# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

99-D39

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| **PROVIDER** - Belmont Hills Hospital<br>Belmont, CA | **DATE OF HEARING-**<br>May 16, 1997 |
| Provider No. 05-4003 | |
| **vs.** | Cost Reporting Period Ended -<br>November 30, 1988 and 1989 |
| **INTERMEDIARY** -<br>Blue Cross and Blue Shield Association/<br>Blue Cross of California | **CASE NO.** 93-1522 |

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ISSUE:

Was the Intermediary's or the Health Care Financing Administration's ("HCFA") determination of the Provider's request for adjustments to the rate-of-increase ceiling proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Belmont Hills Hospital ("Provider") is an acute psychiatric hospital located in Belmont, California. On January 10, 1992, the Provider submitted a request to Blue Cross and Blue Shield Association/Blue Cross of California ("Intermediary") seeking adjustments to its TEFRA[1] target limit for the fiscal years ended November 30, 1988 and 1989.[2] The specific adjustments sought by the Provider are as follows:

Table Of Proposed Adjustments To The
Provider's Rate of Increase Ceiling (TEFRA)
Fiscal Period Ending November 30, 1988

| Nature of Adjustment | Proposed Increase In Medicare Cost Per Discharge | Total Requested Adjustment |
|---|---|---|
| Pharmaceutical Costs | $ 305.49 | $100,200 |
| Laboratory Costs | $ 30.37 | $ 9,960 |
| Dietary Costs | $ 15.23 | $ 4,996 |
| Medical Records Costs | $ 37.74 | $ 2,380 |
| Nursing Costs | $ 245.70 | $ 80,589 |
| Nursing Administration Costs | $ 54.00 | $ 17,711 |
| Treatment Room | $ 35.76 | $ 11,728 |
| Group Therapy | $ 188.35 | $ 61,782 |
| Substance Abuse New Program | $ 71.31 | $ 23,390 |
| 1988 Total Requested Adjustments | | $ 322,736 |
| 1988 Requested Adjustment to TEFRA Target Rate | $ 983.95 | |

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

[2] Provider Exhibit P-41/Intermediary Exhibit I-2.

Fiscal Period Ending November 30, 1989

| Nature of Adjustment | Proposed Increase In Medicare Cost Per Discharge | Total Requested Adjustment |
|---|---|---|
| Pharmaceutical Costs | $ 267.86 | $ 86,519 |
| Laboratory Costs | $ 54.72 | $ 17,676 |
| Radiology Costs | $ 6.25 | $ 2,019 |
| Dietary Costs | $ 18.04 | $ 5,830 |
| Medical Records Costs | $ 38.60 | $ 12,466 |
| Nursing Costs | $ 478.50 | $ 154,555 |
| Nursing Administration | $ 59.70 | $ 19,286 |
| Treatment Room | $ 38.16 | $ 12,328 |
| Group Therapy | $ 153.70 | $ 49,647 |
| Substance Abuse New Program | $ 85.60 | $ 27,649 |
| 1989 Total Requested Adjustments | | $387,975 |
| 1989 Requested Adjustment to TEFRA Target Rate | $1,201.16 | |

Note: The Board notes that, while the Provider discussed the "Substance Abuse - New Program" in its TEFRA adjustment request, no data for this area was included in its submission to the Intermediary, which was, in turn, submitted to the Health Care Financing Administration ("HCFA") for a final determination.

The Intermediary verified the Provider's Medicare reimbursement effect and determined that the maximum amounts available for any exception cannot exceed the excess cost reflected in the Provider's cost reports as follows:

| Appeal Amount | FYE 11/30/88 | FYE 11/30/89 |
|---|---|---|
| Total Operating Cost | $1,312,709 | $1,473,754 |
| Target Amount | 1,278,905 | 1,327,381 |
| Excess Cost | $ 33,804 | $ 146,373 |

The Provider acknowledges that its proposed adjustments exceed the disallowed costs, however, it calculated greater amounts in order to demonstrate that it is entitled to adjustments which will completely nullify HCFA's denial of the earlier requested adjustments.

The issue in dispute ensues from the enactment of TEFRA in 1982, when Congress modified the Medicare program to provide hospitals with incentives to render services more efficiently. Among the TEFRA provisions, the Medicare Act was amended to add 42 U.S.C. § 1395ww(b) to establish a ceiling on the allowable rates of growth for hospital inpatient operating costs. Specifically, the statute states that payment for inpatient operating costs would be based on the relationship between the provider's actual costs and a ceiling determined by a target rate of increase in operating costs per case. TEFRA also added 42 U.S.C. § 1395ww(b)(4)(A) which establishes the Secretary's authority to grant an exemption from, or an adjustment or exception to, a provider's rate-of-increase ceiling. That section states in part:

> The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortions in the costs for the base period against which such increase is measured . . . .

42 U.S.C. § 1395ww(b)(4)(A).

The regulations at 42 C.F.R. § 413.40 implement the statutory provisions of 42 U.S.C. § 1395 ww(b)(4)(A). During the cost years in dispute, section 413.40 provided, in pertinent part:

> (g) Exceptions-- (1) General procedure. HCFA may adjust a hospital's operating costs . . . upward or downward, as appropriate, under circumstances as specified in paragraphs (g) (2) and (3) of this section. HCFA makes an adjustment 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. HCFA may grant an exception only if a hospital's operating costs exceed the rate of increase ceiling imposed under this section.
>
> (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.
>
> (3) Change in case mix. The hospital--
>
> (i) Has added or discontinued services in a year after its base period described in paragraph (b) (1) of this section;
>
> (ii) Has experienced a change in case mix as a result of the addition or discontinuation of services that results in a distortion in the rate of cost increase; and
>
> (iii) Submits data summarizing the case-mix changes and the resulting change in costs.
>
> (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. . . .

42 C.F.R. § 413.40(g) and (h).

In 1991, the regulatory provisions of 42 C.F.R. § 413.40 were revised to combine the above stated subsections (g) and (h) that were in effect during the cost years in dispute. In the instant case, the Provider is seeking an adjustment to its TEFRA target rate based on the revised regulatory provisions set forth in 42 C.F.R. § 413.40 (g) (1991). The relevant portion of the regulations cited by the Provider in this appeals is as follows:

> (ii) Factors. The adjustments described in paragraph (g) (3) (i) of this section include, but are not limited to, adjustments to take into account: . . .
>
> (D) Increases in service intensity or length of stay attributable to changes in the type of patient serviced.

> (E) A change in the inpatient hospital services that a hospital provides . . .such as an addition or discontinuance of services or treatment programs.

42 C.F.R. § 413.40 (g) (3) (1991).

The Intermediary reviewed the Provider's request for adjustments to its TEFRA target limit and forwarded the request with its recommendations to HCFA for a final determination.[3] In its transmittal, the Intermediary recommended an adjustment of $71,397 be granted for FYE November 30, 1988 ($217.67 per discharge), and an adjustment of $186,172 be granted for FYE November 30, 1989 ($576.38 per discharged). On February 24, 1993, HCFA issued its determination on the Provider's request and granted adjustments of $24,577 and $20,687 for the 1988 and 1989 fiscal years, respectively.[4] HCFA's determination letter noted that the Provider based its request on the noncomparability of its FY 1982 base year to the years under appeal due to changes in types of patients served (patients required greater service intensity and staff resulting in costs exceeding the target amount). In response to the Provider's rationale, HCFA stated the following:

> Although treating an increased number of sicker Medicare patients may be partially responsible for costs increasing, there are clearly other factors contributing to costs exceeding the target rate. While total patient days increased 24 percent from FY 1982 to FY 1988, general service costs increased by 65 percent in the same time period. These costs increased another 18 percent in FY 1989, but total patient days decreased slightly. Within these general service costs, administrative and general costs increased 76 percent by FY 1989, nursing administration costs rose 191 percent in 1988 and 243 percent in FY 1989; and employee health and welfare costs increased by 124 percent and 170 percent in FY 1988 and FY 1989, respectively.
>
> [Provider] has requested specific adjustments for increased staffing and various ancillary service increases. However, even though there was a FTE increase in nursing staff from 36.06 to 43.74 in FY 1988, no adjustment is warranted. As demonstrated at Exhibits 1 and 7, current year imputed Medicare costs per discharge were less than the Medicare updated base year costs. The categories of indirect costs specifically mentioned by [the Provider] for adjustment purposes are addressed through the

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[3] Provider Exhibit P-30.

[4] Intermediary Exhibit I-4/Provider Exhibit P-15.

> utilization adjustment within our methodology and are not computed as indicated by the Provider.

Id.

The Provider appealed HCFA's denial to the Provider Reimbursement Review Board (Board) pursuant to the requirements of 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Provider was represented by Laurence D. Getzoff, Esquire, of Hooper, Lundy & Bookman, Inc.. The Intermediary's representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it met the requirements for additional adjustments to its TEFRA limit for the years in question, and that HCFA's determination partially denying the hospital's adjustment requests was contrary to the provisions of the controlling Medicare statute and regulations. The Provider asserts that the increased costs for which it seeks reimbursement were reasonable, separately identified, attributable to the circumstances specified, and have been audited and verified as allowable and reasonable by the Intermediary. It is the Provider's position that sufficient testimony and evidence has been presented to demonstrate a marked increase in patient acuity and change in patient type to justify the increased costs in the adjustment request. Further, various quantifiable indicators support the position that the acuity of the Provider's patients increased, and that the intensity of the services increased as a result. The Provider cites the following indicators in support of its claim:

(1) In 1982, only fifty percent of the Provider's Medicare patients were admitted with acute mental illnesses. (i.e. psychosis, bi-polar disorder or other disabilitating psychiatric illnesses). In 1988, a full eighty-eight percent, and in 1989, virtually all (ninety-nine percent) of the Provider's Medicare patients were admitted with acute psychiatric illnesses.

(2) Overall average patient length of stay (LOS) declined at the hospital from 1982 through the late 1980s, however, the average Medicare patients' LOS actually held roughly constant. Whereas in 1982, approximately forty-five percent of the hospital's acutely ill Medicare patients had a LOS less than the hospital's average LOS, in 1989 over three/forth (seventy-seven percent) of Medicare patients had a LOS two days greater than the average LOS of all patients. This indicates a relative increase in the severity of the Medicare population's illnesses treated at the hospital. Moreover, the Provider treated twice the number of Medicare patients and about seventy-five percent more patients

overall in 1988 and 1989 than it did in 1982. The increased number of admissions of more acutely ill patients for shorter lengths of stay actually increased the Provider's costs, not decreased those costs.

(3) Whereas the majority of patients in 1982 were admitted by their family physician on a voluntary basis, in 1988 and 1989, the vast majority of patients were admitted from emergency rooms, psychiatric emergency teams ("PET") teams or police departments , many on involuntary hold. This change suggests a marked shift to more acutely ill patients in need of more intensive services.

(4) The use of the intensive care or locked unit ("ICU") increased with respect to Medicare patients, from less than one percent of Medicare patient days in 1982, to sixty percent in 1988 and fifty-eight percent in 1989. This change reflects a dramatic need for far more intensive services for Medicare patients.

(5) The presence or absence of assaultive/violent behavior in patients is a clear indicator of acuity and need for intensive services. There was only one reported incident of property damage in 1982, whereas there were forty-eight and seventy-two incidences of such damage reported in 1988 and 1989, respectively. Substantial increases in patient restraints and patient seclusion also occurred during the same time period. These changes in patient types and their respective conditions necessitated the intensification of services provided to patients in the late 1980s as opposed to the early 1980s.

Relying on the testimony of the its former Medical Director and a quality assurance/utilization management consultant, the Provider asserts that there was a dramatic increase in patient acuity between the TEFRA base year and the years under appeal. With the commencement of a substance abuse program in the mid - 1980s, there was a vast increase in the number of substance abuse and dual diagnosis patients who were far more difficult and costly to treat. Further, the noticeable increased needs of younger, mentally ill Medicare patients required the provision of more intensive services in the form of medication and other ancillary services, and that were not necessary in the early 1980s. The tremendous increase in the use of locked or ICU beds led to higher staffing costs, more training of staff, and the use of a higher skill mix, which notably augmented areas such as nurse staffing, medical records, dietary services and ancillary services, including medication and drug costs and group therapy costs.

The Provider notes that, until September of 1994, neither the Secretary through regulations nor HCFA through manual instructions gave any guidance to providers as to how to document changes in acuity for psychiatric patients as part of a TEFRA limit adjustment request. The Medicare regulations at 42 C.F.R. § 413.40 (g)(3) do not inform providers how

to document changes in service intensity, length of stay, or type of patient, even though these elements are listed as specific factors HCFA must take into account when evaluating adjustment requests. Further, by excluding psychiatric hospitals from the prospective payments system, HCFA and the Secretary acknowledged when promulgating the TEFRA limit regulations that quantifying case mix or patient acuity for psychiatric hospitals is extremely difficult. Accordingly, the Provider contends that it is not required to quantify the individual specific basis for its TEFRA limit adjustments in each cost area , and that it has met the necessary burden of proof to establish entitlement to its requested TEFRA limit adjustments.

The Provider believes it has presented extensive testimony and evidence establishing that the increases in its treatment costs, including pharmaceutical costs, laboratory costs, dietary costs and group therapy costs, are directly related to the establishment of new treatment programs, increases in patient acuity, and the overall change in patient type. In addition, the Provider argues that the testimony and evidence demonstratably links its entitlement to a TEFRA limit adjustment to increased costs in several routine cost centers, including dietary, medical records, nursing administration and, in particular, nursing costs. The Provider tenders the following salient points in support of the cost increases for the specific areas affected by the TEFRA limit:

<u>Pharmaceutical Costs</u>:

- Increase in patient acuity, including the dramatic increase in crisis stabilization services, required an increase in the use of psychotropic medications.

- Medications not available in 1982 became available in 1988 and 1989 to effectively stabilize the more acute patient mix. Such medication was essential given the frequently suicidal and assaultive behavior of the more recently hospitalized patients.

- A sharp rise in dual diagnosis patients and patients requiring concurrent treatment for long neglected physical illnesses required additional combinations of medications which were not necessary or available in earlier years.

- HCFA’s decision to grant only a small TEFRA exception for increases in pharmaceutical costs did not adequately address the changes at the Provider’s facility. The Provider’s calculations demonstrate and isolate a significant increase, and this intensified pharmacological usage resulted in higher costs that warrant an additional adjustment to the TEFRA limit.

Laboratory Costs:

- The increase in more acutely ill patients and chemical dependent patients required more complex and extensive laboratory work to check medication interactions and blood saturation levels.

- HCFA's methodology for calculating a laboratory cost adjustment is flawed because it fails to consider the change in the Provider's case mix.

Group Therapy Costs:

- In its base year, the Provider's Medicare population consisted largely of mood disorder and senility disorder patients who were not treated extensively through group therapeutic methods.

- Due to the sharp increase in patient acuity level and number of younger adult patients in 1988/1989, there was a direct rise in group therapy sessions per Medicare patients and costs during the years under appeal.

- HCFA allowed only a very limited group therapy cost adjustment because it failed to recognize that the character of patients changed, and that more group therapy was needed.

- Virtually no group therapy was provided in 1982, and the group therapy costs per patient day was $0.84. Using the TEFRA update factors, the Medicare group therapy cost per day only increased to $1.04 for 1988 and $1.08 for 1989.

- The Provider's actual group therapy Medicare cost per day was $12.96 and $10.40 for 1988 and 1989, respectively. Considering the profound programmatic shifts that occurred, the Provider believes the increases are reasonable.

Dietary Costs:

- In the base year, the Provider's largely mood disorder and senility disorder Medicare population did not appear to require much complex dietary management.

- In 1988 and 1989, a far more acutely ill patient population required more complex pharmacological treatment with a corresponding increase in risk of food-drug interactions. A more vigilant and complex dietary management was required to minimize this risk.

- In the mid-1980s, a full time dietician was hired to plan diets and conduct dietary assessments for specific patients whose condition demanded treatment for eating disorders and substance abuse programs.

- HCFA never ruled on the Provider's adjustment requests of $4,996 for 1998 and $5,830 for 1989 and, thus, it is presumed that HCFA denied the requests without explanation.

Medical Records Costs:

- The sharp rise in patient acuity and change in type of services delivered required more charting and a corresponding increase in medical records costs.

- Since more acutely ill patients were aggressively treated and then transferred, more utilization review matters arose, and records personnel prepared more charts as patients were discharged or transferred to other facilities.

- HCFA never ruled on this matter and, thus, denied the Provider's adjustment requests of $12,380 in 1988, and $12,466 in 1989, without explanation.

Nursing Costs:

- Nursing and nursing administration costs were affected by the change in patient mix and the advent of new treatment programs more than any other factor. Total adjustments requested by the Provider are as follows:

| | 1988 | 1989 |
|---|---|---|
| Nursing Costs | $80,589 | |
| $154,555 | | |
| Nursing Administration Costs | $17,711 | $ 19,286 |

- Nursing Cost increases are largely traceable to two factors:

  - The opening of a new substance abuse program greatly increased use of registered nurses during the initial, labor and observation - intensive critical, first few days of a substance abuse admission.

  - The increase in patient acuity and change in patient type required the utilization of far richer skill mix in the later treatment years than the earlier base year.

- In the later treatment years, registered nurses became essential for:

  - One-to-one observation of emergency and urgent admissions.

  - Dispensing and monitoring the effects of psychotropic medications and controlled substances.

  - Close supervision of less highly skilled levels of health workers.

  - Treatment of concurrent physical ailments and dealing with the plethora of extremely difficult psychotic, depressive, bi-polar and /or violent/assaultive patients.

- More highly trained staffing was required to staff and supervise the locked, intensive care unit, and preparation of care and after care plans.

- Based on calculations taken from official California State Health Planning and Development reports, the change in skill mix between the base year and later treatment years alone, resulted in an increase in nurse staffing costs of over $170,000 in 1988 and $265,000 in 1989.

- While HCFA stated that no increase to adjust for nurse staffing was warranted, HCFA never looked at the Provider's skill mix, and treated all FTEs as equal.

- The Provider's methodology reflects and incorporates into the calculation the types of considerations intended to be taken into account for the purposes of reviewing TEFRA adjustment requests, and gives more recognition to changes such as skill level and costs associated with the intensity of services that were required.

<u>New Substance Abuse Program Costs</u>

- In 1985, the Provider opened a new substance abuse program, which expanded to a dual-diagnosis program operating in several of the hospital's units.

- During the critical, initial phase of the patient's treatment, resource utilization was very intense, often requiring one-to-one specialized nursing care and intensive medication.

- In 1988 and 1989, the Provider's actual direct substance abuse costs per discharge were $71.31 and $85.60, respectively. Multiplying the substance abuse direct costs per
  discharge by the number of Medicare discharges yields a requested adjustment of $23,390 for 1988, and $27,649 for 1989.

- The regulation at 42 C.F.R. § 413.40(g)(3)(E) specifically allows for an adjustment to the TEFRA limits due to a change in inpatient services.

- Despite the Provider's clear request for an adjustment based on direct costs incurred by a program that did not exist in the base year, HCFA never responded to the Provider's request on this point.

In summation of its position, the Provider notes that the Intermediary strongly supported its TEFRA adjustment requests in the transmittal to HCFA, and recommended approval of virtually the entire amount disallowed in HCFA's partial denial. The Provider has calculated greater amounts of proposed adjustments in order to demonstrate far beyond what it must, that it is entitled to adjustments which will nullify completely HCFA's denial of the earlier requested adjustments. As to the Intermediary's and HCFA's suggestion that inefficiencies were somehow the cause of the Provider's cost increases, the Provider insists that there is no evidence to support this vague implication. Contrary to the Intermediary's allegation, the Provider has presented evidence indicating that it undertook numerous efficiency measures to reduce costs and staffing to the bare minimum required. Moreover, the Intermediary audited the Provider's cost reports for 1988 and 1989 and, except for the application of the TEFRA target ceiling, found the reported costs to be reasonable and appropriate. Based on the foregoing presentation, the Provider respectfully requests that the Board fully approve its requested adjustments to the TEFRA target- rate limits.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA's determination of the Provider's request for adjustments to the payments allowed under the TEFRA rate-of-increase ceiling was in accordance with 42 U.S.C. § 1395ww(b) and 42 C.F.R. § 413.40 (e)(f) and (g). The Intermediary asserts that HCFA's determination was not arbitrary and capricious, but was based on the information submitted by the Provider which was reviewed and processed consistent with the pertinent law and regulations.

As evidenced through its findings set forth in the response to the Provider's adjustment request,[5] HCFA has reasonably exercised its authority and discretion in limiting the approved adjustments to only those costs which the Provider has sufficiently demonstrated to be:

(1) Reasonable;
(2) Due to extraordinary circumstances beyond the Provider's control; and
(3) Attributable to the circumstances specified in the Provider's request.

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[5] Intermediary Exhibit I-5/Provider Exhibit P-15.

The Provider did not demonstrate with convincing evidence that it was entitled to all of its requested adjustments. Accordingly, HCFA was within the bounds of its authority not to approve the adjustments for:

(1) Costs which the Provider failed to demonstrate as being reasonable or attributable to the circumstances specified in the request; and

(2) Costs which appeared to be due to conditions of inefficiency and excessive services.

The Intermediary argues that the Provider did not meet its burden of demonstrating the irrationality (if any) of HCFA's findings and determinations. Further, HCFA's determinations were in accordance with the regulatory provisions set forth in 42 C.F.R. §§ 413.20 and 413.24, and the manual instructions in §§ 2300 and 2400 of the Provider Reimbursement Manual ("HCFA Pub. 15-1").

Pursuant to 42 C.F.R. §§ 413.40(e)(4) and 405.1855, the Intermediary advises that the Board should limit its review of HCFA's decision to the data which served as, or formed the basis of, HCFA's determination as set forth in HCFA's response to the Provider's request.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395ww(b) - Payment to Hospitals for Inpatient Hospital Services-Target Amount

§ 1395ww(b)(4)(A) - Exemption, Exception and Adjustment to Target Amount

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

§ 405.1835 - .1841 - Board Jurisdiction

§ 405.1847 - Disqualification of Board Members

§ 405.1855 - Evidence at Board Hearing

§ 413.20 - Financial Data and Reports

§ 413.24 - Adequate Cost Data and Cost Finding

§ 413.40 et seq. - Ceiling on Rate of Hospital Cost Increases

| | | |
|---|---|---|
| § 413.40 (e) | - | Hospital Requests Regarding Applicability of the Rate-of-Increase Ceiling |
| § 413.40 (f) | - | Exceptions to Rate-of- Increase Ceiling |
| § 413.40 (g) | - | Adjustments to Rate-of-Increase Ceiling |
| § 413.40(g)(3) et seq. | - | Comparability of Cost Reporting Periods |

Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

| | | |
|---|---|---|
| § 2300ff | - | Adequate Cost Data and Cost Finding |
| § 2400ff | - | Payments to Providers |

FINDINGS OF FACT, CONCLUSION OF LAWS 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 presented sufficient evidence to establish that a change in the Provider's case mix caused distortions to its operating costs for the years under appeal when compared with the TEFRA base year. It is the Board's finding that various quantifiable indicators support the position that the acuity of the Provider's patients increased, and that these factors satisfy the requirements of 42 C.F.R.
§ 413.40(g) for the purpose of granting additional adjustments to the Provider's TEFRA limit.

The record shows that the Provider experienced notable changes with respect to patient type and type of services provided since its 1982 TEFRA base year. An analysis of Provider Exhibits P-1 and P-7 illustrates that a marked shift occurred in the type of patient admitted to the hospital. Whereas the majority of patient admissions in 1982 were admitted by family physicians on a voluntary basis, the majority of patients admitted in 1988 and 1989 were from emergency room and police/PET team activities, with many of these patients being placed on involuntary holds. Based on the testimony of the Provider's former Medical Director and a quality assurance/utilization management consultant, this change suggests a switch from easier to treat, mood disorder, voluntary patients, to harder to treat, more acutely ill patients in need of more intensive services.[6] This also explains the increased usage of the ICU or locked

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[6] Tr. at 36-37, 84-85.

units which increased dramatically since 1982 to meet the need for more intensive services.[7] With respect to the vastly increased utilization of the ICU/locked units, the Provider's witnesses testified that this change required additional staffing with more highly trained personnel to meet the increased need for close observations of patients, and increased medication costs for rapid stabilization of patients.[8] Another clear indicator of increased acuity is reflected in the frequency of incidents of property destruction and the need to use restraints and/or seclusion. As reflected in Provider Exhibit P-9, the frequency of incidents of property destruction increased from one reported incident in 1982, to forty-eight and seventy-two such incidents in 1988 and 1989, respectively.

Of the various quantifiable indicators presented by the Provider to support the increase in patient acuity and intensity of services, the Board finds the "Comparative Statistics for Diagnosis Group", as set forth in Provider Exhibit P-2, markedly demonstrates the distinct difference in the patient population which occurred since the 1982 base year. Whereas only about 50 percent of the Provider's Medicare patients were admitted with acute mental illnesses in 1982, the number of Medicare patients admitted with acute psychiatric illnesses increased to 88 percent in 1988, and to 99 percent in 1989. By 1989, a high percentage of the Medicare patients were either schizophrenic/psychotic, severely depressed, or bipolar, and were, on average, below the age of 65. Rather than treating elderly, senile patients requiring primarily sub-acute care, the evolving change in the Provider's case mix resulted in the treatment of more seriously mentally ill adult patients requiring acute, intensive care. In conjunction with the increases and changes in the types of patients and overall service intensity, the Provider incurred greatly increased group therapy costs between its base year and subsequent treatment years.[9] Whereas the Provider's largely chronic organic brain disorder Medicare population in 1982 was not treated extensively through group therapeutic methods, the sharp increase in patient acuity level and number of adult patients compared to the type of admissions in the base year directly resulted in a rise in group therapy sessions and associated costs in the subsequent years.

The Board finds that the Provider has amply demonstrated that its facility has changed substantially since the TEFRA base year in terms of its patient population and types of services provided. The Board further finds that a sizeable portion of the Provider's increased inpatient operating costs is directly relatable to the changes in patients served and services rendered. While the controlling statutory and regulatory provisions clearly provide for an adjustment to the TEFRA limits in the case of non-comparability between the base year and later years, the regulations and manual instructions provided little guidance for the preparation of exception requests during the years under appeal. In the absence of definitive instructions

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[7] See Provider Exhibits P-8 and P-10.

[8] Tr. at 42-43, 88-89, 121.

[9] See Provider Exhibit P-3.

on how the document changes in service intensity, length of stay, or type of patients, the Board finds that the Provider has submitted relevant and credible data which conclusively illustrate the changes in acuity of its psychiatric patients.[10] In accordance with the regulatory provisions of 42 C.F.R.
§ 413.40(e), the Intermediary reviewed the Provider's exception requests and recommended to HCFA that an adjustment of $71,397 be granted for FYE November 30, 1988, and adjustment of $186,172 be granted for FYE November 30, 1989.[11] Based on a detailed examination of these documents, the Board finds the Intermediary's analysis and recommendation to be a responsible and reasonable determination which adequately reflects the additional amount relating to the distortion in operating costs of the Provider's inpatient hospital services. Accordingly, the Board accedes to the Intermediary's recommended adjustments, as set forth in Enclosures 10 and 20 of Provider Exhibit P-30, as the most reasonable and appropriates resolution to the Provider's exception requests.

The Board finds HCFA's determination of the Provider's request for adjustments to the rate-of-increase ceiling to be unresponsive to the type of exceptions requested and justified by the Provider.[12] HCFA's adjustment calculations merely update the Provider's TEFRA target rate by the established inflation factors and the Medicare discharges applicable for the fiscal years under appeal. The methodology employed by HCFA does not provide for an evaluation of the Provider's case mix, and totally ignores the changes in the types of services rendered to the Provider's patient population. Although HCFA insinuates that the Provider was inefficient and furnished excessive services to its patients, the record is void of any factual presentation or evidence which demonstrates or supports such allegations. It is the Board's conclusion that the Provider has met its burden of proof consistent with the regulatory requirements of 42 C.F.R.
§ 413.40(g), and that HCFA's adjustments to the rate-of-increase ceiling should be corrected to the Intermediary's recommended adjustments.

DECISION AND ORDER:

HCFA's determination of the Provider's request for adjustments to the rate-of-increase ceiling was not proper. The Board accedes to the Intermediary's recommended adjustments as summarized in Enclosures 10 and 20 of Provider Exhibit P-30.

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[10] See Provider Exhibit P-41.

[11] See Provider Exhibit P-30.

[12] See Provider Exhibit P-15.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Charles R. Barker
Martin W. Hoover, Jr., Esq. (Withdrew from any participation in this case in accordance with 42 C.F.R. § 405.1847)

**Date of Decision**: April 28, 1999

For The Board:

Irvin W. Kues
Chairman