PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D90

PROVIDER -
Rumford Community Hospital,
Rumford, ME

Provider No. 20-0016

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Associated Hospital Services of Maine

DATE OF HEARING-
June 8, 2000

Cost Reporting Period Ended -
June 30, 1994

CASE NO. 97-2601

INDEX

ISSUE:

Was the Intermediary=s denial of the Provider=s request for a sole community hospital decreased volume adjustment proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Rumford Community Hospital (AProvider@) is a 108 bed short-term, acute care, not-for-profit hospital located in Rumford, Maine. The 108 beds include 91 adult and pediatric beds, six intensive care beds, and 11 nursery beds. The Provider qualified and has been reimbursed as a sole community hospital since July 1, 1979.

On November 21, 1995, the Intermediary issued a Notice of Program Reimbursement (ANPR@) for the fiscal year (AFY@) in question. On May 13, 1996, the Provider requested an additional payment of $434,209[1] in the form of a volume adjustment that is available to sole community hospitals that experience a large decrease in volume, pursuant to the regulations at 42 C.F.R. ' 412.92(e).[2] On October 10, 1996, the Intermediary denied the request.[3] The Provider requested reconsideration on December 9, 1996, and the Intermediary denied the reconsideration request on February 21, 1997.[4] On March 11, 1997, the Provider submitted additional information to the Intermediary.[5] This was followed by a meeting on April 3, 1997, and another Provider letter dated April 9, 1997.[6] The Intermediary responded on May, 1, 1997, again declining to award any of the requested relief.[7]

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1 Subsequently, both parties agreed that the amount in contention was incorrectly computed and should have been $357,624. See Tr. at 6 and 165.

2 Intermediary Exhibit I-4.

3 Id. at I-5.

4 Id. at I-6 and I-7.

5 Id. at I-8.

6 Id. at I-9.

7 Id. at I-10.

On August 4, 1997, the Provider filed a timely appeal of the Intermediary=s determination with the Provider Reimbursement Review Board (ABoard@) and has met the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841. The Medicare reimbursement in controversy is $357,624.

The Provider was represented by Charles F. Dingman, Esquire, of Preti, Flaherty, Beliveau & Pachios, LLC. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

STATUTORY BACKGROUND:

Section 1886(d)(5)(D)(ii) of the Social Security Act provides that:

> [i]n the case of a sole community hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph 9) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

The implementing regulations at 42 C.F.R. ' 412.92(e) et. seq. read in part:

> (e) Additional payments to sole community hospitals experiencing a significant volume decrease. (1) For cost reporting periods beginning on or after October 1, 1983, HCFA provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. . . .
>
> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days after the date on the intermediary=s Notice of Amount of Program Reimbursement-

(i) Submit to the intermediary documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to circumstances beyond the hospital=s control.

(3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital=s Medicare inpatient operating costs and the hospital=s total DRG revenue for inpatient operating costs . . . (including outlier payments for inpatient operating costs, . . . additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients, . . . and for indirect medical education costs. . . .

(i) In determining the adjustment amount, the intermediary considers-

(A) The individual hospital=s needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital=s fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under Part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

Additional instructions are provided in HCFA Pub 15-1 which states in Section 2810.1. A. 1:

1.Circumstances Beyond The Hospital=s Control.- In order for an SCH to qualify for additional payment, the decrease in volume must result from an unusual situation or occurrence externally imposed on the hospital and beyond its control. These situations may include strikes, floods, inability to recruit essential physician staff, unusual prolonged severe weather conditions, serious and prolonged economic recessions that have a direct impact on admissions, or similar occurrences with substantial cost effects.

In determining the amount to be paid, HCFA Pub. 15-1 ' 2810.1. B states in part:

> B. Amount of Payment Adjustment.- Additional payment is made to an eligible SCH for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital=s Medicare inpatient operating cost and the hospital=s total DRG revenue.
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> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary directly with utilization such as food and laundry costs.
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> In a hospital setting, however, many costs are neither perfectly fixed nor perfectly variable, but are semifixed. Semifixed costs are those costs for items and services that are essential for the hospital to maintain operation but also vary somewhat with volume. For purpose of this adjustment, many semifixed costs such as personnel-related costs, may be considered as fixed on a case-by-case basis.
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> In evaluating semifixed costs, the intermediary considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment.

In addressing the calculation of the Core Staff requirements, HCFA Pub. 15-1 ' 2810.1. C. 6 reads as follows:

> 6. Core Staff and Services.- A comparison, by cost center, of full-time equivalent employees and salaries in both cost reporting periods must be submitted. The requesting hospital must identify core staff and services in each center and the cost of these staff and services. The request must include justification of the selection of core staff and services including minimum staffing requirements imposed by an external source. The intermediary=s analysis of core staff is limited to those cost

> centers (General Service, Inpatient, Ancillary, etc.) whose costs are components of Medicare inpatient operating cost.

In making a final determination, HCFA Pub. 15-1 ' 2810.1. D offers the following guidance to intermediaries:

> D. Determination on Requests.- The intermediary reviews a hospital=s request for additional payment for completeness and accuracy. If any of the required documentation is missing, incomplete, or inaccurate, the intermediary requests the needed information. The intermediary makes a determination on the request and notifies the hospital of the decision within 180 days of the date the intermediary receives all required information.
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> The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost. Therefore, the adjustment allows an increase in cost up to the prior year=s total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.

PROVIDER=S CONTENTIONS:

The Provider contends that it met the requirements of the regulations and the Provider Reimbursement Manual in that it suffered a decrease in discharges of 5.05%, from 1445 discharges in FY 1993 to 1372 discharges in FY 1994.[8] In that the decrease in discharges was beyond its control, the Provider believes it is entitled to the additional payment for sole community hospitals experiencing a decline in volume.

Specifically, a series of volume decreases, culminating in the FY 1994 decline for which the Provider is requesting an adjustment, began during the FY 1991-1992 period, when three essential physicians terminated their relationships with the Provider. These physicians accounted for approximately 44% of the Provider=s discharges in FY 1991, and accounted for none of the Provider=s discharges by 1993 and thereafter.[9]

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[8] Provider Exhibit P-IX.

[9] Provider Exhibit P-X.

As the Provider encountered difficulty in recruiting replacement physicians to the area, it initially obtained the services of locum tenens (temporary) physicians to fill the gap, beginning in FY 1992 and continuing in 1993. However, due to the prohibitive cost and significant patient dissatisfaction, area residents turned to providers outside of the Provider=s primary and secondary service areas. The Provider contends that it aggressively sought to recruit physicians to meet community needs, both before and after the locum tenens solution proved inadequate. It began by using a physician recruiter, however based on testimony at the hearing it was still unable to attract physicians to the community.[10] Finally, the Provider implemented an alternative strategy during FY 1993 and FY 1994 by creating its own physician group practice, and by obtaining recognition of the area as a health professional shortage area. The Provider received Rural Health Center status for the physician practice in March, 1994. This served to address the inherent and uncontrollable obstacles to physician recruitment in this rural and economically challenged area.[11] The Provider also points out that the difficulties of rural physician recruitment and their significance were recognized as a basis for approving the Provider=s formation of a group practice affiliate by the Maine Health Care Finance Commission.[12]

Equally beyond the Provider=s control was a significant economic recession in the community. The Town of Rumford and surrounding area suffered from sharp increases in unemployment, greater than those experienced in other areas of the State or in the United States as a whole.[13]

The Provider contends that the above described causative factors are among those specifically listed as circumstances qualifying for the adjustment under HCFA Pub. 15-1 ' 2810.1.A which refers to Ainability to recruit essential physician staff, . . . serious and prolonged economic recessions, . . . or similar occurrences with substantial cost effects.@

The Provider also contends that the Intermediary denied the requested adjustment, based upon its dissatisfaction with the speed at which the Provider had managed to adjust its staffing in the face of previous volume declines. The Provider notes that it struggled to improve the availability of physician services, as described above, while at the same time it took measures to reduce its staff.

Specifically, the volume decline of 5.05% in FY 1994 followed other substantial drops in volume that began two years earlier. Recognizing the need to control costs, the Provider engaged the services of both Ernst & Young (AE&Y@)and Watson & Wyatt Worldwide to assist in identifying, reducing, and controlling expenses. The Provider=s witness testified that beginning in 1991 Aa very aggressive

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[10] Tr. at 104 and 106.

[11] Tr. at 137-138.

[12] Provider Exhibit XXIII.

[13] Provider Exhibit XXX.

voluntary early retirement program@ was established as one means of controlling labor costs as volume declined.[14] When this effort did not sufficiently reduce staffing, the Provider carried out a layoff of an additional 29 employees in October 1993 (FY 1994). Through a combination of efforts over time, substantial reductions in staffing were achieved. In total, from FY 1992 through 1995, volume fell 34% and Full Time Equivalents (AFTEs@) were reduced 28%. In summary, the Provider argues that it reduced staff as expeditiously as possible, consistent with maintaining an effective workforce to meet its Sole Community Hospital obligations.

The Provider further contends that its requested adjustment was correctly computed in accordance with the methodology prescribed by HCFA. HCFA Pub. 15-1 '' 2810.1 C. 6 and 2810.1. D provide for an analysis of an applicant=s Acore staffing@ requirements, using the Hospital Administrative Services (AHAS@) Monitrend Data Bank accumulated by the American Hospital Association. If the actual FTEs in the year of the volume decline are greater than the HAS Monitrend peer data, the staffing in excess of peer group FTEs must be subtracted from costs in the relevant cost centers. Once excess salary costs are eliminated the cost report is re-run, generating a new Program Inpatient Operating Cost that is the basis for the payment adjustment. The Provider contends that its application corresponds to Example B in HCFA Pub. 15-1 ' 2810.1. C. 6 wherein it used the same cost centers (Adult and Pediatric and ICU), calculated core staffing (using 1988 HAS data), and determined a cost reduction based on an excess of Adult and Pediatric FTEs above the HAS Monitrend level. The cost report was than re-run to calculate the requested adjustment.[15]

The Provider finally contends that the Intermediary incorrectly arrived at the conclusion that an adjustment was not warranted by using an improper computation methodology. The Intermediary made adjustments to the Provider=s FY 1993 Program Inpatient Operating Costs to reflect the Intermediary=s opinion that a certain level of cost reductions should have been made in that earlier period. These adjustments to a prior year are not consistent with the HCFA Manual instructions, and require the Provider to compare itself to a cost level that only the Intermediary believes could have been achieved. This rationale creates an impossible performance standard and is inconsistent with the underlying rationale expressed by HCFA in adopting the Sole Community Hospital adjustment rule in 1983.

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[14] Tr. at 94-99.

[15] Applying the upper limit on the adjustment pursuant to HCFA Pub. 15-1 ' 2810.1.D reduced the original requested amount of $434,209 to the mutually agreed to contested amount of $357,624.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that there are at least five impediments to an award of a volume adjustment in this case. They are as follows:

1. Failure to furnish sufficient reliable and creditable documentation required under the applicable Medicare regulations and Program Instructions.

The Intermediary contends that the Provider failed to use current data as required by 42 C.F.R. '' 413.20 and 413.24, as well as Program instructions found at HCFA Pub. 15-1 ' 2810.1. C. 6. The use of 1988 Monitrend data should not be acceptable when both parties are aware of the existence of Monitrend data for 1993.[16] In that the Provider failed to use the current Monitrend data, the Intermediary used the Provider specific 1992 (E&Y) report as the best available data source.[17]

2. Failure to prove that discharges declined due to circumstances beyond the Provider=s control, and that adequate measures to address the effects of the decline were beyond the Provider=s control.

First, the Intermediary contends that the Provider did not contemplate making any immediate layoffs even upon noting a drop in discharges of 21% in FY 1992, following an overall decline in discharges of 15.88% since 1985. The Provider did not implement its Voluntary Employee Retirement Plan (AVERP@) until 1993, and even then its most positive effects are on long term costs.[18] No layoffs were instituted until well into FY 1994, during which time the discharges dropped another 9% from the prior FY.[19] The Provider did not reach the E&Y target mean staffing level until the end of FY 1995; some three years after the E&Y report. By that time, discharges had fallen another 13.09%.[20]

The Intermediary contends that reasonable actions to make necessary cost reductions were not made in a reasonable period of time. Had the problem occurred over a short period of time, the outcome of the Provider=s request might have been different. However, the Provider did not take necessary action

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16 Tr. at 178-180, 206 and 250-251.

17 Tr. at 241.

18 Tr. at 122-123.

19 See Intermediary Exhibit I-16.

20 Id. Also, Tr. at 288.

although the period of decreased utilization continued since 1985. The Intermediary points to HCFA Pub. 15-1 ' 2810.1. B as the requirement for a provider to respond timely. It states that:

> [i]n evaluating semifixed costs, the intermediary considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs are considered fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses. Therefore, if a hospital did not take such action, some of the semifixed costs may not be included in determining the amount of the payment adjustment.

HCFA Pub. 15-1 ' 2810.1.B

Second, the evidence shows that a shift in the delivery of health care services from inpatient to outpatient settings was a major factor for the decline in discharges. The Provider=s witness testified that the hospital was actually pursuing an outpatient strategy.[21] Documentary evidence indicated that every lost Medicare inpatient discharge was matched by new Medicare outpatient visits, as the total Medicare revenue remained relatively constant.[22]

Third, the Intermediary observed from the testimony at the hearing that the Provider had demonstrated a difficulty in recruiting essential physicians, but not an inability to recruit which would serve to endanger or compromise patient care.[23] Therefore, one of the potential circumstances (inability to recruit essential staff) for which an adjustment may be granted, as per HCFA Pub. 15-1 ' 2810.1. A.1, was not met. In addition, the Provider did not introduce any evidence that it was unable to provide essential medical services. The Provider continued to treat all manner of illnesses and conditions throughout the 1993-1994 period with no noticeable effects on patient care.[24]

Finally, the Intermediary contends that the Provider did not introduce any specific evidence linking an economic recession in the area to a direct impact on its admissions. While the HCFA guidelines at HCFA Pub. 15-1 2810.1.A.1 provide for a volume adjustment based on Aserious and prolonged economic recessions that have a direct impact on admissions@, the Intermediary contends that the Provider=s demonstration showing a disparity in per capita personal income between the Provider=s county and the rest of Maine does not adequately document a recession.

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[21] Tr. at 55 and 57-58.

[22] See Intermediary Exhibit I-27.

[23] Tr. at 124-125, 246, 292-293 and 318.

[24] Tr. at 125.

3. Failure to justify a staffing level above its consultant=s suggested mean.

The Intermediary contends that the Provider had the E&Y study as of June 15, 1992, which recommended a target mean staffing level of 171.95 FTEs. Since the Provider had over one year to make necessary cost reductions, the Intermediary contends that it was correct to reduce the Provider to the E&Y target mean staffing level for 1993. It then added the required inflation factor to arrive at a reasonable and necessary non-capital cost for FY 1994. Since the resulting figure was lower than both the actual allowable non-capital cost for FY 1994 and the DRG payments, the Provider was not entitled to the volume adjustment.

4. Failure to justify a need for more than the Aminimum@ core staff suggested by the consultant.

The Intermediary points out that it gave the Provider the benefit of the doubt by using the target mean level in its analysis. It contends that it had a strong case for using the target low or minimum staffing level, in as much as those levels still represented enough FTEs to run the facility safely and effectively.[25] Of course, using the target low level would show that any Provider volume adjustment is even less warranted.

5. Failure to properly interpret Medicare instructions in analyzing entitlement to the volume adjustment.

The Intermediary contends that the Provider erred in its analysis. First, the Provider compared its staffing levels to a benchmark in only two cost centers instead of all cost centers affecting inpatient costs. The Intermediary indicates that HCFA Pub. 15-1 ' 2810.1.C.6 states in part:

> Core Staff and Services.-- A comparison by cost center, of full-time equivalent employees and salaries in both cost reporting periods must be submitted. The requesting hospital must identify core staff and services in each center and the core of these staff and services. The request must include justification of the selection of core staff and services including minimum staffing requirements imposed by any external source. The intermediary=s analysis of core staff is limited to those cost centers (General Service, Inpatient, Ancillary, etc.) whose costs are components of Medicare inpatient operating cost.

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[25] Tr. at 283, 285 and 287.

The Intermediary followed this instruction by making comparisons between the E&Y target mean and actual FY 1993 Provider staffing in 22 cost centers.[26] However, the Provider=s calculations only involved comparisons in two cost centers even though both the Provider and Intermediary witnesses testified that other cost centers did impact on inpatient costs.[27]

Second, the Intermediary contends that HCFA Pub. 15-1 ' 2810.1.B. requires that prior year circumstances and trends be reviewed in determining whether and how much of a volume adjustment is warranted. It states in part that:

> in evaluating semifixed costs, the intermediary considers the length of time the hospital has experienced a decrease in utilization. For a short period of time, most semifixed costs are consider fixed. As the period of decreased utilization continues, we expect that a cost-effective hospital would take action to reduce unnecessary expenses.

HCFA Pub 15-1 ' 28101.1.B.

The Intermediary contends that it was merely carrying out the mandate of the HCFA instructions in looking at the period of decreased utilization, which in the instant case spanned several years. Since the Provider had sufficient time to make significant cost reductions but failed to do so, the Intermediary did not include some of the semifixed costs in determining the amount of the payment adjustment. Specifically, the Intermediary adjusted 1993 costs to remove the semifixed costs that were unnecessarily incurred.[28]

Based on these factors, the Intermediary concludes that the Provider=s request for a volume adjustment is without merit.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Social Security Act:

' 1886(d)(5)(D)(ii) - Sole Community Hospital Volume Adjustments

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[26] See Intermediary Exhibit I-14.

[27] Tr. at 183 and 218-219.

[28] Tr. at 220-221 and 249.

2. Regulations - 42 C.F.R.

'' 405.1835.-1841	-	Board Jurisdiction
' 412.92(e) et. seq.	-	Special treatment- Sole community hospital
' 413.20	-	Financial data and reports
' 413.24	-	Adequate cost data and cost finding

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

' 2810.1	-	Additional Payments to SCHs that Experience A Decrease In Discharges
' 2810.1.A	-	Criteria for determining eligibility for additional payments
' 2810.1 A.1	-	Circumstances beyond the hospital=s control
' 2810.1.B.	-	Amount of payment adjustment
' 2810.1.C.	-	Requesting additional payments
' 2810.1C.6 et seq.	-	Core staff and services
' 2810.1.D.	-	Determination on requests

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

The Board, after consideration of the controlling laws, regulations, and program instructions, facts, parties= contentions, evidence in the record, and the testimony at the hearing, finds and concludes that the Provider is entitled to the additional payments that it requested for a volume decline it experienced in its fiscal year ending June 30, 1994.

The Board finds that the Provider is a Sole Community Hospital (ASCH@) and has been since 1979. In reviewing financial data in the record, the Board notes that the Provider was profitable up to and including 1991. However, in 1992, 1993, and 1994, the hospital lost $1.0 million, $2.2 million, and $.7 million, respectively. When discharges decreased by 20.63% in FY 1992, hospital management reacted by decreasing FTE staff by 14.54%. Similarly, decreases in discharges of 9.06% in FY 1993 and 5.05% in FY 1994 were followed by FTE reductions of 7.62% and 6.99%, respectively.

The Board finds that the purpose of the adjustment to payment amounts allowed under Section 1886(d)(5)(D)(ii) of the Social Security Act is to fully compensate a SCH for fixed costs incurred in providing services, including the cost of maintaining necessary core staffing services during a cost reporting period in which it experiences a decline in the total number of inpatient discharges. Specifically, the regulation at 42 C.F.R. ' 412.92(e) specifies that the hospital must experience a more than 5% decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. The provider must also show that the decrease is due to circumstances beyond the provider=s control.

The Board finds that in the instant case the 5% decrease criteria is not in dispute. With regard to the second criteria, the Board finds significant evidence that the circumstances were beyond the Provider=s control. There is considerable evidence to indicate that the loss of three key physicians accounting for 44% of discharges had a significant impact on the Provider. This was followed by aggressive attempts to recruit physicians to the area, which included the use of a professional recruiting organization. The Rumford area was also designated as a health professional shortage area. In fact, the Maine HealthCare Finance Commission recognized the difficulty in obtaining physicians in approving the Provider=s application to form a group practice affiliate.

The Board finds that, based on these factors, the Provider meets the criteria of 42 C.F.R. ' 412.92(e) in that the circumstances surrounding the Provider=s discharges were beyond its control.

The Board finds that the Intermediary analysis/computations surrounding the denial of the Provider=s request were problematic and without merit. The Board notes that the HCFA instructions state that the Provider Inpatient Operating Costs for the cost reporting period for which the payment is requested, in this case FY 1994, must be adjusted to the extent they reflect staffing in excess of core staffing requirements. Each year is to stand on its own wherein a separate request, comparison and analysis is required. In the instant case, the Intermediary did not comply with the implementing manual instructions of HCFA Pub. 15-1 ' 2810.1. It denied the proposed request by superimposing its judgement that a certain level of cost reductions should have been made by the Provider in earlier years. Using that rationale, the Intermediary adjusted FY 1993 operating costs for various amounts it deemed to be excessive. The resulting amounts were trended forward and used as basis for contending that Medicare reimbursements in FY 1994 were adequate without the adjustment sought by the Provider.

The Board also finds that there were two sets of data in the record regarding FTE labor standards; the 1988 HAS Monitrend peer group data, and the Provider=s own productivity study from 1992 prepared by (E&Y). The instructions at HCFA Pub. 15-1 ' 2810.1.C.6. a provide for the use of the Monitrend data which was, in fact used by the Provider in its adjustment request. The Intermediary argued that since more recent Monitrend data for 1993 may have been available, but not used by Provider, it was proper to use the more current E&Y data as a substitute. Testimony at the hearing revealed that reasonable inquiries were made relative to the use of the 1988 data and the availability of the 1993 Monitrend data. In addition, the Intermediary was unable to secure the 1993 Monitrend data. In that the 1993 Monitrend data is not in the record, there is no basis for comparison with the E&Y study data advocated by the Intermediary. Secondly, the Board notes that the Intermediary proposes to use the E&Y data to modify the FY 1993 cost report period and trend those results to FY 1994.

The Board finds that the inability to verify the accuracy of the E&Y data as well as its improper application nullifies its usage. The Board also notes that subsequent to the hearing, the Provider filed a motion to enter new calculations relating to the adjustment amount into the record. The Board finds this information to be untimely, and will not consider it in the Board=s decision. Therefore, the Board further finds that the best evidence in the record is the 1988 Monitrend data.

The Board finds that there is no basis in either 42 C.F.R ' 412.92 or HCFA Pub. 15-1 ' 2810.1 to support the Intermediary=s contention that the Provider did not act promptly enough in addressing its staffing level. Nor is there any support for the Intermediary to adjust FY 1993 data and trend it forward to the year in issue. The Intermediary also contended that the Provider should have applied staffing data to all affected cost centers, rather than the two used by the Provider (Adults/Pediatric & ICU). The Board notes that the Provider used two cost centers, as set forth in the example found in the HCFA manual instructions. The available Monitrend data did not produce data on other cost centers. Nor did the Intermediary determine the impact of the Provider not using all cost centers in its adjustment computation. In fact, the use of all cost centers may result in an even greater volume adjustment than that requested by the Provider. In view of these factors, the Board finds the Provider=s computation to be the most accurate.

DECISION AND ORDER:

The Intermediary=s decision denying the Provider=s volume adjustment was improper. The Intermediary=s decision is reversed and the Provider is granted an additional payment for its FY 1994 year of $357,624.

Board Members Participating:

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

Date of Decision: September 28, 2000

For The Board

Irvin W. Kues
Chairman