PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D69

PROVIDER -
San Francisco Medical Center
San Francisco, California

Provider No. 05-0076

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company
(replacing Aetna Life Insurance Company)

DATE OF HEARING-
March 14, 2000

Cost Reporting Period Ended -
December 31, 1983

CASE NO. 90-1357

INDEX

ISSUE:

Was the Provider entitled to an adjustment to its TEFRA target rate as a result of the addition of cardiovascular surgery services during the last three months of its TEFRA base year?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

San Francisco Medical Center (AProvider≅) is a not for profit hospital located in San Francisco, California. The Provider requested an adjustment to its 1982 target amount calculated under the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248 (ATEFRA≅), codified at 42 U.S.C. ∋ 1395ww(b), for costs associated with its new cardiovascular surgery services.[1] The Aetna Life Insurance Company (AIntermediary≅), (subsequently replaced by Mutual of Omaha) filed a TEFRA recommendation with the Health Care Financing Administration (AHCFA≅).[2] HCFA granted a TEFRA exception for Fiscal Year Ended (AFYE≅) 1983, but not a permanent adjustment to the FYE 1982 base year rate as requested.[3] The Provider filed an amended notice of appeal from HCFA=s determination to the Provider Reimbursement Review Board (ABoard≅) and has met the jurisdictional requirements of 42 C.F.R. ∋∋ 405.1835-1841. The approximate amount of Medicare reimbursement at issue is $70,000.

Pursuant to TEFRA, the Office of Direct Reimbursement (AODR≅) of HCFA, the Provider=s intermediary at that time, calculated the Provider=s 1982 TEFRA target amount, based upon an audit by Arthur Young and Company. The Provider objected to ODR=s failure to take into account the annualized effect of the Provider=s addition of cardiovascular surgery on September 14, 1982, during its FYE December 31, 1982. It was asserted that the increased costs associated with this new service had not been extrapolated over the twelve month base period and therefore, the rate of increase in cost that occurred during 1983 and subsequent years was overstated.

The Provider requested an adjustment to its TEFRA target amount.[4] The Intermediary (then Aetna Life Insurance Company) filed the formal TEFRA adjustment recommendation to HCFA in May 1988.[5] On June 16, 1993, HCFA partially granted a TEFRA exception for FYE 1983, but not a permanent adjustment to the TEFRA target amount for FYE 1982.[6] The Provider filed

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1 Provider Exhibit 1.

2 Provider Exhibit 2.

3 See Provider Exhibit 3.

4 See Provider Exhibit 1.

5 See Provider Exhibit 2.

an amended notice of appeal with the Board when it received HCFA=s determination.[7]

In its decision to grant a partial exception to the FYE 1983 rate of increase ceiling, HCFA first noted that the Provider had exceeded its TEFRA cost limit by $1,798,309, and as a result, received a penalty payment of $449,577 for a net disallowance of $1,348,732.[8] HCFA concluded that no permanent adjustment to the target amount per discharge was warranted for the less than twelve months of cardiovascular intensive care units services in the TEFRA base period. HCFA noted that the cost per diem for cardiovascular services in FYE 1982 was $1,147.50, but that it had decreased in FYE 1983 to $740.17. HCFA concluded that the increased cost of the cardiovascular units was attributable to increased utilization and that the Provider was entitled to adjustments for increased routine and ancillary services due to the increase in utilization over the base year.[9]

HCFA administered its adjustment methodology for increased routine service for three hospital units: adult and pediatrics, intensive care and cardiovascular intensive care. HCFA determined that only the cardiovascular intensive care unit qualified for an adjustment to the rate of increase ceiling in the amount of $309,840.[10] HCFA computed the following adjustments for increased service intensity: cardiovascular operating room services, $397,952; radiology diagnostic service, $93,175, laboratory clinic services, $503,308; laboratory pathology service, $2,094; blood storage service, $38,529; drugs charged to patients in the cardiovascular service, $59,233; and cardiac catheterization, $102,087.[11] Total adjustments calculated equaled $1,506,218.[12] HCFA noted that the Provider was entitled to the lower of the total adjustments or costs in excess of the target amount. Since the Provider had been $1,798,309 over the limit, but had received $449,577 in penalty payments, there remained $1,348,732 in excess of the target amount. Therefore, an adjustment of the lower amount, the costs over the target amount, was made for $1,348,732.

The Provider was represented by Mark W. Jordan, Esquire, of Kaiser Foundation Hospitals and John Hellow, Esquire, of Hooper, Lundy and Bookman. The Intermediary was represented by

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6 See Provider Exhibit 3.

7 See Provider Exhibit 4.

8 See Provider Exhibit 3.

9 Id. at 2.

10 Id. at 3.

11 Id., attached Exhibits 5-21.

12 Id., attached Exhibit 22.

Paul R. Gulbrandson, CPA, of Aetna Life Insurance Company.

PROVIDER=S CONTENTIONS:

The Provider contends that it made a request for an adjustment that HCFA denied. The Provider asserts that the proper methodology to address an addition of a new service at the end of a base year is an adjustment and not an exception. The Provider contends that it properly calculated the amount of the adjustment to which it is entitled. And finally, that it is entitled to reimbursement up to the full amount of the TEFRA adjustment, including any incentive bonus amounts.

The Provider notes that there has been confusion over the differences between exceptions and adjustments under TEFRA. See Redbud Community Hospital, HCFA Administrator, April 26, 1993, Medicare and Medicaid Guide (CCH) & 41,417, at 35,656. In clarifications to the regulation, See 56 Fed. Reg. 43196, 43231 (August 30, 1991), it was stated that there had been no distinction between the two provisions. The Intermediary letter to HCFA indicates that Athe request was made pursuant to regulation 42 C.F.R. ə 413.40(e), (g), and (h).≅[13] HCFA=s subsequent response states that Awe do not conclude that a permanent adjustment to target amount per discharge is warranted for less than 12 months of cardiovascular intensive unit care services in the base period. . . . An increase in utilization does not warrant a permanent adjustment to the target amount because utilization varies over time.≅[14] The Provider asserts that HCFA=s decision, whether denying an adjustment or exception, is subject to review by the Board. 42 C.F.R. ə 405.463(e).

The Provider claims that the regulations require that an adjustment be granted. The TEFRA regulation at 42 C.F.R. ə 405.463(g) and (h), identify the circumstances under which either an adjustment or exception to the TEFRA target rate will occur. HCFA grants a provider=s exception request under ə 405.463(g)(3)(I) for changes in case mix when a hospital Ahas added or discontinued services in a year after its base year described in paragraph (b)(1) of this section.≅ (emphasis added). The Provider indicates that the service change took place during, not after, its base year, and thus the adjustment provisions in ə 405.463(h) is the appropriate remedy for the facts in this case. The exception that HCFA granted Afor an increase in service intensity≅ falls, if at all, under ə405.463(g)(3).

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[13] Provider Exhibit 2 at 120.

[14] Provider Exhibit 3 at 2.

The Provider notes that adjustment provision states that:

> HCFA may adjust the amount of operating costs considered in establishing the cost per case for one or more cost reporting period(s), including both periods subject to the ceiling and the hospital=s base period, to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services. Such factors may include a decrease [or increase in 1983 revisions] in inpatient hospital services the hospital provides . . .

42 C.F.R. ∋ 405.463(h)(1).

The Provider refers to a letter from the Director of HCFA=s Division of Hospital Payment Policy, dated April 24, 1996(sic) cited in Newport Hospital and Clinic, Inc. v. Sullivan, No. 88-2490-LFO (D.D.C. September 24, 1990), Medicare and Medicaid Guide (CCH) & 38,844, for guidance on when adjustments are appropriate. It states that A[s]ince the changes that resulted in the distortion occurred in the base year, [Newport=s] target amount should be increased by $1756.60 . . . This amount is based on the estimate of the costs from the modified short period cost report for the seven-month period ended 6/30/83. Id. at 24,060.

The Provider also notes that the Board, in Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Case No. 93-D42, May 20, 1993, Medicare and Medicaid Guide (CCH) & 41,558, rev=d, HCFA Administrator July 19, 1993, Medicare and Medicaid Guide (CCH) & 41,671, aff=d, C.A. No. 93-1943(WBB) (D.D.C. July 21, 1995, Medicare and Medicaid Guide (CCH) & 43,591, aff=d, No. 95-5318(D.C.Cir. November 1, 1996), Medicare and Medicaid Guide (CCH) & 44,780 (AHarmarville≅) assessed the circumstances that necessitated adjustments versus exceptions. It states in pertinent part that:

> [t]he Board concludes that the provider is qualified for an adjustment to achieve comparability of cost reporting periods under 42 C.F.R. ∋ 405.463(h) because the provider has demonstrated that there was an extraordinary factor that caused a significant distortion in the operating costs for inpatient provider services affecting both the base year and the period subject to the TEFRA year. Therefore, the operating costs considered in establishing the cost per case between the base year and the rate year are not comparable; and, the distortion occurred at the midpoint of the base year and the first rate year subject to the ceiling as explained below.

Harmarville, Medicare and Medicaid Guide (CCH) & 41,558, at 36,413.

The Provider asserts that the Board decision in Harmarville was overturned because of failure of the provider to demonstrate a nexus between increased costs and the extraordinary circumstance, but that in the instant case, HCFA has acknowledged a nexus by granting an exception, even though the provider claims that the proper remedy is an adjustment.

The Provider claims that it properly calculated the requested adjustment.[15] The $574.89 requested is based on actual 1982 data and 5 months of data from the beginning of 1983, service volume projections and the elimination of start-up costs associated with the cardiovascular intensive care unit (AICU≅) and operating room. The Provider also supplemented its request with audited 1982 and 1983 cost reports. According to the Provider, HCFA denied the adjustment but apparently granted an exception for the same basis, drew erroneous conclusions from the Provider=s adjustment methodology, and applied the wrong statistical bases in processing the exception to the target rate.

The Provider presented testimony that it performed a cost center by cost center analysis of the impact of the cardiovascular services at the hospital. It assumed that there would be 475 open heart surgeries and that Medicare would be 30 percent of those cases. Trending back to 1982, it calculated that it would incur $1,524,400 in cardiovascular surgery operating room costs which would need to be added to the TAC Form 1007 in lieu of partial year data.[16] The same was used to calculate costs for the cardiovascular ICU. For the increased effect on ancillary services, the Provider tracked the ancillaries used by its 17 Medicare discharges in 1982 and trended this forward for the 143 expected Medicare patients in 1983. These were then substituted for the actual 1982 cost incurred in 1982 on the TAC Form 1007. The Provider notes that it used the same method used to make revisions for the malpractice insurance and labor room corrections.[17]

The Provider claims that its adjustment is more accurate than HCFA=s exception. The Provider witness testified that the target rate would have been $4,276.83.[18] If one allows the amount allowed through HCFA=s exception process, $1,348,732,[19] to the allowable inpatient operating cots plus TEFRA incentive,[20] and dividing that by discharges, the equivalent TEFRA Target rate would be $4,234.45, which is well in excess of the original rate and within $40 of the rate

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15 See Provider Exhibit 1 at 6-119.

16 Tr. at 57.

17 Tr. at 80-81.

18 Tr. at 46.

19 Provider Exhibit 12, column V, last line.

20 Id., column V, second to the last line.

requested.

When one compares the amount of reimbursement under the HCFA exception versus the adjustment proposed by the Provider, it yields a $105,000 under-reimbursement. The Provider proposes two reasons for the discrepancy. First, the adjustment more accurately reflects the actual costs of the addition of the service under TEFRA and second, HCFA used the wrong statistical basis in its exception calculation. The Provider refers to its revised comparable target amounts based on as-filed and audited 1983 cost reports and notes that they more closely reflect what it proposed as an adjustment than the originally assigned TEFRA target amount or even what could be derived from adding back in the HCFA exception amount to calculate a new rate.

HCFA=s determination is in error because it finds that no permanent adjustment is needed because the increased costs result mainly from increased utilization. HCFA inappropriately compared the cardiovascular per diem in 1982 with that in 1983. The Provider presented testimony indicating that the higher costs in 1982 were do to start-up costs.[21] The requested adjustment stripped out start up costs and adjusted for utilization and had a per diem cost of $613.33. This amount was less than the actual cost in FYE 1983. The Provider concluded that their adjustment tool takes into account increased utilization and focuses instead on service intensity.

The Provider witness also questioned HCFA=s statistical basis for determining an increase of the ancillary services associated with cardiovascular services.[22] The Provider is a no charge structure provider and thus there are no charge statistics for apportioning cost to the Medicare program. Under HCFA Pub. 15-1 ə 2208.1, it is required to use method A to step down costs and HCFA should have been required to use the same method. With respect to apportioning operating room costs, operating room hours rather than inpatient days are used to apportion.[23] Likewise, HCFA understated increases for radiology-diagnostic service, laboratory-clinical service, whole blood service, blood storage, renal dialysis and cardiac catheterization by $569,766. Under the method used by HCFA nothing was allowed for whole blood services whereas the correct statistic yields an increase of $116,540. The Provider notes that open heart surgery is a heavy blood utilizer and it is unreasonable to have no increase for whole blood costs. The same is true with renal dialysis services. HCFA granted no exception and the correct statistic yields an increase of $59,165. If the Provider receives a properly calculated HCFA exception methodology, it would be entitled to more than it requested in terms of an adjustment.

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[21] Tr. at 69-71.

[22] Tr. at 71-76, 89-92, 100-103, and 111-114. See Provider Exhibit 12, Attachment H at 786.

[23] Id. at 736.

Although the Provider is not presently in a bonus situation in FYE 1983, even if granted the adjustment, it may be in a bonus situation if other disputed issues are settled in its favor. Therefore, the Board should indicate whether the provider is entitled to a TEFRA bonus. The Provider claims that the statute or regulation does not limit adjustments or exception to providers who exceed their cost limit as HCFA tried to do retroactively in the 1988 regulations. See 53 Fed. Reg. 38476, 38480, Column 1 (September 30, 1988). The Board has found that the 1988 rule did not apply to the fiscal years prior to 1988. See Harmarville, supra. The Provider points out that testimony in Harmarville from a former HCFA official questioned whether the 1988 rule was in fact HCFA policy prior to 1988.[24]

INTERMEDIARY=S CONTENTIONS:

The Intermediary asserts that the Provider is disputing a HCFA determination. The Provider has requested an exception to the TEFRA target rate which was established by ODR. The basis for the Provider=s exception request was that it opened a cardiovascular unit in the latter part of the TEFRA base year and thus, a full year costs for this new service was not included in the cost report. The Provider sought to recast the cost report to impute a full year of equivalent costs for the new service. The Provider=s request for exception was reviewed by HCFA and the rate was modified.

The Intermediary notes that the Provider=s initial Position Paper discusses an exception request while in the Provider's revised position paper, it asserts that it is seeking an adjustment of the TEFRA rate. It is the Intermediary=s position that HCFA made a proper determination in this matter.

Without regard to the change in position, the Intermediary states that the regulatory language that controls in this matter is unequivocal. The Intermediary indicates that exemptions, exceptions, and adjustments, are discussed. 47 Fed. Reg. 43282, 43288 (September 30, 1982). This discussion is presented in four segments; a general discussion; exemptions; exceptions; and adjustments. The general discussion is the significant portion. In this portion, it clearly indicates that the process of exemption and exception allows the hospital to have its ceiling revised to take costs into account which would otherwise be disallowed by application of the ceiling. It also mentions that HCFA's decision on a request for exemption or an exception may be appealed by the hospital to the Board under 42 C.F.R. Part 405, Subpart R. Noticeably absent from this paragraph is any discussion of the appeal rights under the adjustments portion of this discussion.

The segment that covers the adjustment factor states that:

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[24] See Provider Exhibit 9.

> it may be necessary to make an adjustment to inpatient operating costs that in either the base period or in a period that is subject to the rate of increase ceiling to take in account such factors such as a decrease in inpatient services that would distort a comparison of costs per case between the cost reporting periods. A decrease in the hospital services, such as closing the special care unit, or changing the arrangements under which a particular service is furnished, such as leasing a department, are examples of situations with such effects. In these and other cases, we will adjust the amount of in-patient operating costs considered in establishing the costs per discharge in order to maintain a comparability of costs between periods.

47 Fed. Reg. 43282, 43289 (September 30, 1982).

The Intermediary states that A[c]learly, the language under adjustment indicates the intent of an adjustment was not such that would encompass the issue which is involved in this matter; i.e., a temporary strike in the base year.≅[25]

The Intermediary also indicates that it is clear from 47 Fed. Reg. 43282, 43288 and 43289 (September 30, 1982) that, in order to obtain an exception, a provider must be beyond the cost ceiling. In 48 Fed. Reg. 39412, 39414 (August 30, 1983) it states that Aa hospital subject to the ceiling may request an exception to it on the basis of a change in the case mix or extraordinary circumstances beyond the hospital's control with substantial cost effects.≅ Further, in response to a comment, HCFA again asserted that an exception would be considered when it is determined that the costs will exceed the rate of increase target or cost limit. Id. at 39419.

The Intermediary notes revisions that occurred to the regulation in 1988. 53 Fed. Reg. 9337 (March 22, 1988). A discussion of exceptions and adjustments includes the following.

> We are also proposing to revise ə 413.40(g) and (h) to clearly state that we would not grant an exception or adjustment to a hospital's rate-of-increase ceiling if the hospital's costs do not exceed its target amount. We believe that an actual disallowance of costs as a result of the application of the rate-of-increase ceiling is a necessary precondition to HCFA=s granting an exception or adjustment under ə 413.40(g) and (h) and that the exceptions and adjustments provided under section 1886(b)(4) of the Act should not be used to increase a hospital=s incentive payment under section 1886(b)(1)(A)of the Act.

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[25] Intermediary Post Hearing Brief at 5.

The rate-of-increase ceiling provision was added to the Act by section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248). The Conference Report that accompanied Pub. L. 97-248 (H.R. Rep. No. 760, 97th Cong., 2d Sess. 419-421 (1982)) does not contain any explicit expression of congressional intent with regard to whether an exception or adjustment should be granted only if a hospital exceeds its target amount. Rather, the report states, AThe Secretary of HHS would be required to provide for appropriate exemptions, exceptions, and adjustments as in the Senate provision.≅ Thus, it appears that Congress deferred to the Secretary=s judgment in implementing the exemption, exception, and adjustment process.

We also note that the report does state that it was the Senate provision the Conference Committee adopted with regard to this process. The State amendment did not provide for incentive payments to hospitals with costs below the target amount. Thus, the language in the statute authorizing the exemptions, exceptions, and adjustments was added by the Senate without its contemplating that this process would apply in cases in which the hospital=s costs do not exceed the target amount and the hospital receives an incentive payment. Based on this evidence, we believe that our policy is consistent with congressional intent.

Even though the current regulations do not specifically state that we will not grant an exception of adjustment to increase incentive payments, there are references to this policy in the preamble to the interim final rule, 47 Fed. Reg. 43282, September 30, 1982, and final rule, 48 Fed. Reg. 39412, August 30, 1983, that first added 42 C.F.R. ə 413.40 (then ə 405.463) to the regulations. In the interim final rule, in defining the exceptions process, we stated, A[a]n exception allows a hospital to have its ceiling adjusted to take costs into account that would otherwise be disallowed by application of the ceiling.≅ See 47 Fed. Reg. 43288. In addition, in the final rule, in addressing a comment concerning when an exception request may be filed, we stated, AUnder both the rate-of-increase ceiling and the total cost limits, a hospital may request an exception whenever it has a reasonable basis for estimating that its costs will exceed its rate-of-increase target amount or cost limit.≅ See 48 Fed. Reg. 39419.

> We believe that these statements make it clear that it has always been our policy not to award exceptions or adjustments under the rate-of-increase ceiling if there has been no disallowance of a hospital=s actual costs. Therefore, we are proposing to revise ə 413.40(g) and (h) to clearly state our current policy concerning the granting of exceptions and adjustments.

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

The subject was again addressed in 53 Fed. Reg. 38476, 38481 (September 30, 1988).

> 3. Adjustments to the Rate-of-Increase Ceiling and Hospital Cost Limits
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> Comment: One comment was received from a law firm protesting the clarification that a hospital cannot receive an adjustment to its rate-of-increase ceiling if the hospital=s costs do not exceed its target amount. The commenter asserted that the effect of the proposed rule would be to directly contravene Congressional intent that hospitals receiving incentive payments be permitted to receive exceptions or adjustments solely for the purpose of increasing these incentive payments rather than to recover cost disallowances.
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> Response: We disagree with the assertion that there was any Congressional intent to award hospitals additional incentive payments under the exemption, exception, or adjustment authority in section 1886(b)(4) of the Act. The rate-of-increase provisions are an extension of the cost containment provisions in section 1886(a)(1)(A)(I) of the Act (limits on inpatient operating costs). The relationship between the two separate cost containment measures can be seen in the parallel language used under both provisions with respect to providing an exemption from, or an exception and adjustment to, the methods of payment. Also, in addressing the incentive payment and excess cost disallowance section 1886(b)(1) of the Act states A. . .except that in no case may the amount payable under this title . . . with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).≅ The interrelationship of the two limitation methodologies enforces the intent of the Act to promote cost containment.

> As stated in the proposed rule, the Senate provision regarding the adjustment process was adopted by the Conference Committee (H.R. Rep. No. 760, 97th Cong., 2nd Sess. 419-421 (1982). Since the Senate amendments did not contain an incentive payment provision, it could not be construed that the exemption, exception, and adjustment process was contemplated without the knowledge or consideration of an incentive program. Also, it seems that the Senate was concerned about hospitals reducing costs through elimination of patient services. This concern can be seen in the discretionary authority given to the Secretary for providing other exemptions from, and exceptions and adjustments to, the limit methodology, Section 1886(b)(4) of the Act states Athe Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which result in a significant distortion in the operating costs of inpatient hospital services.≅
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> It was recognized that hospitals, through this cost containment effort, would have to cut costs but not to the detriment of services being furnished to beneficiaries. The area of patient care was the only area of reductions to be evaluated under these provisions. Therefore, since the reductions employed by a hospital to create incentive payments, other than those decreasing inpatient services, are not adjusted upward in determining an incentive payment, the increases should not be adjusted downward to provide for additional incentive payments. We still believe that the main concern in the exemption, exception, and adjustment provisions was to protect hospitals from being harmed by the rate-of-increase provisions for reasons outside the control of hospital management.

Id.

The Intermediary asserts that the intent was that a Provider had to exceed the cost limits before it can get an exception. The same would apply, if a Provider is eligible for an adjustment, which the Intermediary believes this Provider is not eligible for.

The Provider is not entitled to an adjustment because an adjustment does not apply to the circumstances of the instant case. The Intermediary believes that the Provider has been afforded all that it is entitled to pursuant to Medicare law, regulations, and manual instructions. HCFA reviewed the Provider's request for exception and determined that because the Provider exceeded

the cost limits that it was entitled to relief for the cost report year which is in dispute in this matter. Relief was granted. The Provider=s concern is that it should be granted an adjustment and/or permanent relief. The record clearly reflects that the Provider is not entitled to anything more than what it received based upon what it presented.

The Provider is not entitled to an adjustment because the provisions under which an adjustment apply do not fit the Provider's situation in this case. The determination by HCFA is proper and should be sustained.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

ə 1395ww(b)	-	Rate of Increase in Target Amounts for Inpatient Hospital Services

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

Subpart R	-	Provider Reimbursement Determinations and Appeals
əə 405.1835-.1841	-	Board Jurisdiction
ə 405.463 et seq. (redesignated ə 413.40)	-	Ceiling on Rate of Hospital Cost Increases

3. Provider Reimbursement Manual (HCFA Pub. 15-1):

ə 2208.1	-	All-Inclusive Rate or No-Charge Structure Hospitals

4. Cases:

Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania , PRRB Case No. 93-D42, May 20, 1993, Medicare and Medicaid Guide (CCH) & 41,558, rev=d, HCFA Administrator July 19, 1993, Medicare and Medicaid Guide (CCH) & 41,671, aff=d, C.A. No. 93-1943(WBB) (D.D.C. July 21, 1995, Medicare and Medicaid Guide (CCH) & 43,591, aff=d, No. 95-5318(D.C.Cir. November 1, 1996), Medicare and Medicaid Guide (CCH) & 44,780.

Newport Hospital and Clinic, Inc. v. Sullivan, No. 88-2490-LFO (D.D.C. September 24, 1990), Medicare and Medicaid Guide (CCH) & 38,844.

Redbud Community Hospital, HCFA Administrator, April 26, 1993, Medicare and Medicaid Guide (CCH) & 41,417.

5. Other:

47 Fed. Reg. 43282 (September 30, 1982).

48 Fed. Reg. 39412 (August 30, 1983).

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

53 Fed. Reg. 38476 (September 30, 1988).

56 Fed. Reg. 43196 (August 30, 1991).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, evidence presented, testimony elicited at the hearing, and post hearing briefs, finds and concludes as follows:

The Board finds that the issue in the instant case is whether the Provider is entitled to an adjustment to its 1982 TEFRA base year rate. The Board notes that HCFA found that the Provider had exceeded its rate of increased ceiling in FY 1983 and that the Provider was entitled to an exception due to the increase in the number of cardiovascular units from the base year to the appeal year. The Board finds that HCFA=s decision to grant the Provider relief under the exception regulation was appropriate and resulted in all of the Provider=s reasonable costs being covered. The Board also finds that it does not agree with the Provider that FY 1983 cost and utilization data should be utilized to adjust the TEFRA base year.

The Board notes that the Provider=s initial requested relief from the TEFRA limits was under 42 C.F.R. ə 405.463(g)(1) and (3) which pertains to exceptions.[26] The Board notes, however, that the proposed methodology was to utilize the FY 1983 cost and utilization data to impute what the cost would have been had the cardiovascular unit been in operation for the entire TEFRA base year.[27] Further submissions by the Provider to HCFA prior to its determination also

[26] See Provider Exhibit 1 at 2.

[27] Id. at 1.

indicate that the Provider is seeking an adjustment to its TEFRA base year rate.[28] The Board also notes that HCFA considered, but did not grant, a permanent adjustment to the Provider's target amount per discharge.[29] Finally, the Board notes that the Provider was granted all of its incurred costs for FY 1983 under the exception relief granted by HCFA, but if the Provider were allowed the adjustment to the TEFRA base year rate, it might also be entitled to an incentive payment since its costs would have been be under the adjusted TEFRA limit.[30] The Board therefore finds that the issue in this case is whether the Provider is entitled to an adjustment to its 1982 TEFRA base year and as a result additional compensation in the form of an incentive payment.

The Board finds that the Provider is entitled to relief due to the additional number of more intensive cardiovascular units in FY 1983, and the resulting increased costs that exceeded the cost limits. The Board notes that HCFA found that the Provider had exceeded its rate of increased ceiling in FY 1983 and that the Provider was entitled to an exception due to the increase in the number of cardiovascular units from the base year to the appeal year.[31]

The Board notes that HCFA recognized that the Provider=s cardiovascular unit had operated for only three and one half months in the base period but determined that the increased cardiovascular intensive care unit costs were principally due to increased utilization which did not warrant a permanent adjustment to the target rate because utilization varies over time. Instead, HCFA applied its adjustment methodology for increased routine and ancillary services and found that the cardiovascular unit qualified for an adjustment and computed adjustments for the increases in service intensity. HCFA made adjustments for increased service intensity in the following areas: cardiovascular operating room, radiology diagnostic, laboratory clinical, laboratory pathology, blood storage, drugs charged to patients in the cardiovascular unit and cardiac catheterization. The combined adjustments allowed exceeded all of the allowable costs above the TEFRA target limit experienced by the Provider and thus, HCFA granted an exception for all of the Provider=s allowable costs for FY 1983.

The Board notes that HCFA did not grant the Provider a permanent adjustment but instead granted an exception. The Board disagrees with the Provider=s assertion that the regulations do not permit granting an exception under the facts of this case. The regulations at 42 C.F.R.ə 405.463(g)(3)(i) state that a case mix exception may be granted in a situation where there are added services after the base year. The Board does not interpret "added services" to mean only

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28 See Provider Exhibit 6.

29 See Provider Exhibit 3 at 2.

30 See Tr. at 106-7.

31 See Provider Exhibit 3.

"completely new" services. The Board can envision a situation where a hospital can experience a substantial number of additional services in one of its more intensive services areas, that may have been in place for many years, and as a result have a case mix change that distorts the rate of cost increase. The Board finds that HCFA=s decision to grant the Provider relief under the exception regulation was appropriate and that it resulted in all of the Provider's reasonable costs, that is, costs actually incurred in FY 1983, being reimbursed.

The Board also finds that it does not agree with the Provider=s proposed adjustment methodology. The Provider=s methodology makes adjustments to the FY 1982 TEFRA base year by estimating what the utilization of the cardiovascular unit would have been had it been operating for all of FY 1982. After determining the number of discharges, the Provider adds the costs of those services to the base year costs and recalculates a new FY 1982 TEFRA base year rate. The Board finds that there is insufficient evidence to extrapolate the 1983 data into FY 1982 and is reluctant to add costs, not actually incurred into the base year. If an adjustment were to be made, the Board believes that actual costs from FY 1983 should be used to establish a new TEFRA base year.

In summary, the Board finds that the exception granted by HCFA was proper and resulted in the Provider recovering all of its reasonable costs. In addition, the Board finds that errors that may have been made by HCFA in calculation of the exception are immaterial because the Provider was reimbursed for all of the costs it actually incurred. The Board also finds that any issue concerning an incentive payment is moot because an adjustment to the TEFRA rates was not warranted.

DECISION AND ORDER:

HCFA=s decision to grant the Provider an exception from its TEFRA base year limits was proper. HCFA=s decision is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., EsquireCharles R. Barker
Stanley J. Sokolove

FOR THE BOARD:

Irvin W. Kues
Chairman