used in the TEFRA target rate determination already includes wages as part of the update factor. It was not until April 1, 1990 that Congress authorized an increase to the TEFRA limits for an individual provider based on individual wages. Accordingly, an adjustment to the TEFRA target limit due to wages was not applicable to fiscal year 1988.[30] At the hearing, the Intermediary's witness from HCFA read from the Federal Register of August 30, 1991 the following excerpt:

> Until October 1, 1991, significant increases in wages since the base period were not recognized as a basis for an adjustment in the target amount under Section 413.30(h). This is because wage increases were accounted for by the update factor only. One of the assumptions behind the rate of increase limit has been that if a hospital needed to increase costs in one area beyond the amount provided by the update factor, cost containment measures would be taken in other areas.[31]

Fed. Reg. 43232 (August 30, 1991).

In summary, the Intermediary contends that the Provider has not met the nexus requirement set forth under the regulatory provisions of 42 C.F.R. § 413.40(g) and (h). Based on the evidence presented, the real reason the Provider's costs increased between fiscal years 1987 and 1988 in the therapy area was due to the increase in rehabilitation beds without a correlative increase in utilization. The Provider added four beds and the associated staffing

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29 Tr. (Dec. 19, 1996) at 139-140.

30 Tr. (Dec. 19, 1996) at 140.

31 Tr. (Dec. 19, 1996) at 121.

for these beds when the original 12 beds were underutilized. While it was the Provider choice to increase it rehabilitation unit to 16 beds, it is clear that the Provider did not act in a cost-conscious manner in its expansion of physical therapy activities. This factor coupled with a substantial increase in outpatient activities and overhead costs do not justify the granting of an exception to the TEFRA target amount. Accordingly, the Board should deny the Provider's request for additional TEFRA relief.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395ww(a) et seq.	-	Payment to Hospitals for Inpatient Hospital Services
§ 1395ww(b) et seq.	-	TEFRA Rate of Increase Ceiling
§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Regulations - 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.30(f)	-	Limitations on Reimbursable Costs - Exceptions
§ 413.40 et seq.	-	Ceiling on Rate of Hospital Cost Increases

3. Program Instructions - Medicare Part A Intermediary Manual (HCFA Pub. 13-3 Part 3):

§ 3101.11D.3	-	Relatively Intense Level of Rehabilitation Services

4. Case Law:

Idaho Elks Rehabilitation Hospital v. Shalala, 1995 WL 864079 (D. Idaho).

Idaho Elks Rehabilitation Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Oregon, PRRB Decision No. 93-D97, September 23, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,744, rev'd HCFA Administrator, November 24, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,962.

5. Other:

56 Fed. Reg. 43,232 (August 30, 1991).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing and post-hearing briefs, finds and concludes that the Provider has not demonstrated that it is entitled to additional relief from its TEFRA target amount beyond the adjustment granted by HCFA under the three-hour rule. The Board further concludes that the methodology employed by HCFA to calculate the TEFRA adjustment was a reasonable approach for granting partial relief to the target rate and is not in conflict with the governing regulatory provisions set forth under 42 C.F.R. § 413.40ff.

Under the governing regulatory provisions of 42 C.F.R. § 413.40(g) and (h), HCFA may grant relief from the TEFRA ceiling where events beyond the hospital's control or extraordinary circumstances create a distortion in the costs for the base period. Such an adjustment may be granted only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, separately identified by the hospital, and verified by the intermediary. An adjustment to the operating cost per case for one or more cost reporting periods subject to the TEFRA ceiling may also be made by HCFA to take into account factors that could result in a significant distortion in the operating cost of inpatient hospital services. Accordingly, the Board considered both of these subsections in determining whether the Provider satisfied the respective requirements.

The principal arguments put forth by the Provider for obtaining additional relief from the TEFRA target ceiling addressed an increase in operating costs due to continued efforts to comply with the three-hour rule coupled with a change in patient case mix that required increased levels of treatment. In this regard, the Board notes that the Provider also applied for TEFRA relief for its preceding fiscal year 1987, and was granted increase adjustments by HCFA for both the three-hour rule and increases in average length of stay. The total relief granted for fiscal year 1987 in the amount of $165, 141[32] actually exceeded the Provider's requested target increase of $162,345.[33] With respect to the Provider's application for TEFRA relief for fiscal year 1988,[34] the Provider requested a target increase of $265,485 citing essentially the same contributory factors as those expressed in its fiscal 1987 application as follows:

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[32] See Attachment D to Provider Exhibit 4.

[33] See Intermediary Exibit 31.

[34] Provider Exhibit 4/Intermediary Exhibit 17.

Increased severity of patient disability and underlying medical conditions which resulted in both:

- Increased therapy and medical treatment each day, and
- Longer length of stay

In response to the Provider's request, HCFA granted partial relief for fiscal 1988 in the amount of $182,533,[35] which consisted of approximately $155,000 for the average length of stay increase and about $27,000 for therapy costs relating to the three-hour rule.[36] Recognizing that the implementation of the three-hour rule would have a cost distorting effect on the rehabilitation unit's fiscal year comparison, HCFA effectively rebased the Provider's cost per discharge by adjusting the discharge amount in fiscal year 1985 (base year) by the increase granted in fiscal 1987 for compliance with the three-hour rule. The adjusted average cost per discharge for fiscal year 1985 was then updated by the rate of increase percentage through fiscal year 1988. HCFA explained that this methodology eliminates any aberrant increases in costs resulting from increases over the allowable rate of increase percentage recognized for each fiscal year, and would obviate the need to request an adjustment each year to ameliorate the impact of the three-hour rule.[37]

While the Provider is seeking additional relief for unavoidable increased costs associated with the implementation of Medicare's three-hour rule for therapy services, the Board finds that the Provider has failed to establish a causal connection between the circumstances it claims precipitated the increased costs and the actual cost incurred. The record shows that therapy hours per service day increased 16.61 percent between fiscal years 1987 and 1988; from 2.95 hours in 1987 to 3.44 hours in 1988.[38] During this same two-year period, the Provider reflected an increase in therapy cost per day of 50.26 percent; an increase from $75.35 in 1987 to $113.22 in 1988.[39] Whereas the Board accedes to an increase in therapy hours of 16.61 percent, the Board finds no evidentiary support as to why the associated therapy costs would escalate by 50.26 percent to accommodate the additional therapy services. Although the Provider alleges that a change in case mix caused increased levels of treatments, the record merely contains a summary of the types of costs incurred and does not link those costs to an increase for inpatient therapy services. Accordingly, the Board concludes that the

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35 Provider Exhibit 5/Intermediary Exhibit 18.

36 Tr. (Dec. 19, 1996), at 26.

37 Provider Exhibit 5/Intermediary Exhibit 18.

38 Provider Exhibit 4 - Table 4.

39 Provider Exhibit 4 - Table 10 and Enclosure 1 to Attachment D.

Provider has not met its burden of proof by sufficiently demonstrating that the costs for which it sought exception were attributable to the circumstances claimed.

It is the Board's conclusion that the Provider has not established that the increased operating costs were specifically attributable to increased levels of therapy services as required under subsections (g) and (h) of 42 C.F.R. § 413.40. Accordingly, the Board affirms HCFA's denial of the Provider's request for additional relief from its TEFRA target amount.

DECISION AND ORDER:

The Health Care Financing Administration properly denied the Provider's request for reconsideration of the TEFRA exception request. The Board affirms HCFA's determination.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: July 02, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman