PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D37

PROVIDER -
Saint Francis Medical Center
Pittsburgh, PA

Provider No. 39-0029

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Assn./Blue Cross of Western Pennsylvania, d/b/a Veritus, Inc.

DATE OF HEARING-
September 25, 1997

Cost Reporting Period Ended -
June 30, 1989, 1990, and 1991

CASE NO. 95-2401, 95-2402, and 95-2043

INDEX

ISSUE:

Did the Health Care Financing Administration ("HCFA") properly: 1. Deny the Provider's requests for:

- a permanent adjustment to its TEFRA base year in fiscal years ("FY") 1989 and 1990?; and
- the "assignment of a new base period" in FY 1991?

2. Grant only limited cost year specific adjustments?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Francis Medical Center ("SFMC"/"Provider"), receives Medicare reimbursement under the Prospective Payment System ("PPS"). The Provider also operates a PPS-exempt[1] distinct part Rehabilitation Unit ("RU") originally certified for 89 beds and later reduced to 71 beds, which is reimbursed under the Tax Equity and Fiscal Responsibility Act of 1982[2] ("TEFRA") cost ceiling system. The RU's Medicare TEFRA "target amount" per patient was determined by dividing the number of patient discharges into the total amount of reasonable and necessary costs incurred in operating the RU during the base year of FY 1985. The TEFRA target amount determines the maximum amount of Medicare reimbursement that the Provider can receive per patient in subsequent years since that amount is only adjusted annually for inflation and other factors. To achieve and maintain a PPS-exempt status, the regulations[3] mandate that 75% of the patients in the rehabilitation distinct part unit must require intensive rehabilitation services for the treatment of one or more of ten

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[1] Exempted effective for cost reporting periods beginning July 1, 1984. Provider Exhibit P-1.

[2] Pub. L. No. 97-248.

[3] In order to be excluded from the prospective payment system, a distinct part rehabilitation unit must meet the following requirements:

> (a) except as provided in sections 412.30, have treated, during its most recent 12-month cost reporting period, an inpatient population of which at least 75 percent required intensive rehabilitative services for treatment of one or more of the conditions listed in section 412.23(b)(2).
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> 42 C.F.R. § 412.29(a).

listed conditions in 42 C.F.R. § 412.23(b)(2).[4] The PPS-exempt units are surveyed annually for compliance with the 75% Rule.

The TEFRA amendment[5] directed the Secretary to implement regulations[6] to provide for exemptions, exceptions, and adjustments to the TEFRA target amount which may apply to the base year and/or subsequent individual cost report periods. The implementing regulation at C.F.R. § 413.40 et seq. sets forth the criteria and circumstances beyond the hospital's control that may have caused a significant distortion of costs related to the TEFRA target amount; and the procedure for submitting a request for relief to HCFA including the appeal process pertaining thereto.

Provider's Exception Requests:

The Provider timely submitted three separate TEFRA exemption and/or adjustment requests [see Exhibits A-1 to A-3] during January to March 1994 for FYs 1989, 1990, and 1991 that were ultimately considered simultaneously and substantially denied by HCFA. The cost distortion circumstances relevant to all three FYs were substantively the same.

For FY 1989 and 1990, the Provider requested a permanent adjustment to its FY 1985 base year costs because the actual operating circumstances between the FY 1985 base year and subsequent FYs were not comparable because:
a) In FY 1986 there was the:

> a) i) shifting of certain patients out of the RU resulting in the termination of certain medical services and/or treatment programs, ii) expansion of

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[4] (i) Stroke. (ii) Spinal cord injury.
(iii) Congenital deformity (iv) Amputation.
(v) Major multiple trauma.
(vi) Fracture of femur (hip fracture).
(vii) Brain injury.
(viii) Polyarthritis, including rheumatoid arthritis.
(ix) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.
(x) Burns.

42 C.F.R. § 412.23(b)(2)

[5] 42 U.S.C. § 1395ww(b)(3)(A).

[6] 42 C.F.R. § 413.40(f) to (h). In 1991, these provisions were combined to form 42 C.F.R. § 413.40(g) (1993).

existing ancillary programs,iii) change in patient mix, iv) change in length of stay, and v) increased costs related to the physical plant expansion completed in FY 1986;

b) The initiation of two new ancillary services in FY 1989; and

c) Increased indirect costs due to all the above stated items.

With essentially the same rationale, the Provider requested the "assignment of a new base period" (FY 1986) in the FY 1991 request which was the first year a rebasing adjustment was available.

Alternatively, each request asked for cost year specific ("CYS") relief which amounted to about $570,000 and $840,000 for FY 1989 and 1990 respectively.

With respect to the rebasing request, the regulations[7] were amended in FY 1991 permitting HCFA to assign a new base period to establish a revised ceiling amount--i) if the new base period was more representative of the reasonable and necessary cost of furnishing inpatient services, and ii) provided certain conditions were satisfied.

The reimbursement impact of the three requests are summarized as follows [See Exhibit A-1 to A-3 attached]:

TEFRA REQUEST FOR FY APPEALED	PERMANENT ADJ TO FY 85 BASE YR	INCREASED REIMBURSEMENT	BONUS PAYMENT	TOTAL REIMB
FY 1989	$1,687,600	$1,879,200	$521,200	$2,400,400
FY 1990	$1,696,900	$1,998,900	$756,100	$2,755,000

FY 1991 -- REQUESTED A NEW BASE YEAR OF 1986 WHICH WOULD:

1. Eliminate the $318,000 of excess costs over the ceiling.
2. Result in a new TEFRA ceiling amount of $9,378.39 per case as compared to the current amount of $8,748.77

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[7] 42 C.F.R. § 413.40(j).

In the alternative, if HCFA denied a permanent adjustment and/or denied the rebasing request, then the Provider requested cost-year-specific adjustments of $570,000 for FY 1989 and $840,000 for FY 1990.

Intermediary

Blue Cross of Western Pennsylvania, d/b/a Veritus, Inc. serves as the Provider's Medicare fiscal intermediary ("Intermediary").

The Intermediary processed the Provider's TEFRA adjustment and/or rebasing requests[8] to HCFA as follows:

A. On February 17, 1994,[9] the Intermediary forwarded the Provider's requests for FYs 1989 and 1990. The Intermediary's letter:

1. Summarized the basis for the permanent adjustment, i.e., compliance with the 75/25 Rule, and costs of a new building program; and alternatively a cost year specific adjustment due to a change in the type of patient served.

2. Advised that these requests were similar to a prior request for FY 1986. HCFA denied; and it was appealed.

3. However, upon appeal to the Board, an administrative resolution[10] ("AR") granted relief for the length of stay ("LOS") distortions which were extended for FYs 1986, 1987, and 1988.

4. If the same LOS relief were afforded in FYs 1989 and 1990, costs in the RU would still exceed the TEFRA ceiling by about $296,000 and $141,100 respectively.

5. The Provider's request for cost specific relief amounted to about $570,000 and $840,000 respectively for the two FYs.

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[8] A permanent TEFRA adjustment was requested for all three years; rebasing was only requested for 1991, the first year that re-basing was available. Although these cases were separately docketed, the Board conducted a joint hearing.

[9] Intermediary FY 1991 PP, Exhibit I-68.

[10] Id. Intermediary Exhibit I-64.

6. Concluded [without discussion]: "We do not believe that the circumstances presented in this application warrant a permanent base year adjustment."

B. On April 5, 1994,[11] the Intermediary forwarded the Provider's request for FY 1991 stating:

1. This request was similar to the two requests recently submitted for FYs 1989 and 1990 and should be review together.

2. The two main arguments are repeated in this request, namely, compliance with the 75/25 Rule, and costs of a new building program.

3. "[T]he February 17, 1994 letter chronicles this Provider's request for rebasing and/or relief from ceiling that began in April 1988. As before, we do not believe that the circumstances presented in this application warrant a permanent base year adjustment."

HCFA's Determination:

Summary:

HCFA denied any permanent adjustment to the FY 1985 base year for FYs 1989 and 1990; denied the request for designating FY 1986 as the new base year; and only granted part of the specific cost year relief requested consisting of two elements:

1. For all disputed FYs, cost adjustments relevant to length of stay ("LOS") distortions pursuant to an Administrative Resolution ("AR") agreement pertaining to the prior appeal of FY 1986 [Intermediary Exhibit I-64]; and

2. FY 1989, adjustments for two new ancillary services added-- radiology and renal dialysis.

HCFA's Denial Letter:

On March 29, 1995, the Intermediary transmitted HCFA's denial of the Provider's three requests, dated March 23, 1995.[12] HCFA's denial stated:

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[11] Id. Exhibit I-67.

[12] Intermediary FY 1991 PP, Exhibit I-69.

1. The circumstances presented for the years currently under appeal do not warrant a permanent base year adjustment nor justification for a new base year.

2. A new base year period only would be considered if permanent, substantial and significant changes had been made in the entire focus of patient care. Generally, the existing adjustment process effectively addresses distortions created by changes in patient care or services between the base year and the appeal year. This is not to say that the adjustment process is intended to meet the total Medicare inpatient costs for a given year in all cases.

3. The circumstances presented are essentially the same as the bases for the FY 1986 appeal. The outcome of that appeal remains in effect for subsequent years.[13] These adjustments have been made accordingly.

4. However, for FY 1989, the provider added radiology and renal dialysis as ancillary services. We authorize adjustments for these services, if warranted, using the same methodology previously approved.

Appeal:

The Provider challenged HCFA's determination denying any permanent TEFRA adjustments to the FY 1985 base year for FY 1989 and 1990: the denial to assign FY 1986 as a new base year in its FY 1991 request; and the determination to only grant a partial relief for specific cost year adjustments in all three FY's.

Further, the Provider states the basis for HCFA's denial of rebasing was improper because it was under 42 C.F.R. § 413.40(i)(1)(C); and it also challenges the validity of that regulation as arbitrary and capricious, as well as inconsistent with the plain language and legislative intent of the rebasing statute.

The Provider timely filed the three TEFRA requests for relief under 42 C.F.R. § 413.40; and timely filed for review to the Provider Reimbursement Review Board ("Board") for each fiscal year in dispute and has met the jurisdiction requirements thereunder per 42 C.F.R. §§ 405.1835-1841 and 413.40(e). The amount in controversy, as set forth above, is approximately $2,400,400 for FY 1989, $2,755,000 for FY 1990 relative to the permanent adjustment request; and for the rebasing request in FY 1991 over $318,000 of excess costs over the limit would be eliminated while establishing a new TEFRA target amount of $9,378.39 per case as compared to the current amount of $8,748.77. Alternatively, in lieu of the permanent adjustments or rebasing, the Provider requested CYS adjustments of $570,000

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[13] NOTE: Parties made an Administrative Resolution Agreement.

for FY 1989 and $840,000 for FY 1990. The Provider has met all the necessary jurisdiction requirements[14] for all years in dispute, i.e., FYs 1989 to 1991.

The Provider was represented by David Thomas, Esquire, of Nash and Company. The Intermediary was represented by Michael P. Berkey, Esquire, for the Blue Cross and Blue Shield Association.

Medicare Statutory and Regulatory Background:

From 1966 to 1982, the Medicare law established that health care providers furnishing services to Medicare patients were to be reimbursed the reasonable cost ("RC") of providing such services. 42 U.S.C. § 1395x(v)(1)(A) defines RC as "the costs actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." Id.

Congress authorized the Secretary of Health and Human Services ("Secretary") to promulgate regulations to implement the RC statutory provision.

Congress became concerned that providers of services had no incentive to limit their costs under the RC principles and amended the Medicare law. First, the law was amended at 42 U.S.C. § 1395ww(a) - Limits on Operating Costs, authorizing the Secretary to promulgate regulations to establish prospectively, limits on the amount of costs recognized as reasonable in furnishing patient care. The implementing regulations are at 42 C.F.R. § 413.30 - Limits on Cost Reimbursement.

Later, Congress enacted TEFRA[15] in 1982 modifying the RC reimbursement methodology to provide incentives to render services more efficiently and economically since RC generally increased each year. The TEFRA amendment imposed a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. The TEFRA ceiling amount [target amount][16] is determined upon the allowable net Medicare operating costs in the hospital's base year divided by the number of discharges. The TEFRA target amount determines the maximum amount of Medicare reimbursement that the Provider can receive per patient in subsequent years which is only adjusted annually for inflation and other factors. Costs incurred above the TEFRA target amount are disallowed while costs below the target amount may result in an "incentive payment" ("IP") for efficiency. The IP is equal to fifty percent of the difference between the actual costs and the target amount, 42 U.S.C. § 1395ww(b).

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[14] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1841(a), 405.1889 and 413.40(e)(4)(ii); HCFA Pub. 15-1, Ch. 29, Appendix A §§ B. 2 and B. 6, and § 3006.

[15] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248.

[16] The terms "rate-of-increase ceiling [or limit];" "TEFRA limit;" "target rate;" and "target amount [or limit]" are used interchangeably.

The implementing regulation at 42 C.F.R. § 413.40, pursuant to the statute, establishes the procedure and criteria for providers to make requests to HCFA for exemptions, exceptions, and adjustments to the rate-of-increase ceiling amount which may also be appealed [Id. sub-section (e) through (g)] to the Board.

Congress completely changed hospital reimbursement in 1983, by enacting Pub. L. No. 98-21, creating the Prospective Payment System ("PPS"). Congress, however, excluded certain types of providers from PPS that continued to be paid under the RC system subject to both the reasonable cost limits and the TEFRA rate-of-increase limit under 42 C.F.R. §§ 413.30 et seq. and 413.40 et seq. For example, like the Provider in this case, the distinct-part rehabilitation unit of a hospital is excluded from PPS so long as it meets certain requirements including the 75% Rule.

PROVIDER'S CONTENTIONS:

The Provider contends that it experienced a substantial permanent distortion of costs pertaining to the FY 1985 TEFRA base year when compared to subsequent FYs [and particularly FY 1986]; and the regulations permit either a permanent adjustment to the base year and/or the assignment of a new base year-[See IV below].

The cost distortions warranting a permanent adjustment to the FY 1985 base year were attributable to the following aspects:

I. The Medicare regulations require that 75% of the RU's patients receive intensive rehab services to maintain its PPS-exemption. To comply with the 75% Rule, it was necessary to restructure the medical services and treatment programs within the RU, and to transfer some non-qualifying patients out of the RU.

   A. HCFA failed to submit timely information concerning the regulatory requirements for compliance with the 75 % Rule regarding some of its patients.

   B. Based on HCFA's tardy responses, there was the need to restructure the medical services and treatment programs in the RU to comply with the 75% Rule. The restructuring involved: a) the transfer of some non-qualifying patients, b) the elimination of some treatment programs, c) the expansion of other programs, d) change of physical aspects within the RU, such as decertification of beds, e) change in patient mix and length of stay, and f) affect on indirect costs.

II. The organization responsible for the Certification of Rehabilitation Facilities ("CORF") cited certain concerns affecting licensure and accreditation requiring the undertaking of: a) a significant physical plant expansion program involving a Certificate of Need ("CON"), and b)

expansion of ancillary services, etc.[17] Construction was completed in FY 1986 with expanded ancillary service units that treated the RU patients. This affected both direct and indirect costs.

III. In 1989, the Provider added two new ancillary services: Renal Dialysis and Radiology.

The Provider also contends that a change in the regulation in 1991 permitted the assignment of a new base year if the comparability aspects of a new base period would be more representative of the reasonable and necessary cost of furnishing inpatient services in the RU.

IV. A. The Provider claims it meets the new regulatory requirements set forth in 42 C.F.R. § 413.40(j) entitling it to a new base year of FY 1986.

B. HCFA's rebasing denial was improperly made under 42 C.F.R. § 413.40(i)(1)(C), and the Provider challenges the validity of that regulation.

The Provider also challenges the Intermediary's claim that the terms of an Administrative Resolution ("AR") Agreement preclude a permanent base year adjustment and limits CYS relief to those items granted by HCFA in this case.

V. A. The Provider asserts the Intermediary has breached the confidentiality requirement of the AR Agreement by putting the terms of that Agreement at issue.

B. The Provider states the AR Agreement did not address claims for a permanent adjustment of the TEFRA 1985 base year costs.

C. The Provider claims the terms of the AR Agreement do not preclude a permanent base year adjustment nor was it intended to limit CYS relief.

VI. The Provider asserts three court cases supporting its position of a permanent adjustment of the base year; and that HCFA has granted an adjustment of a new base year and/or permanent base year adjustments in two similar provider situations.

The factors causing a substantial permanent distortion of costs relative to the TEFRA base year [FY 1985] when compared to subsequent FYs [and particularly FY 1986] warranting a permanent adjustment are:

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[17] Provider Exhibit P-26.

I

Medicare 75% Rule Compliance:

A. HCFA's untimely response.

The Medicare regulations require that 75% of the RU's patients receive intensive rehab services to maintain its PPS-exemption.
The Provider states prior to the Medicare certification of the RU and its exemption from PPS, it had existed for almost 25 years treating a wide range of patients. Traditionally, treatment encompassed a wide variety of highly-specialized conditions including those set forth in the regulations [18] requiring Intensive Rehab services as well as a group of patients known as Comprehensive Rehab Patients ("CRP"). CRP included paraplegic and quadriplegic patients, cerebral palsy and other neuro-muscular disorders, and victims of industrial accidents suffering from neck, back, knee and shoulder injuries. Although Medicare had initially granted a PPS-exemption to the RU, questions subsequently arose whether some of the CRP qualified for Intensive Rehab services.

On May 2, 1984, during the base year, the Provider queried the Intermediary whether the CRP satisfied the 75% Rule.[19] For example, contracture patients (suffering from neuro-muscular disorders) and trauma patients arguably could be classified as Intensive Rehab Patients. The Provider's request was referred to HCFA for technical advice.[20] Seven months later, on February 6, 1985, the Provider again requested clarification of the status of the CRP.[21]

The Provider states that HCFA's untimely response, on March 21, 1985, stated the paraplegic and quadriplegic patients were not Intensive Rehab Patients relative to the 75% Rule; and that contracture patients and trauma patients would require a case-by-case evaluation. [22] At this point, the Provider states the base year was about three fourths complete with some non-qualifying patients included in the RU which would require some immediate changes.

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[18] 42 C.F.R. § 412.23(b)(2).

[19] Provider Exhibit P-9.

[20] Provider Exhibit P-10.

[21] Provider Exhibit P-11.

[22] Provider Exhibit P-12.

B. Required Changes in the RU's Operations.

Based on HCFA's response, the Provider made a variety of changes terminating certain services and/or treatment programs which also included physical changes. On March 28, 1985, the Provider initiated preparations to exclude "back injuries and genitourinary evaluation patients" from the RU. [23] The Provider redesignated Unit 3500 as one of its general medical/surgical units. Id.

On April 23, 1985, the Intermediary's annual 75% Rule survey report stated that only 70% of the RU's patients qualified as Intensive Rehab Patients, i.e., receiving intensive rehabilitation services; and the RU was decertified effective July 1, 1985, i. e., FY 1986.[24]

HCFA however, subsequently supplied further advice, indicating that some contracture patients might qualify as Intensive Rehab Patients.[25] The Provider then requested a reaudit by the Intermediary. On May 31, 1985, the Intermediary concluded 80% of the RU's patients qualified as Intensive Rehab Patients;[26] and recertified the RU as PPS-exempt for the 1986 fiscal year.[27]

The Provider maintains it was required to institute corrective measures to comply with HCFA's advice that resulted in the RU's compliance with the 75% Rule which ultimately adversely impacted the costs of the TEFRA FY 1985 base year to the extent it was not comparable to subsequent FYs. Starting in FY 1986, the Provider instituted a pre-admission screening process, to exclude CRP from the RU and treat such patients in the acute care units because of the risk of PPS-exempt decertification. [28] Excluding the CRP generated a bed reduction[29] resulting in reduced patient days in the RU and other distortions.

Discontinuing the treatment of CRP was a permanent change that caused a significant distortion of the 1985 base year costs because: (i) there was a change in the patient mix; (ii) the more Intensive Rehab Patients remained in the RU requiring more intensive nursing care and costs; (iii) the more severely ill patients required increased ancillary services thereby increasing those costs; (iv) the CRP required a

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[23] Provider Exhibit P-14 at p. 1.

[24] Provider Exhibit P-15.

[25] Provider Exhibit P-16.

[26] Provider Exhibit P-18.

[27] Provider Exhibit P-19.

[28] Tr. at pp. 88-89 and 113.

[29] Provider Exhibits P-16 and P-21.

different level of services and related costs; and (v) the reduction in certified beds for CRP caused a reduction in space, beds, and patient days.

In FY 1986 and later years the cost distortions involved:

> i) the establishment of a screening process, ii) the transfer and/or the elimination of some non-qualifying CRP patients out of the RU, iii) the elimination of some treatment programs, iv) the expansion of other programs, v) required physical changes within the unit, vi) change in the patient mix, vii) change in the length of stay ("LOS"), viii) increased costs per patient for the Intensive Rehab Patients including ancillary services, and
> ix) affected the allocation of indirect costs.

The impact of these changes caused a permanent and substantial distortion of costs to the FY 1985 base year compared to subsequent FYs.

II

Physical Plant Expansion:

The Provider asserts the national organization that reviews and accredits "Comprehensive Outpatient and Rehabilitation Facilities" ("CORF") issued a report stating there was a need to change and expand the physical plant and to provide more ancillary services. With its accreditation in jeopardy, the Provider obtained a Certificate of Need ("CON") to make a costly expansion of its physical plant which was completed in FY 1986.

The plant expansion program resulted in enlarged ancillary service units. The accounting effect of enlarged ancillary service areas was the allocation of significantly larger amounts of indirect "A&G" costs [such as-- administrative and general, plant operation and maintenance/repair expenses] to the RU in FY 1986 and subsequent FYs.[30]

III

Ancillary Services:

The Provider also expanded all its existing ancillary services; and, in FY 1989, two new ancillary services were initiated--renal dialysis and radiology causing a significant and permanent distortion in the TEFRA cost limits.

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[30] Provider Exhibit P-2 at pp. 15-19.

The Provider objected to HCFA's granting of only a CYS relief rather than a permanent TEFRA adjustment for the cost of these new ancillary services which is more appropriate.[31]

Moreover, the Provider argues that the three above matters were the result of extraordinary circumstances beyond its control which were permanent in nature causing a significant distortion of costs between the FY 1985 base year and other years. The Provider maintains a permanent adjustment is more appropriate because of the permanent nature of the changes in rendering services within the RU to comply with the 75% Rule, the physical plant expansion, and the new ancillary services added which combined caused the significant distortion in costs as contemplated by the regulations.

The Provider maintains HCFA's improper denial of the permanent adjustment request produces a negative impact from several standpoints: i) it is inconsistent with the regulations, ii) it will require yearly requests to seek relief, and iii) it reduces the Provider's legitimate prospect of achieving a TEFRA bonus by improving the efficient delivery of services.

The Provider claims Congress directed the Secretary to make adjustments where circumstances cause a significant distortion of costs to the TEFRA limits.[32] This is true under the regulations for TEFRA § 413.40 and for relief from the cost limits under § 413.30, etc.

With respect to the circumstances in this case, the Provider states § 413.40(g)(3) specifically applies:

> (3) Comparability of cost reporting periods.
> (i) Adjustment for Distortion. HCFA may make an adjustment to take into account factors that would result in a significant distortion in operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits.
> (ii) Factors. The adjustment described in paragraph (g)(3)(i) of this section, include, but are not limited to,
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> * * * *
>
> (D) Increases in service intensity or length of stay attributable to changes in the type of patient served.
> (E) A change in the inpatient hospital services that a hospital provides, and that are customarily provided directly by similar hospitals, such as the addition or discontinuation of services or treatment programs.

42 C.F.R. § 413.40(g)(3)(i) and (ii) (emphasis added).

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[31] Provider Exhibit P-4 at 1.

[32] 42 U.S.C. § 1395ww(b)(4)(A).

The Provider asserts these regulatory provisions directly apply to the circumstance of this case warranting a permanent change to the TEFRA base year of FY 1985, and HCFA's denial was improper.

IV

A. The Provider contends the cited circumstances warrant the "assignment of a new base period," under 42 C.F.R. § 413.40(j), from FY 1985 to FY 1986 because the costs in FY 1986 were more representative of furnishing the RU's inpatient services.

The regulation states:

> (j) Assignment of a new base period--(1) General rule.
> (i) Effective with cost reporting periods beginning on or after April 1, 1990, HCFA may assign a new base period to establish a revised ceiling if the new base period is more representative of the reasonable and necessary cost of furnishing inpatient services and all the following conditions apply.
> (A) The actual allowable inpatient costs ... in the cost reporting period ... affected by the revised ceiling exceed the target amount established....
> (B) The hospital documents that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base period.
> (C) The exceptions and adjustments described in paragraphs (g) and (h) ... would not result in recognition of the reasonable and necessary costs of providing inpatient services.
> (ii) ....
> (2) New base period. The new base period is the first cost reporting period that is 12 months or longer that reflects the substantial and permanent change.
> (3) ....

42 C.F.R. § 413.40(j).

The Provider claimed the circumstances cited in I, II, and III above satisfied all of the regulatory requirements, and it was entitled to a new base year of FY 1986. The Provider claimed HCFA's denial was improper and unsupported.

The Provider seeks a permanent rebasing adjustment to its base year costs because the actual operating circumstances between FY 1985 and FY 1986 were not comparable. The Provider states starting in FY 1986: 1) the RU discontinued certain services and/or treatment programs resulting in a change of the inpatient services rendered and the related direct costs of nursing and ancillary costs; 2)

there was a change in patient mix and length of stay; 3) the physical expansion program was completed; and 4) the indirect costs allocated were not comparable due to the change of services and a significant increase in the physical area occupied thereby increasing the square footage statistic for the allocation of indirect costs. These factors were the result of extraordinary circumstances beyond the Provider's control.

The Provider avers the permanent base year adjustment was more appropriate because of the permanent change in rendering services resulting in the distortion of costs. The Provider states the denial of this request results in a negative impact of requiring yearly requests to seek relief, and it reduces the Provider's legitimate prospect of achieving a TEFRA bonus by improving the efficient delivery of services.

The Provider asserts the above discussion demonstrates it has met all the requirements of the regulation and should be awarded a new base year of FY 1986.

B. The Provider claims HCFA improperly made its denial determination for the rebasing request pursuant to 42 C.F.R. § 413.40(i)(1)(C); and it challenges the validity of that regulation as being arbitrary and capricious, as well as inconsistent with the plain language and legislative intent of the rebasing statute.

V

A. The Provider asserts the Intermediary has breached the confidentiality requirement of the AR Agreement by putting the terms of that Agreement at issue. The Provider states the AR Agreement specifically provided that the terms thereof "may not be used or introduced in this or any other Medicare proceeding past, present or future."[33] Nonetheless, the Intermediary and HCFA improperly relied on the Agreement's terms when denying the TEFRA permanent adjustment requests for FY 1989 and 1990;[34] and in only granting limited CYS relief pursuant to the Agreement.

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[33] Provider Exhibit P-28 p. 10.

[34] See, Provider Exhibit P-3 (Intermediary's recommendation letter), and Provider Exhibit P-4 (HCFA's denial determination letter).

The Agreement:

The Provider acknowledges that its FY 1986 appeal[35] also addressed claims for relief from the cost distortions caused by essentially the same factors raised in the present appeals, which was partially settled by an AR Agreement.[36]

The Provider states the Agreement:

1. Encompassed CYS TEFRA relief pursuant to 42 C.F.R. § 413.40(h), granting relief for the average length of stay ("ALOS") and increased services rendered by the "nursing service and speech, physical and occupational therapy departments."[37]

2. These CYS adjustments were also applicable to future years. 3. However, they were subject to any change in the law or regulations affecting such adjustments.[38]

4. It expressly did not resolve claims for TEFRA incentives.[39]

5. Was not intended to cover permanent TEFRA adjustments.[40]

B. The Provider states the AR Agreement did not address claims for a permanent adjustment of the TEFRA 1985 base year costs as pursued in the current appeals. The permanent TEFRA adjustments to the base year would result in a target amount comparable to the substantially different, actual operating conditions in the RU in subsequent years.

The Provider asserts when the Agreement was made, it was the stated position of the Secretary and HCFA that the TEFRA adjustment process could not be employed to obtain TEFRA incentives. See, Provider Exhibit P-47 (53 Fed. Reg. 9337, 9340, March 22, 1988), as corrected at 53 Fed. Reg.

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[35] PRRB Case No 88-1039.

[36] Provider Exhibit P-28.

[37] Provider Exhibit P-28 pp. 3 and 5.

[38] Id. pp. 4 and 6.

[39] Id. pp. 9-10.

[40] Tr. at pp. 89-92.

12641 (April 15, 1988), stating that TEFRA adjustments, provided for in 42 U.S.C. § 1395ww(b)(4)(A), could not give rise to the payment of TEFRA incentives under 42 U.S.C. § 1395ww(b)(1)(A)). The Provider states that despite these Federal Register statements, the Secretary argued in court, for the first time in 1993 when the Provider was appealing the FY 1985 base year, that through an application of the new regulations it would be possible to address a cost year post-dating the base year and obtain a permanent TEFRA base year adjustment which would lead to TEFRA incentives. See Provider Exhibit P-32 at 3 and 6. The Third Circuit agreed that such relief is now available. See, St. Francis II, 32 F.3d 805 (3d Cir. 1994), at 806-07 and 813. This revised interpretation of 42 U.S.C. § 1395ww(b)(4)(A) is now memorialized in HCFA Pub. 15-1 §§ 3004.1.C.4 and 3004.2, published in August, 1994.

The Provider also notes that its original appeal to the Board of its FY 1985 base year was ultimately dismissed because there was no reimbursement amount in dispute. The United States Court of Appeals for the Third Circuit concluded that, because a base year adjustment would only impact reimbursement in subsequent years, there was no amount in controversy for 1985, St. Francis Medical Center v. Shalala, 962 F.2d 1110 (3d. Cir. 1992). This case was further appealed as St. Francis II, 32 F.3d 805 (3d Cir. 1994). During the briefing of that case, the Secretary argued that the TEFRA adjustment regulations potentially authorized "base period adjustments premised on cost years after the base period."[41] The Secretary also contended -- for the first time -- that permanent post-base year relief would "enhance" St. Francis' "prospects" of receiving TEFRA incentive payments. Id. at p. 3. The Provider states that avenue of relief is now being pursued, i.e., seeking permanent TEFRA adjustments for fiscal years 1989, 1990 and 1991.

The Provider further states the provisions in HCFA Pub. 15, issued in August of 1994, authorize a "permanent adjustment to the hospital's ceiling amount." HCFA Pub. 15 § 3004.2 cites as one example when a permanent adjustment to the TEFRA ceiling is appropriate,i. e., the addition of a new service. Provider Exhibit P-33. In addition, § 3004.l.C.4. provides: Similarly [to the addition of new services], any deletion of services warrants a permanent change to the TEFRA target amount. Provider Exhibit P-34.

C. The Provider also challenges the CYS relief granted because the AR Agreement does not limit or preclude further relief. HCFA only granted CYS relief in each FY's request, related to the LOS distortion pursuant to the AR Agreement of the FY 1986 appeal. The Provider states by the terms of that Agreement, it was agreed these adjustments would also be applicable to future years beyond FY 1986. The Provider asserts the CYS adjustments requested in the current appeals were more expansive; and, that the subsequent yearly adjustments were not limited by the terms of the FY 1986 AR agreement as claimed by the Intermediary.

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[41] Provider Exhibit P-32 at 15.

VI

A. The Provider claims three court cases hold that a permanent adjustment to the base year was required because of new construction.

The Provider states the following three court cases held that a provider was entitled to permanent adjustment to their PPS base year for purpose of obtaining increased PPS hospital specific rate reimbursement: 1) Community Hospital of Chandler, Inc. v. Sullivan, 963 F. 2d 1206 (9th Cir. 1992); 2) The Methodist Hospital v. Sullivan, [1992-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 39,627 (D.D.C. Sept. 20, 1991); and 3) Newport Hospital and Clinic, Inc. v. Sullivan, [1991 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,844 (D.D.C. Sept. 24, 1990).

The Provider states that in all three cases, there was a new facility constructed within one to two years after the PPS base year. The court's analysis indicated that both the PPS and TEFRA statutory adjustments are stated in 42 U.S.C. § 1395ww(b)(4)(A) and require permanent base year adjustment were there was a significant distortion in costs of the base year.

In Chandler, the court stated:

> We hold that the Secretary has not fulfilled his obligation to Chandler under 42 U.S.C. § 1395ww(b)(4)(A). Whether or not Chandler is a "new hospital" under ... [the regulations], it is a hospital that has experienced a "distortion in the costs of the base period." To the extent that Chandler's base year reflects costs incurred at CCH [the old facility], it is unrepresentative of actual costs at Chandler [the new facility]. The Secretary's failure to make some adjustment to this base year cost figure violates 42 U.S.C. § 1395ww(b)(4)(A)'s requirement that the Secretary "shall provide for an exemption from, or an exception to [sic: and] adjustment to "the normal process of calculating a hospital's base year cost. ...

963 F.2d at 1214 (emphasis added).

In Methodist, the court required a permanent adjustment to account for the costs of a new facility. The court analyzed the TEFRA scheme, recognizing that 42 U.S.C. § 1395ww(b)(4)(A) mandates adjustments where "extraordinary circumstances ... create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured)." Methodist, [1992-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 39,627 at p. 28,116. The provider argued "that the increased operating costs associated with their capital improvements are precisely the type of extraordinary expenses that would have merited an increased reimbursement under TEFRA and its implementing regulations." Id. at p. 28,118. The court agreeing stated:

> The regulations under TEFRA indicate, for example, that the base year should be adjusted '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 (1989). The increased operating costs incurred by plaintiff in conjunction with their one-time massive capital expenditures appear to fit within that description.

Id.[42]

In Newport, the court also required a permanent adjustment to base year costs to account for new construction that occurred in the middle of the base year when the provider moved into a new facility. The court found that the provider's "cost per discharge was significantly greater in the new facility than the old facility." Newport, [1991 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,844 at p. 24,060. The court agreed that the base year cost adjustment should be made to reflect an entire year of costs incurred at the new facility and appropriate under 42 U.S.C. § 1395ww(b)(4)(A). Id. at pp. 24,063-64.

The Provider claims its facts were substantially similar to these three cases; and that its base year should have a permanent adjustment to account for the increased operating costs generated by the one-time capital expenditure which has caused a significant distortion of costs by its renovation program.

The Provider also claims that a permanent adjustment was warranted because of the two new ancillary services added in FY 1989, renal dialysis and radiology.[43] The permanent adjustment was mandated by both the regulation and HCFA Pub. 15-1 § 3004.1. C.4 published in August 1994, about eight months after its TEFRA exception request. The permanent adjustment was more appropriate and in accordance with both the regulations and HCFA manual provisions. HCFA's granting only a CYS adjustment for FY 1989 was inadequate.

B. The Provider asserts that HCFA has granted a permanent adjustment in at least two similar provider situations:

1. where a rehabilitation hospital substantially changed its patient mix by focusing only on patients with brain injuries.[44]

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[42] Provider Exhibit P-22.

[43] Provider Exhibit P-2 at p. 22.

[44] Tr. at pp. 236-37.

2. where drug an alcohol ("D&A") patients were improperly included in a provider's psychiatric unit during the base year.[45]

The Provider claims the facts of the second provider situation was virtually identical to this case. In that situation, a category of patients (D&A) were erroneously included in the patient population of a PPS-exempt psychiatric unit during the TEFRA base year, and later removed. A permanent base year adjustment was granted for the distortion of costs caused by the inclusion of those patients. The Provider in this case, had included some CRP that were removed both during the FY 1985 base year and the subsequent FY, 1986.

The Provider asserts HCFA's determination to deny a permanent base year adjustment and/or to deny a new rebasing year adjustment was erroneous and inconsistent treatment with other similar situated providers in the Medicare program; and inconsistent with the regulations.

INTERMEDIARY'S CONTENTIONS:

The Intermediary asserts the HCFA's denial of permanent base year adjustments in FY 1989 and FY 1990; and the denial of creating a new base year adjustment were proper. Further, granting only a part of the requested CYS relief was proper because it was in compliance with the AR Agreement. With respect to CYS relief, the Intermediary argues the Provider was not entitled to any exceptions/adjustments which were beyond the terms of the AR agreement pertaining to the appeal of FY 1986 [which also pertains to future years].

In support thereof, the Intermediary makes the following primary contentions:

I. The Provider failed to demonstrate any entitlement to a TEFRA exception pertaining to the patient shifting and plant expansion theories.

II. Since the exception requests, particularly the FY 1991 request was a continuation of its FY 1986 TEFRA appeal, the August 2, 1990 AR prohibits any additional TEFRA exceptions or adjustments beyond the scope of the exceptions specified therein.

III. With respect to CYS relief, the Provider failed to demonstrate that the costs in excess of the TEFRA target rate were due to the forced shift of patients and capital expansion program, as the regulations require.

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[45] Provider Exhibit P-53.

IV. The Provider failed to meet the regulatory requirements for rebasing the TEFRA base year.

I

The Intermediary asserts that the Provider admitted in its FY 1991 appeal request to the Board,[46] that the appeal was a continuation of its prior appeal of FY 1986. So in both FYs, two claimed events, beyond the control of the Provider, caused a distortion of costs between the TEFRA base year of FY 1985 and FY 1986 [and beyond], i.e, patients being shifted out of the RU relative to the 75% Rule and costs attributable to a building expansion program to maintain its licensure and accreditation.

The Intermediary incorporated the arguments from its position paper of the appeal for FY 1986[47] which state the Provider's two reasons for an adjustment failed to demonstrate any entitlement to a TEFRA exception because:

A. Patient Shifting

1. The Provider was not "forced" to take any action to preserve its PPS-exempt status relative to the 75% Rule.

a. HCFA can not require providers to do anything relative to the manner of treatment of patients. Moreover, a statutory provision prohibits such interference.[48] Thus, a provider may or may not comply with the 75% Rule at its option.

b. When the Provider's PPS-exempt status was terminated, no conditions or requirements were imposed requiring actions as a precedent for reinstatement.

c. The regulations specifies 75% of the patients must receive intensive rehabilitation services, thereby allowing 25% to be non-qualifying who will receive a higher reimbursement than normal. The Provider ultimately chose to transfer certain patients which yielded only 20% of non-qualifying patients.

! The Provider was overpaid in FY 1985 for the non-qualifying patients who required less services and costs, but was reimbursed at the RU's TEFRA target

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[46] Intermediary Exhibit I-63.

[47] Intermediary Exhibit I-65 at pp 11 - 20.

[48] Section 1801 of Social Security Act, as amended.

rate of $7,112.78 rather than average PPS rate of $4,941.81. The Provider claims that 125 patients discharged or 20.4% of its total RU discharges made a significant distortion of costs. The Provider was overpaid for these 125 patients in the amount of $271,371 (difference between the above two rates: $2,170.97 x 125).

d. Any shifting of patients in FY 1986 was a voluntary unilateral action since the Provider was not forced to do anything.

2. Since the termination occurred at end of FY 85, any shifting of patients in that year could not have significantly effected the costs.

3. Based on a re-audit, the Provider's RU was in compliance with the 75% Rule in both FY 1985 and FY 1986. Therefore, there could be no distortion of costs between these years.

4. The shifting was not an extraordinary circumstance, and any action taken to meet the 75% Rule was obviously within the Provider's control.

5. As indicated in 1. c above, the Provider received excess reimbursement in both FY 1985 and 1986 to the extent the RU had any non-qualifying patients (within the 25% portion).

6. A permanent adjustment was not warranted for the above stated reasons. Further, it would result in an unwarranted windfall. Eliminating the shifted patients from the base year of FY 1985 would increase the TEFRA target rate permanently thereby increasing the reimbursement in FY 1985 when there has already been an overpayment described in 1. c. above.

7. No adjustment or exception was justified in FY 1986 [or future years] because of the annual inflation adjustment rate that was 7.05% for FY 1986. The inflation rate more than offsets any alleged cost distortion particularly when considering the actual inflation rate was only 3.5% + .25% market basket yielding a total of 3.75%. The amount granted by the Secretary was more than generous [almost double]. Thus, there was no need for an adjustment to increase the TEFRA target rate more than the 7.05%.[49]

8. Other factors were responsible for the cost distortions between FY 1985 and FY 1986. Namely, a significant decrease in the RU's utilization; and the Provider failed to make proper changes. For example:

The number of beds were reduced by 20.2%; and Medicare days and discharges dropped 15.5% and 24.7%, respectively. Overall utilization

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[49] Intermediary Exhibit I-65 at pp. 20 - 22.

> was only 72.0% in FY 1985 compared to 63.0% in FY 1986. The Provider failed to reduce its staffing in FY 1986; and the excess staffing costs was the predominate reason for exceeding the TEFRA cost limits.
>
> Further, the overhead costs increased dramatically in every category, and these costs are generally not related to patient care. It was noted the number of beds were reduced from 89 to 71, but the square footage in the RU was only reduced from 28,173 sq ft to 22,577 in FY 1986.
>
> The patient length of stay (LOS) also increased.
>
> Although the TEFRA exception request did not ask for a case-mix exception, this aspect was reviewed. However, no relief was warranted under the regulation requirements because there was no evidence that specific rehabilitation services were added or discontinued -or-that there in fact was any change in the case mix in FY 1986.

B. Plant Expansion Program

The Provider completed a major plant expansion in FY 1986 costing about $83,687,000[50] primarily affecting the hospital and only marginally the RU. In fact, there was no expansion of the RU in FY 1986 responding to the CORF report.

1. The program was not an extraordinary circumstance, and it was within the Provider's control. Thus, no relief was warranted.

2. The CORF report did not specifically state that the Provider's license or accreditation was in jeopardy. It merely stated:

> it is evident the physical plant is not large enough to accommodate the growing number of patients and staff. Adequate storage space continues to be a major problem. An intensive planning effort should be undertaken to provide for additional storage space to prevent a fire and safety hazard.[51]

In CORF's 1981 survey report, only the storage problem was restated. Thus, there was no evidence of a CORF requirement to expand the plant.

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[50] Provider Exhibit P-8.

[51] Provider Exhibit P-7, pp. 4-5 (1980 survey).

3. The expansion program was questionable since the Provider was experiencing a reduction in utilization.

4. The plant expansion program created increased capital-related costs that were "pass-through" costs and not relevant to this TEFRA adjustment request since the target amount was not affected.

5. The Provider's arguments that the expanded ancillary departments servicing RU patients caused additional A&G costs to be allocated to the RU were unsupported. The Intermediary believes these increased costs reflects the Provider's failure to properly manage a decline in patient utilization which also affects ancillary services and costs.

In summary, the regulation requirements for a TEFRA adjustment under 42 C.F.R. § 413.40(h) [52] have not been met. The regulations were specific regarding the kinds of circumstances that warrant adjustment. None of the illustrated examples apply to this case. Patient shifting and an plant expansion program do not qualify under the regulations even if the two alleged circumstance had merit; and there was no evidence they have merit.

The Intermediary states that the provisions of 42 C.F.R. § 413.40(g)(2)[53] have not been met. Namely, that the circumstances were beyond the control of the Provider. The shifting of patients was within the control of the Provider, and HCFA did not impose any requirement to shift patients to comply with the 75% Rule. It appears the plant expansion program was not required by CORF to maintain licensure and/or accreditation. Moreover, the basic cost of the expansion program is irrelevant to the TEFRA target rate since the capital-related costs were fully reimbursed as a PPS "pass-through" cost.

Further, the provisions of 42 C.F.R. § 413.40(g)(3) pertaining to case-mix exception was not met because none of the regulatory requirements was satisfied.

Lastly, the Provider's request for a "suitable retroactive corrective adjustment" under the Act [54] was simply not applicable. The Intermediary cites two cases in support of this position.

1. The US court of appeals for the District of Columbia held the provider's claim for inadequate indirect medical education costs under the retroactive correction clause provision was not applicable. The court ruled that clause was not designed to authorize post hoc reassessment of fairness of more relevant regulatory standard, but rather was intended only to ensure that providers received what they actually due under the standard. Since additional reimbursement

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[52] Previously designated as 42 C.F.R. § 405.463(h).

[53] Previously designated as 42 C.F.R. 405.463(g)(2).

[54] 42 U.S.C. 1395x(v)(1)(A).

was not warranted under the medical education regulation, the provider could not claim entitlement to any retroactive adjustment under this clause.

2. The court held in Daughters of Miriam Center for the Aged v. Matthews, et al., 590 F2d 1250, (CA 3rd Cir. 1978) that 42 U.S.C. § 1395x(v)(1)(A) does not require the Secretary to promulgate regulations to give retroactive effect to every change made in the methods and formulas for determining reasonable cost. The court stated the section refers to the final reconciliation at the end of the provider's FY regarding the interim payments made and the audited amount due. The language was never intended to turn the cost limits on their ear by providing blanket authority for reimbursement in excess of the cost limits except where regulations so provide and the criteria has been met.

The Intermediary asserts the retroactive clause was not applicable, and the above stated arguments demonstrate the Provider has not met the requirements under § 413.40 where relief could be granted.

II.

The Intermediary contends the Provider's exception requests were essentially a continuation of its prior FY 1986 TEFRA appeal that was AR by an agreement dated August 2, 1990[55] which prohibits any additional TEFRA exceptions or adjustments beyond those stated in the agreement.
The Intermediary further asserts:

A. By the terms of the AR, the Provider effectively agreed to forgo TEFRA exceptions and adjustments beyond those explicitly specified in the agreement.

> The agreement provided for average length of stay adjustments and adjustments for increased routine nursing and ancillary services for FY 1986 and beyond to subsequent target rate years.

B. HCFA's denial determination[56] in these appeals granted the AR adjustments, and it also granted a cost year specific adjustment for the two new ancillary services started in FY 1989, radiology and renal dialysis.

C. The AR agreement at p. 9 prevents the granting of any TEFRA incentive payments due to the capital expansion program; and the Provider was seeking incentive payments per Provider Exhibit 73 at pp. 7-8.

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[55] Intermediary Exhibit I-64.

[56] Intermediary Exhibit I-69.

III.

The Intermediary claims the Provider has failed to demonstrate that the costs in excess of the TEFRA target rate were due to the forced shift of patients and capital expansion program, as the regulations require. The Intermediary states the required nexus between the excess costs and the criteria cited within the regulations was not shown.

A. Since the same circumstances involved the FY 1986 appeal were also presented in these appeals, then most of the arguments stated in "I" above were also applicable.

B. The essential arguments pertain to a voluntary shifting of patients which was not an extraordinary circumstance, and it was within the control of the Provider. More importantly, there were other factors responsible for the excess costs rather than the two alleged. For example, the RU experienced low utilization which management did not counter balance by reducing staff resulting in excess staffing costs, etc.

C. The Intermediary asserts the Harmarville[57] case supports this position. In that case, the provider had sought a TEFRA exception because of mid-year change in the Medigap coverage that increased costs. The court concluded: 1) the hospital failed to establish a causal relationship between the costs in excess of the target limit amount and the Medigap policy change, and 2) factors other than the policy change caused the hospital to exceed the rate-of-increase ceiling amount.

The Intermediary asserts the same was true in this case. The Provider has not shown how the alleged circumstances relate directly to the excess costs over the ceiling amount, and there were other factors causing the excess costs.

IV.

The Intermediary asserts the Provider was not entitled to have FY 1986 established as a new base year for failure to met the regulatory requirements.

The statute at 42 U.S.C. § 1395ww(b)(4)(A)] was amended by section 6015(a) of PL 101-239 authorizing the Secretary to provide regulations for the assignment of a new base year, if it was more representative, as determined by the Secretary, of the reasonable and necessary costs of inpatient services. This would include those circumstances the Secretary deems necessary to take into account a decrease in inpatient services which results in a significant distortion in costs of the inpatient services.

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[57] Harmarville Rehabilitation Center v. Shalala, 107 F.3d 922 (CA DC 1996)

HCFA published the implementing regulations on April 20, 1990[58] effective for cost reporting periods beginning on or after April 1, 1990. This regulation provides for rebasing:

> (1) General Rule. (i) ...
>
> [i]f the new base period is more representative of the reasonable and necessary cost of furnishing inpatient services and all of the following conditions apply:
>
> (A) The actual allowable inpatient costs in the cost reporting period that would be affected by the revised ceiling exceed the target amount established....
>
> (B) The hospital documents that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base period.
>
> (C) The exceptions and adjustments described in paragraphs (h) and (g) of this section would not result in recognition of reasonable and necessary costs of governing inpatient services.
>
> (ii) The revised ceiling will be based on the necessary and proper costs incurred during the new base period. Increased in overhead costs (for example, administrative and general and housekeeping costs) will not be taken into consideration unless the hospital documents that these increases result from substantial and permanent changes in furnishing patient care services.

42 C.F.R. § 413.40(j)

The Intermediary states section 4005(c)(2) of PL 101-508 added a new section to the statute at 42 U.S.C. § 1395ww(b)(4)(B) setting forth factors the Secretary must consider in determining whether to assign a new base period, such as:

1. Changes in applicable technologies and medical practices.
2. Differences in the severity of illness among patients.
3. Increases in wages and wage-related costs for hospitals in the area that exceeded the national average increases.
4. Such other factors as the Secretary considers appropriate.

56 FR 43236 (Aug. 30, 1991)[59]

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[58] 42 C.F.R. § 413.40(j), Intermediary Exhibit I-77.

[59] Intermediary Exhibit I-79.

The Intermediary indicates the above cited Federal Register also stated that the Conference Committee report[60] accompanying the legislation noted that in the assignment of the new base period, the Secretary was required to take into consideration certain factors [items 1-3] yet had discretionary authority [item 4] for other factors deemed appropriate.

The Intermediary also asserts that HCFA stated in the Federal Register[61] the conditions when rebasing would be warranted:

> In the April 20, 1990 final rule [at 55 FR 15157], we provided that we would authorize the assignment of a new base period only under limited circumstances and only when an adjustment cannot be accomplished through other provisions.
>
> In order to justify the assignment of a new base period, a hospital must have a permanent, substantial, and significant change in the nature of services provided that results in costs exceeding its rate-of-increase limit. [For example], ... a change ... by a psychiatric institution that previously had only provided limited care ... then changed the entire focus of its work to providing a comprehensive range of psychiatric services ....
>
> However, should a hospital experience a significant change in patient care services and its costs exceed the rate-of-increase limit, the remedy is not automatically be the assignment of a new base period. A general increase beyond the limit is not grounds for rebasing. As discussed above, if a hospital adds a new service that results in increased costs, a permanent adjustment may be made to the hospital's limit to alleviate the distortion created by the new service and total rebasing would not be warranted.
>
> Another situation that could occur is ... a significant change in patient care services, but all the costs incurred above the ceiling my not be reasonable and necessary. One area we give particular attention to in this respect is indirect costs ....
>
> The increase in indirect costs are often the result of factors ... not directly related to patient services; therefore, any excessive increases

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[60] H.R. Rep. No. 964, 101st Cong. 2nd Sess. 704 (1990).

[61] 55 FR 36003, Intermediary Exhibit I-78.

> are not included in any adjustments and would not be included fir the assignment of a new base period were approved. Rather, we expect cases of this nature to result in a rebasing of direct patient care costs only.

55 FR 36003 (September 4, 1990) (emphasis added).

The Intermediary argues that from HCFA's above description, the Provider has not met the requirements for a rebasing.

The Intermediary asserts it demonstrated in I-III above that the Provider's two theories for the increased costs were unsupportable, and that other factors were responsible for the increased costs. Further, the Intermediary points out the necessary nexus between the regulatory bases for an exception or a rebasing has not been demonstrated by the Provider.

The Intermediary contends the Provider failed to meet is burden of showing a permanent, substantial, and significant change in the nature of inpatient services rendered between FY 1985 and FY 1986 as required by 42 C.F.R. § 413.40(i)(1)(B). Therefore, the rebasing request must be denied.

The Intermediary concludes that the above contentions and arguments demonstrate the Provider did not satisfy the regulatory requirements, and the HCFA's denial of the requests for permanent adjustments and rebasing were proper. Further, CYS relief was properly limited to the items included in the AR settlement agreement of August 2, 1990; and HCFA's grant of additional CYS relief for the two new ancillary services initiated in FY 1989 was appropriate in recognition of the Provider's FY 1989 request.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395oo(a)	-	Board Jurisdiction
§ 1395ww(a)	-	Limits on Operating Costs
§ 1395ww(b) et seq.	-	Payment to Hospitals for Inpatient Hospital Services-Target Amount
§ 1395ww(b)(4)(A)	-	Exemption, Exception and Adjustment to Target Amount
§ 1395ww(b)(4)(B)	-	New Base Period Adjustment

Public Laws:

PL 97-248
PL 98-21
PL 101-239
PL 101-508

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

§ 405.1800 et seq.	-	Provider Reimbursement Determinations and Appeals
§ 405.1835 - 1841	-	Board Jurisdiction
§ 412.23 et seq.	-	Excluded Hospitals-Classifications
§ 412.25	-	Excluded Distinct Part Hospital Units: Common Requirements
§ 412.29 et seq.	-	Distict Part Rehabilitation Units: Additional Requirements
§ 412.30 et seq.	-	Exclusion of New Distinct Part Rehabilitation Units and Expansion of Units Already Excluded
§ 413.30 et seq.	-	Limits on Cost Reimbursement
§ 413.40 et seq.	-	Ceiling on Rate of Hospital Cost Increases

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

§ 2800ff	-	Prospective Payments
§ 2900	-	Provider Payment Determinations and Appeal Procedures
§ 3000 et seq.	-	Payments to Non-PPS Hospitals and Distinct Parts

4. Cases:

Community Hospital of Chandler, Inc. v. Sullivan, 963 F.2d 1206 (9th Cir. 1992).

Daughters of Miriam Center for the Aged v. Matthews, et al., 590 F.2d 1250, (CA 3rd Cir. 1978).

Harmarville Rehabilitation Center v. Shalala, 107 F.3d 922, (CA DC 1996).

Hennepin County v. Bowen, 883 F.2d 85, (CA DC 1989).

The Methodist Hospital v. Sullivan, [1992-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 39,627 (D.D.C. Sept. 20, 1991).

Newport Hospital and Clinic, Inc. v. Sullivan, [1991 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 38,844 (D.D.C. Sept. 24, 1990).

St. Francis Medical Center v. Shalala, 962 F.2d 1110 (3d. Cir. 1992).

St. Francis II, 32 F.3d 805 (3d Cir. 1994).

5. Other:

53 Fed. Reg. 9337, 9340, (March 22, 1988).

53 Fed. Reg. 12641 (April 15, 1988)

55 Fed. Reg. 36003 (September 4, 1990)

55 Fed. Reg. 15157 (April 20, 1990)

56 Fed. Reg. 43236 (August 30, 1991).

H.R. Rep. No. 964, 101st Cong. 2nd Sess. 704 (1990).

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 as follows:

I. HCFA properly denied the Provider's TEFRA exception requests for:

a) A permanent adjustment to the TEFRA 1985 base year made in both FY 1989 and FY 1990, and

b) A new base year adjustment of 1986 made in FY 1991.

II. HCFA improperly limited the CYS adjustment.

a) Based on the evidence, the Provider was entitled to, and the Board grants, the Provider's entire CYS adjustment request for both FY 1989 and 1990.

b) HCFA improperly granted only a partial CYS adjustment for FY 1989 and 1990 which was improperly limited to the terms of the Administrative Resolution ("AR") agreement pertaining to the appeal of FY 1986.

[The Board notes: to the extent possible, the basis and methodology used for the granted CYS adjustment in II a) above should also be used in future years in the same fashion as the referenced AR Agreement.]

c) With respect to the two new ancillary services of Renal Dialysis and Radiology, HCFA improperly limited its CYS adjustment to only FY 1989. FY 1990 should also have been included in the CYS adjustment which is granted by the Board in II a) above.

d) To avoid any duplicate payment, the amount of HCFA's partial CYS adjustment is modified to increase that amount to the level of the Provider's total requested adjustments, i.e., about $570,000 and $840,000 for FYs 1989 and 1990 respectively. [See Provider Exhibit P-2, Exh. 20.]

I

A. The Board finds that there were a combination of factors in opposition to the Provider's request for a permanent base year adjustment under 42 C.F.R. § 413.40(g)(3). With respect to the two primary contentions for the permanent adjustment [1. the shift of patients out of the RU and 2. the plant expansion program], the Board finds that:

1. The shift of certain Comprehensive Rehab Patients ("CRP") out of the RU was a strategy to maintain the facility's PPS-exempt status for the RU because the regulations require, at least, 75% of the RU patients must receive intensive rehabilitation services.

2. The Provider's desire and efforts to meet the Medicare 75% Rule to maintain the RU's PPS-exempt status was a voluntary undertaking.

3. The Medicare regulations were clear regarding both the type of patients and the conditions requiring intensive rehabilitation services. Thus, the tardiness and/or confusion of HCFA's responses concerning the CRP was not an essential factor since the Provider's professional staff should have been able to address the basic problem of patient qualification for the RU.

4. Even though there was a change in patient mix caused by the Provider's election to limit the admission of CRP to the RU, there was no supporting clinical evidence concerning the level of care or intensity of services pertaining to the CRPs either moved out of the RU or those that were ultimately denied admission.

5. There was inadequate evidence supporting the actual number of patients shifted in the base year, when shifted, and other relevant essential information.

6. There was no clinical evidence addressing the alleged increase of intensity of rehabilitation services to the remaining patients in the RU.

7. The change in patient mix caused by eliminating certain types of patients does not rise to the regulatory requirement level of a "change in treatment programs" warranting a permanent adjustment.

8. There was no evidence of a change in treatment programs. There was only the assertion that CRP were no longer treated in the RU.

9. a) The Provider's favorable comparison and reference to a case where HCFA permitted a permanent adjustment was misplaced. (Provider Exhibit P-53). The referenced case involved a situation where alcohol and drug ("A&D") patients were removed from a psychiatric unit. Hence, there was a recognized difference in both the type of patient and the specific treatment programs for these two types of patients.

   b) Medicare specifically exempts both psychiatric and alcohol & drug hospitals and/or distinct parts thereof from PPS[62] because there is a definitive treatment program for such patients where such care is rendered in a separate specialized setting. It was implicit that an adjustment was necessary because, in that case, there would be two separate distinct part units (psychiatric and A&D) requiring base year data for separate reimbursement of each unit.

   c) The Provider in this case has not demonstrated that a new or separate treatment program pertained to the CRPs as required by the regulations for a permanent adjustment. Further, the shifted CRPs merely did not qualify for intensive rehab services in the RU as required by the regulations for the RU to have a PPS-exempt status.

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[62] 42 C.F.R. §§ 412.23 and 412.25.

10. With respect to the physical plant expansion program:

a) there was no evidence that its completion in FY 1986 had a significant direct impact concerning the RU's base year;

b) when completed, there was no evidence that the building program had more than a diminutive direct impact on the RU which did not warrant a base year permanent adjustment. A significant impact may have affected the main hospital;

c) there was no evidence identifying or demonstrating what specific operating costs increased regarding the operations of the RU or related areas directly affecting the RU.

d) the direct capital costs of the expansion program became a pass-through cost under PPS;

e) some indirect costs were included in the granted CYS adjustment in II above; and

f) the citation of three court cases were misplaced, i.e., Chandler, Methodist Hospital, and Newport Hospital.[63] Although all three court decisions analyzed the relevance and application of 42 U.S.C. § 1395ww(b)(4)(A) for both PPS and TEFRA regarding adjustments and exceptions to the base year, particularly where there were distortions of costs, the cases were different factually and in substance.

i) In all three cases, the issue was the need for a permanent adjustment to the PPS base year (not TEFRA). Even though the regulatory scheme for both PPS and TEFRA have similarities regarding distortions in the base year, the situation in those cases were completely different from this case.

ii) In each case, a new facility was constructed and occupied which had significant increased operating expenses resulting from and associated with the capital expenditure because a new facility became operable.

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[63] Provider Position Paper for 1990 Request, Volume I of IV at pp. 30 to 33.

- ! As indicated in b) & c) above, there was no evidence of any significant increased operating costs associated with the expansion program that directly affected either the RU or other areas affiliated with the RU.

- ! This Provider was involved in an expansion program where specific areas affected could be identified as compared to a new facility where all areas were affected.

- ! This Provider was a distinct part of the main hospital that incorporated the expansion program.

- ! In this case, to the extent the capital program expanded the ancillary departments servicing the RU, the full CYS adjustment requested and approved by the Board includes some indirect costs associated with these ancillary departments.

iii) In all three cases, the reimbursement methodology for each was the initial stages of PPS where the base year was used in part to reflect historical costs for inpatient operating costs via the Hospital Specific Rate. Thus, distortions affecting inpatient operating costs for the base year was a critical factor even though capital costs were also a "pass through cost."

11. There was no evidence to demonstrate that the costs in excess of the TEFRA target rate were due to the shift of patients and/or capital expansion program, as the regulations require. Thus, the required nexus between the excess costs and the criteria cited within the regulations was not shown by the submitted evidence.

B. The Board finds the evidence submitted does not demonstrate a significant distortion of costs warranting an adjustment for a new TEFRA base year under 42 C.F.R. § 413.30(j). The Board finds that:

1. The same problems identified in A. above also apply to the rebasing request which are incorporated by reference.

2. Provider could have elected FY 1986 as its TEFRA base year. The Provider was aware PPS decertification was an immediate problem in FY 1985. An evaluation of the entire PPS-exempt status situation in the late stages of FY 1985 may have shown it more prudent to forego the PPS-exempt status for FY 1985 due to the frantic actions in the last quarter of FY 1985 and elect FY 1986 as its TEFRA base year.

3. The CON was broad based which only indirectly impacted the RU via the expanded ancillary services departments used by the RU.

4. The major direct capital construction costs became a pass through cost under PPS and could not significantly distort the RU's costs as alleged.

The Board notes that although the Provider made a bare allegation regarding the validity of this regulation, the matter is moot since no evidence or legal arguments were submitted.

II.

With respect to the issue of cost year specific ("CYS") adjustments, the Board finds that:

1. That the evidence in the record[64] does support the Provider's entitlement to the entire CYS adjustment request for both FY 1989 and 1990 which the Board hereby grants.

2. HCFA improperly granted only a partial CYS for FY 1989 and 1990.

3. HCFA improperly limited the CYS adjustment for the two new ancillary services of Renal Dialysis and Radiology to only FY 1989, and it should have also been included for FY 1990.

4. HCFA improperly limited the CYS adjustment based on the alleged terms of an Administrative Resolution ("AR") Agreement.

   a. The Agreement terms did not limit the amount or scope of the adjustment as asserted by HCFA and/or the Intermediary.

   b. HCFA and/or the Intermediary's reliance and introduction of the Agreement as evidence was inappropriate. Identifying it as the methodology source was sufficient.

[The Board notes:

- the methodology used in the AR and the Provider's request were very similar and closely followed the HCFA format. However, the standard HCFA format should be used.

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[64] Provider Exhibit P-2, Exh. 20.

- to the extent possible, the basis and methodology set forth in the Provider's request should also be used for CYS adjustments in future years in the same fashion as the referenced AR Agreement.]

The Board concludes that to avoid any duplicate payment while implementing the granted CYS adjustment, that the amount of HCFA's partial adjustment must be modified by increasing that amount to the level of the Provider's total requested adjustments, i.e., about $570,000 and $840,000 for FYs 1989 and 1990 respectively.[65]

DECISION AND ORDER:

1. HCFA properly denied the Provider's FY 1989 and FY 1990 TEFRA exception request for permanent adjustments to the TEFRA base year of FY 1985; and properly denied the FY 1991 request for a new base year adjustment of 1986. HCFA's determination on this aspect is affirmed.

2. The Provider was entitled to the total amount requested for cost year specific ("CYS") adjustment for both FY 1989 and 1990 rather than the partial amount allowed by HCFA.

The amount of HCFA's partial CYS adjustment is modified to increase that amount to the level of the Provider's total requested adjustments, i.e., about $570,000 and $840,000 for FYs 1989 and 1990 respectively.

BOARD MEMBERS PARTICIPATING

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: March 27, 2000

FOR THE BOARD

Irvin W. Kues
Chairman

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[65] Id.

EXHIBIT A-1

ST FRANCIS MEDICAL CENTER
THREE TEFRA REQUESTS

SUMMARY OF BASIS FOR THE
FY 1989 AND 1990 REQUESTS:

The Provider seeks a permanent adjustment to its FY 1985 base year costs because the actual operating circumstances between FY 1985 and subsequent FYs were not comparable due to a variety of factors starting in FY 1986 that were extraordinary circumstances beyond the control of the Provider. A permanent adjustment is more appropriate because of the permanent change in rendering services causing the distortion in costs.

I--FY 1989

Permanent Adjustment:

The Provider submitted an application for a TEFRA adjustment with its FY 1989 cost report[66] that was supplemented by a request on January 24, 1994[67] which was prior to the issuance of an NPR. Therefore, it was timely under 42 C.F.R. § 413.40(e). The request seeks, pursuant to 42 C.F.R. § 413.40(g)(1), both a permanent adjustment to its FY 1985 base year;

Alternative Relief:

Only if the permanent adjustment is denied, then alternatively a cost year specific ("CYS") adjustment to the FY 1989 TEFRA ceiling amount.

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[66] As permitted under 42 C.F.R. § 413.40(e) which requires the request no later than 180 days from the NPR date; however, prior requests may alleviate the financial strain of the hospital from waiting for an NPR.

[67] Intermediary Position Paper ("PP") for FY 1989, Exhibit I-64.

The request seeks a permanent adjustment of about $1,687,600[68] to the FY 1985 base year that would result in an estimated increase in Medicare reimbursement for FY 1989 of $1,879,200[69] and an incentive bonus payment of about $521,200 or a total of $2,400,400.

The alternative CYS request results in an adjustment increasing Medicare reimbursement about $570,000 for FY 1989.[70]

II--FY 1990 EXHIBIT A-2

The Provider submitted a timely[71] application, under 42 C.F.R. § 413.40(g)(1), for both a permanent base year adjustment, and in the alternative [conditioned on a denial of the permanent request] a cost year specific ("CYS") adjustment to the FY 1990 TEFRA ceiling amount on January 24, 1994.[72]

The requested permanent adjustment involved about $1,696,900[73] to the FY 1985 base year would cause an estimated increase in Medicare reimbursement for FY 1990 of about $1,998,900 and a TEFRA bonus payment of about $756,100 for a estimated total of $2,755,000.[74] It would also increase reimbursement in subsequent fiscal years.

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[68] Id. at p. 19. Consisting of two elements:

1. Adjustment for compliance with 75/25 rule	$ 460,400
2. Adjustment for new Building program	1,227,200
Total	$1,687,600

[69] Id. at p. 20.

[70] Id. at p. 23. The Adjustments consists of two elements:

1. Increase in routine nursing service costs	$492,000
2. Increase in indirect cost allocation	78,000
Total	$570,000

[71] Within 180 days of FY 1990 NPR, dated July 28, 1993.

[72] Intermediary FY 1990 PP, Exhibit I-75.

[73] Id. at p. 18. The adjustment consists of two elements:

1. Adjustment for compliance with 75/25 rule	$ 504,100
2. Adjustment for new building program	1,192,800
Total	$1,696,900

[74] Id. at p. 19.

The alternative CYS request for FY 1990[75], results in an adjustment increasing Medicare reimbursement about $840,000.

EXHIBIT A-3

III--FY 1991

On March 24, 1994,[76] the Provider submitted a request for the "assignment of a new base period," under 42 C.F.R. § 413.40(j), from FY 1985 to FY 1986 because the costs in FY 1986 were more representative of furnishing services in the RU. The regulation states:

> (j) Assignment of a new base period--(1) General rule.
> (i) Effective with cost reporting periods beginning on or after April 1, 1990, HCFA may assign a new base period to establish a revised ceiling if the new base period is more representative of the reasonable and necessary cost of furnishing inpatient services and all the following conditions apply.
>
> (A) The actual allowable inpatient costs ... in the cost reporting period ... affected by the revised ceiling exceed the target amount established....
>
> (B) The hospital documents that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base period.
>
> (C) The exceptions and adjustments described in paragraphs (g) and (h) ... would not result in recognition of the reasonable and necessary costs of providing inpatient services.
> (ii) ....
>
> (2) New base period. The new base period is the first cost reporting period that is 12 months or longer that reflects the substantial and permanent change.
> (3) ....

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[75] Id. at p. 22. The adjustment consists of two elements:

1. Increase in routing nursing costs	$756,700
2. Increase in indirect cost allocation	83,300
Total	$840,000

[76] Intermediary FY 1991 PP, Exhibit I-66.

42 C.F.R. § 413.40(j).

The Provider claims it meets the regulatory requirements. With FY 1986 as the new base period, the excess costs beyond the TEFRA ceiling of about $318,000 would be eliminated. The change would result in a new annual cost per case of $9,378.39 as compared to the TEFRA amount of $8,748.77.[77]

The Provider alleges the denial for rebasing was improperly denied under 42 C.F.R. § 413.40(i)(1)(C); and it also challenges the validity of that regulation as arbitrary and capricious, as well as inconsistent with the plain language and legislative intent of the rebasing statute.

[77] Intermediary Position Paper FY 1991, Exhibit I-67.