PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D14

PROVIDER -
Olive View Medical Center
Sylmar, CA

Provider No. 05-0040

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
United Government Services, LLC -CA

DATE OF HEARING-
April 19, 2001

Cost Reporting Periods Ended -
June 30, 1992 and June 30, 1993

CASE NOS. 94-3354 and 95-1196

INDEX

ISSUE:

Was the Intermediary and Center for Medicare and Medicaid Services ("CMS," formerly the Health Care Financing Administration) denial of the Provider's request for a change in its base period for purposes of the TEFRA rate of increase ceiling for its PPS-exempt psychiatric unit in the fiscal years ending ("FYE") June 30, 1992 and June 30, 1993 proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Olive View Medical Center (the "Provider") is a general acute care hospital owned and operated by the County of Los Angeles ("County"). The Provider has a psychiatric unit that is exempt from reimbursement under the Prospective Payment System ("PPS") and is reimbursed under the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248 ("TEFRA") target rate limits. On May 1, 1995[1] the Provider sought both a rebasing of the rate for its exempt unit and an exception to the TEFRA target rate. Blue Cross of California (the "Intermediary") and CMS reviewed the request and on March 3, 1998 CMS approved an exception but denied the rebasing request.[2] The Provider filed a timely appeal of the denials and has met the jurisdiction requirements of 42 C.F.R. §§ 405.1835-.1841. The Medicare reimbursement at issue for both fiscal years is approximately $250,000.

a. Medicare Statutory and Regulatory Background

From the Medicare program's inception in 1966 until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. § 1395f(b)(1); see generally Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993). The statute at 42 U.S.C. § l395x(v)(1)(A) defines reasonable costs as "the costs actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services." Congress ultimately amended the reasonable cost payment system because it was concerned that while being reimbursed the reasonable costs of covered services, providers had no incentive to provide services efficiently or otherwise limit their costs. Congress first modified the law by enacting 42 U.S.C. § 1395ww(a), which established limits on operating costs and authorized the Secretary of the Department of Health and Human Services ("Secretary") to promulgate regulations to establish prospective limits on the costs recognized as reasonable in furnishing patient care. One of the regulations the Secretary promulgated to provide such limits on cost reimbursement was 42 C.F.R. § 413.30.

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[1] Intermediary Exhibit 7.

[2] Intermediary Exhibit 8.

In 1982, Congress enacted TEFRA, again modifying the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. TEFRA imposed a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. The TEFRA ceiling amount, or target amount, is calculated based upon the allowable Medicare operating costs in a hospital's base year (net of certain other expenses including capital and medical education costs) divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually based on an inflation factor. If a provider incurs costs below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement for its reasonable costs plus an additional incentive payment. Because the TEFRA target amount serves as a ceiling, a provider may not be reimbursed for its costs above the applicable TEFRA target amount for a particular year. The regulation implementing TEFRA, 42 C.F.R. § 413.40, establishes the procedure and criteria for providers to make requests to CMS for exemptions and adjustments to the rate-of-increase ceiling amount.

In 1983, Congress enacted the Social Security Amendments, P. L. No. 98-21, which created PPS for hospital operating costs. After the implementation of PPS, only providers and units within providers exempt from PPS that continued to be paid under the reasonable cost system were subject to the TEFRA rate-of-increase limit. In this case, the Provider's inpatient psychiatric unit, exempt from PPS, continues to be subject to TEFRA and its rate-of-increase limit.

Congress, in 42 U.S.C. § 1395ww(b)(4)(A), authorized the Secretary to assign a hospital a change in base period for TEFRA purposes when a new base period would be "more representative of the reasonable and necessary cost of inpatient services . . . ." Pursuant to that statute, the Secretary promulgated a regulatory process at 42 C.F.R. § 413.40(i) for changing the base period for cost reporting periods beginning on or after April 1, 1990. In determining whether to award a new TEFRA base period under 42 C.F.R. § 413.40(i), CMS must determine whether the proposed new base period is "more representative of the reasonable and necessary cost of furnishing inpatient services" than the existing base period. In making this determination, all of the following conditions must be satisfied: 1) the actual allowable inpatient costs of the hospital in the cost reporting period that would be affected by the revised ceiling exceed the TEFRA target amount; 2) the hospital documents that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base period; and 3) the TEFRA adjustment process would not result in the recognition of the reasonable and necessary cost of providing inpatient services. Id. In evaluating whether a provider has established that the higher costs are the result of substantial and permanent changes, HCFA may consider, among other things: i) changes in the services provided by the hospital; ii) changes in applicable technologies and medical practices; and iii) differences in the severity of illness among patients or types of patients served. Id.

If a provider is awarded a new TEFRA base period, the new base period is the first twelve month cost reporting period that reflects the substantial and permanent change in the provider's operations. 42 C.F.R. § 413.40(i)(2). The revised TEFRA limit will be based on the necessary

and proper costs incurred during this new base period. Id.

b. Facts and Procedural History

In 1965 the County began to construct a new facility in Sylmar, California. This new 888-bed, 650,000 square foot facility was opened in October 1970.[3] At 6:00 a.m. on the morning of February 9, 1971 an earthquake with a magnitude of 6.5 on the Richter Scale hit Los Angeles County.[4] The new facility, located less than two miles from the epicenter, was severely damaged. The extensive damage caused the Provider to abandon and demolish the entire facility.[5]

Immediately after the earthquake the Provider's patients were transferred to LAC/USC Medical Center and San Fernando Community Hospital.[6] As a longer term solution and in order to provide services while the new facility was being replaced, the Provider took up temporary residence in a facility in Van Nuys, California near the end of 1971. Known as Mid-Valley, this building was the Provider's primary campus during FYE June 30, 1985, the Provider's base period for TEFRA reimbursement purposes.

Mid-Valley was approximately 120,000 square feet and licensed for 113 beds.[7] At the time Mid-

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[3] Tr. at 55.

[4] Tr. at 56.

[5] Tr. at 58.

[6] Tr. at 63.

[7] Tr. at 69.

Valley was acquired, it was not licensed to provide inpatient psychiatric care. In response to the inability to provide inpatient psychiatric care at Mid-Valley, the County "leased" 22 psychiatric beds from San Fernando Community Hospital and LAC/USC Medical Center.[8] The Provider's arrangement to lease psychiatric beds eventually became insufficient to satisfy the needs of the community. As a result, the County converted part of a unit at the Mid-Valley facility into an inpatient psychiatric ward.[9] Counting the inpatient psychiatric ward at Mid-Valley and the leased psychiatric beds, the Provider was operating approximately 50 PPS exempt psychiatric beds in 1985, the base year for TEFRA purposes.[10]

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[8] Tr. at 70.

[9] Id.

[10] Tr. at 71.

The County found that Mid-Valley, with only 113 acute care beds and a limited psychiatric unit, was simply too small to serve as a permanent solution to the problem created by the destruction of the Olive View facility in the 1971 Sylmar earthquake.[11] As a result, while treating patients at Mid-Valley, the County was working to build a new hospital to replace the facility destroyed in the earthquake.[12] Despite numerous obstacles, hurdles and delays, the construction of the new facility was completed and the first patient was admitted for treatment on May 9, 1987.[13]

The Provider filed a timely request that its base period under TEFRA be changed from FYE June 30, 1985 to FYE June 30, 1988 for its FYE June 30, 1992 on September 20, 1994. On May 1, 1995 the Provider timely submitted a second request that its TEFRA base period be changed from FYE June 30, 1985 to FYE June 30, 1988 for its FYE June 30, 1993. The Provider submitted these requests because it believed that FYE June 30, 1985 was not representative of the reasonable and necessary costs of rendering inpatient psychiatric care at the permanent rebuilt facility; because during its FYE June 30, 1985 base year, the Provider was operating out of the temporary, inadequate Mid-Valley facility. The Provider believed that FYE June 30, 1988, the first full cost reporting year following the move to the permanent replacement facility, was much more representative of the costs of providing inpatient psychiatric care.

CMS did not rule on either the Provider's FYE June 30, 1992 or FYE June 30, 1993 requests for a change in its TEFRA base period within the 180 day time limit established by Congress in 42 U.S.C. § 1395ww(b)(4)(A)(i). On March 3, 1998, nearly 3 years after the Intermediary filed its recommendations with CMS, CMS denied the Provider's requests. In its denial letter, CMS seemed to indicate that part of the reason the rebase requests were denied was because the Provider, a County run public hospital, did not rebuild quickly enough after the Sylmar earthquake. The Provider preserved this issue by making TEFRA loss a part of its FYE June 30, 1992 appeal by letter to the Provider Reimbursement Review Board ("Board") dated September 21, 1994 and by making TEFRA loss a part of its FYE June 30, 1993 appeal by letter to the Board dated February 27, 1995.

The Provider was represented by Jon P. Neustadter, Esquire, and Hope R. Levy-Biehl, Esquire, of Hooper, Lundy and Bookman, Inc. The Intermediary was represented by Bernard M. Talbert,

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[11] Tr. at 69.

[12] Tr. at 73-74.

[13] Tr. at 102.

Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that this is not a typical case in which a provider has requested a change in its TEFRA base period. In a typical rebase case, a hospital requests a new TEFRA base period because of a change within the PPS exempt unit that has the effect of dramatically increasing the costs in the unit. The Provider believes that in this case, unlike a typical rebase case, there was an unforeseen, unexpected *force majeure* that dramatically impacted both the Provider's PPS exempt psychiatric unit as well as the entire hospital. As a result, the Provider contends that in order to analyze the Provider's request properly, the Board should look at the substantial and permanent changes to the entire Olive View facility between the fiscal years ending in 1985 and 1988 in order to understand why it is patently unreasonable to equate the costs in Olive View's psychiatric unit in FYE June 30, 1992 and June 30, 1993 with the costs incurred in the psychiatric unit during the existing FYE June 30, 1985 base year.

The Provider contends that it has satisfied each of the regulatory requirements for the award of a new base period. First, the Provider believes it has established, through a number of different cost comparisons (including an analysis of the averaged TEFRA losses and costs per discharges in the years prior to and subsequent to the move), that FYE June 30, 1988 is much more representative of the reasonable and necessary costs of furnishing inpatient services in Olive View's psychiatric unit in the years following the move to the permanent facility than the existing FYE June 30, 1985 base year.[14] The Provider also contends it has established that its actual allowable inpatient costs in the psychiatric unit in each of the FYEs June 30, 1988, June 30, 1992 and June 30, 1993 exceeded the TEFRA target amount.

Next, the Provider contends that its higher costs were the result of substantial and permanent changes in furnishing patient care services since the FYE June 30, 1985 TEFRA base period. Towards this end, the Provider contends that it experienced a number of substantial and permanent changes in services, changes in the applicable technologies and differences in the severity of illness of patients following the move to the permanent facility. On the most basic level, the Provider contends that the permanent facility bears little or no resemblance to the temporary facility being occupied during the FYE June 30, 1985 base year in terms of size, number of beds or types or scope of services rendered.

The Provider believes that the permanent facility offered a number of services not offered nor capable of being offered at the temporary facility during the TEFRA base year, including a comprehensive maternity and newborn service (including labor and delivery rooms, birthing rooms, a neonatal intensive care unit and prenatal assessment services), an emergency room capable of receiving 911 paramedic ambulance transports as well as a number of additional, more sophisticated ancillary, diagnostic and treatment modalities, just to name a few. The

[14] Provider's Post Hearing Brief Exhibit 2.

Provider contends that the permanent facility also had more advanced equipment and technologies, including an on-site electrical plant and other mechanical systems not available at the temporary facility. As for the psychiatric unit, the Provider contends that it also experienced significant changes following the move to the permanent Olive View facility, including the addition of a 12-bed adolescent psychiatric service, a larger staff and enhanced psychiatric emergency services.

The Provider contends that each of these changes, as well as the more global change of moving to the larger, more sophisticated, more advanced permanent facility, had a direct impact on the quality and type of patient care services available to its patients both at the Hospital and psychiatric unit level. For example, at the permanent facility the Provider contends it was able to treat more acutely ill patients, including multiple diagnosis psychiatric patients with coextensive medical problems. The Provider contends that at its new facility it was able to admit adolescent psychiatric patients as well as patients suffering from emergency psychiatric episodes from its emergency room. The Provider also asserts that it was able to offer its inpatient psychiatric patients a host of other services not capable of being offered at the temporary facility during the current TEFRA base year, including newborn and maternity services and more sophisticated ancillary, diagnostic and treatment services.

Ultimately, the Provider contends that these changes, taken together, evidence the substantial and permanent changes in furnishing patient care services following the move to the permanent facility in 1987 that justify the award of a new base period. Furthermore, the Provider contends that the direct result of the addition of these services and technologies and the ability to treat more acutely ill patients following the move was an increase in the cost of operating the Hospital as a whole as well as the psychiatric unit. For example, the Provider believes that as a result of the move, the costs of operating, maintaining and repairing the Hospital increased. The Provider also contends that as a result of the move, certain direct costs increased, including the direct costs in the psychiatric unit associated with offering the new adolescent ward and the associated increase in staffing. The Provider contends that it is this direct connection between the substantial and permanent change of moving to the permanent facility (and the associated changes in services, technologies and patient mix) and the increase in Hospital and psychiatric unit operating costs that warrants a change in its TEFRA base period in this case.

The Provider further contends that the existing TEFRA adjustment process did not result in the recognition of its reasonable and necessary cost of providing inpatient psychiatric services. The Provider believes it has established that in each of the fiscal years ending in FYE June 30, 1988, June 30, 1992 and June 30, 1993, it was granted various adjustments to the TEFRA limit but nonetheless, in each year its allowable inpatient psychiatric costs continued to exceed the TEFRA target amount. The Provider asserts that by virtue of the extraordinary conditions under which it was operating during FYE June 30, 1985 (including operating out of a split facility with leased psychiatric beds located off campus), it was impossible for it to obtain meaningful relief from the TEFRA limit adjustment process. The Provider contends that despite these challenges, its costs in excess of the TEFRA limit following the grant of various TEFRA adjustments in FYE June 30, 1988, June 30, 1992 and June 30, 1993 were the reasonable and necessary costs of

providing inpatient psychiatric care at the new facility, as evidenced by the numerous opportunities the Intermediary had to audit these costs and coupled with the reasonableness of the costs when compared with the costs incurred by other similarly situated inpatient psychiatric units.

The Provider further contends that the fact that the reasonable and necessary costs of the new facility's psychiatric unit continued to exceed the TEFRA limit following the application of the TEFRA limit adjustments provides further evidence of the sheer impropriety of using the existing FYE June 30, 1985 TEFRA base period for purposes of evaluating the reasonableness and reimbursability of the post-move costs in the Provider's psychiatric unit.

Next, the Provider contends that CMS' March 3, 1998 denial of the Provider's rebase request was poorly reasoned and insufficient in light of the Provider's clear satisfaction of the regulatory requirements for the award of a new base period. The Provider believes CMS' March 3, 1998 denial evidences a few possible rationales. First, CMS seems to challenge whether the provision of services at the temporary site was, in fact, temporary. In addition, CMS also seems to question the length of time it took the County to rebuild the destroyed facility. The Provider contends that both of these assertions are baseless and otherwise insufficient to deny the Provider's request for a new base period. First and foremost, as outlined above, the Provider contends that it has satisfied each of the regulatory requirements for a change in base period. Furthermore, the Provider contends that it offered extensive testimony at the hearing that established, beyond any doubt, that from the very beginning, Mid-Valley was always considered a temporary solution to the problem of the destruction of the original facility by the Sylmar earthquake and was simply too small and limited a facility to ever be viewed as a permanent replacement facility. The Provider also contends that the delay in completing the permanent facility was completely justified. The Provider believes that the fifteen year process of rebuilding its facility was perfectly reasonable in light of cost of the project and the extensive obstacles the County had to face, including its struggles in obtaining an adequate Federal disaster relief grant, the ensuing difficulty in securing sufficient financing, the passage of Proposition 13 in California, as well as the County's ongoing attempt to build a replacement facility that satisfied the needs of the San Fernando Valley while also being guided by sound health policy.

Ultimately, the Provider notes that in determining whether to grant a new TEFRA base period in this case, the Board should look to the requirements outlined in the regulation and not be unduly influenced by other extraneous factors highlighted by the Intermediary in an attempt to muddy the rebase analysis. Specifically, the Provider contends it is inappropriate to rely extensively on the cost per Medicare discharge figures from FYE June 30, 1988 through FYE June 30, 1993 to the exclusion of the factors specifically enumerated in the regulation as determinative of whether a new base period should be granted. The Provider contends that there are significant problems with relying on the utilization of the psychiatric unit, the Medicare cost per discharge figures or simply the costs in the psychiatric unit in a vacuum without also evaluating the larger context of the substantial and permanent nature of the move to the permanent facility and its impact on the types of services and care provided both at the Hospital and psychiatric unit level. The Provider contends that the variation in its cost per discharge figures can be explained (and was explained

at the hearing), and that this explanation, coupled with a detailed analysis of the requirements and factors outlined in the governing regulation, mandate a finding that FYE June 30, 1988 is more representative of the reasonable and necessary costs of providing care in the permanent PPS-exempt psychiatric unit following the move than the existing FYE June 30, 1985 TEFRA base period. For each of these reasons, the Provider contends that it was inappropriate for the Intermediary and CMS to deny its requests for a new TEFRA base period in the fiscal years ending on June 30, 1992 and June 30, 1993.

The Provider further contends that if it is awarded a new base period for TEFRA purposes, the new base period must be FYE June 30, 1988, the first twelve month cost reporting period following the substantial and permanent change in the Provider's operations as a result of the move to the permanent facility. The Provider also contends that the new TEFRA limit for FYE June 30, 1988 should include both the direct and indirect costs of providing patient care in its psychiatric unit. The Provider believes this is absolutely necessary, since both the direct and indirect costs of operating the psychiatric unit at the new facility were impacted by the substantial and permanent change of moving to the permanent, larger, more sophisticated facility in 1987 and the resulting changes in furnishing patient care. The Provider further contends that it makes perfect sense to include both the direct and indirect costs of furnishing inpatient psychiatric services when calculating the new TEFRA base period for FYE June 30, 1988, since both the direct and indirect costs of the facility's psychiatric unit were included in the initial calculation of the current FYE June 30, 1985 base year. The Provider also believes that the Provider Reimbursement Manual, Part I ("CMS Pub. 15-1") § 3005.3 does not impact on whether the new TEFRA limit should include direct and indirect costs, because it is both inapplicable to the fiscal years at issue in this appeal and in violation of the Administrative Procedure Act. In fact, the Provider notes that the Intermediary's own attorney conceded that to the extent a new base period is granted, both the direct and indirect costs in the Provider's psychiatric unit in FYE June 30, 1988 should be included in the calculation of the new limit base.

Lastly, to the extent the Board assigns FYE June 30, 1988 as the Provider's new base period, for each subsequent year in which the Provider has a cost report that has not been finalized and that is subject to reopening, the Provider contends that the Intermediary must recalculate a new TEFRA target amount. The Provider contends that for all the foregoing reasons, the Board should order CMS and the Intermediary to grant the Provider a change in its TEFRA base period from FYE June 30, 1985 to FYE June 30, 1988.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that CMS' denial of the Provider's request for a new base period was justified. The Intermediary contends that, although the Provider has established that it moved to a larger facility in 1987 and that the costs in its psychiatric unit were higher during FYE June 30, 1988, it nonetheless failed to satisfy the regulatory requirements for the award of a new TEFRA base period.

The Intermediary also contends that the Provider's move to the permanent facility was not the cause of the increase in costs of operating the inpatient psychiatric unit. The Intermediary believes that because the cost per discharge in the Provider's psychiatric unit rose in FYE June 30, 1988 but dropped slightly in the subsequent cost reporting years, the move to the permanent facility was not responsible for the increase in costs in the psychiatric unit. The Intermediary contends that because the increase in costs in the Provider's psychiatric unit did not consistently go up and up in every year after 1987, it was appropriate to deny the Provider's request for a new TEFRA base period in this case.

The Intermediary notes that after exceptions were granted, the Provider's operating costs still exceeded its TEFRA target. For fiscal periods starting after April 1, 1990, the regulation at 42 C.F.R. § 413.40(i) created a new remedy for providers adversely affected by the TEFRA target limit. The new remedy was to have the target rate recalculated from a new base period. The prior existing remedies of exemptions and adjustments stayed in place. To obtain relief from costs lost due to the application of the TEFRA target in FYEs June 30, 1992 and June 30, 1993, the Provider requested that June 30, 1988 be designated its base period. The Provider's changing of physical plants triggered the request. CMS denied the request.

CMS' denial letter gave the following description of the Provider's request:[15]

> OVMC [Olive View Medical Center] lost its facility to an earthquake in 1971 and was relocated to another facility that the provider refers to as "temporary." The provider also was leasing psychiatric beds at another location when the psychiatric unit became certified as a Medicare excluded unit making FY 1985 the base year period. In FY 1987, the provider moved to a "permanent" facility which the provider asserts substantiates a new base period in FY 1988.

CMS' denial letter addressed these concerns a follows:[16]

> We are denying the request for a new base year period. Although the provider describes its location during the FY 1985 base period as "temporary," hospital services had not been rendered in the destroyed facility for 14 years. In FY 1987, the provider moved to a new and larger facility, added a new adolescent ward, and altered services. These changes may distort the costs in the base year as

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[15] Provider Position Paper Exhibit 8, Paragraph 2.

[16] Id. at Paragraphs 3 and 4.

> compared to FY 1992 and FY 1993, but they are not justification for a new base year. Although the costs in FY 1992 and FY 1993 may have increased when compared to the base period, the adjustment process of 42 C.F.R. § 413.40 is not required to reimburse all costs over the target amount in order for it to be the appropriate avenue to address cost distortions.
>
> Moving to a larger facility and/or increasing bed capacity are not considered justification for a new base year nor, for that matter, an adjustment. It is expected that when a facility expands its capacity, cost increases should be offset by increased utilization. Moreover, adding an adolescent ward should result in minimal impact on Medicare utilization. We have, however, recognized the increased financial burden of moving to a new facility because of the destruction of the Provider's original facility under extraordinary circumstances, and agree with your calculation of an adjustment for start-up costs at Exhibit 6 of $7,214 for FY 1992 which is the last year qualifying for the amortized start-up costs.

The Provider interpreted CMS' characterization as being critical of the time it took to open the new physical plant, until 1987, after the 1971 earthquake ended the life of the earlier plant shortly after it opened. The Provider operated in what was clearly viewed as a temporary set-up during the 16-year period.

The statement in the CMS letter was not intended to criticize the Provider and the process. The Provider presented testimony and exhibits about the political processes involved in replacing the destroyed hospital building to explain the time lag. As fascinating as the narration was, the explanation is not relevant.

The primary CMS point was that the request for a new base period as a result of the move was rejected because there was no demonstrated correlation between alleged new and higher costs in 1987 and 1988 due solely to the move and any TEFRA overruns in 1992 and 1993. Instead, a cold-blooded review of financial performance during relevant time periods rebuts any cause and effect argument.

The Intermediary refers to the new base period relief as follows:

> 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 of the hospital in the cost reporting period that would be affected by the revised ceiling exceed the target amount established under paragraph (c) of this section.

(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 exception and adjustments described in paragraph (g) and (h) of this section would not result in recognition of the reasonable and necessary costs of providing inpatient services.

(ii) The revised ceiling will be based on the necessary and proper costs incurred during the new base period. Increases in overhead costs (for example, administrative and general costs 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.

(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) New applicable rate of increase percentages. The revised ceiling resulting from the assignment of a new base period is increased by the applicable rate of increase percentages described in paragraph (c)(3) of this section.

42 C.F.R. § 413.40(i).

The preamble does not add much enlightenment to how to interpret or apply the concepts embodied in 413.40(i).[17] The Intermediary indicates that the natural operation of this regulatory opportunity is that there would be a dramatic event in year one, that would cause a significant cost spike in year two, that could be clearly linked back to year one. The effect should be both substantial and permanent. In order to know if the impact was permanent, a longer time span observation would be needed. In the instant case, the Provider is seeking to look back 4 and 5 years for a rebasing.

The allegation is that an event that occurred in late FY 1987 and was in place for all of FY 1988 had a substantial and permanent cost impact in 1992 and 1993. This time sequence invites a

[17] See Intermediary Hearing Exhibit 2.

look at the entire time continuum starting before the move and continuing through the second year in which the relief is sought.

The Intermediary presented a chart of TEFRA performance from 1986 through 1993.[18] The Provider responded with its own chart from 1985 (the actual base year) through 1993. For purposes of presentation, the Provider's exhibit will be used, since it should clearly reflect the most recently settled cost reports.[19]

FYE June 30	Final TEFRA Target Rate	Final Cost per Discharge Subject to TEFRA	Difference Difference	Number of Discharges
1985	$ 4,359.44	$ 4,359.44	0	188
1986	$ 4,635.83	$ 4,998.68	$ 362.85	170
1987	$ 4,660.71	$ 5,768.91	$ 1,108.20	130
1988	$ 4,282.58	$ 6,705.64	$ 1,887.06	92
1989	$ 4,822.11	$ 5,559.33	$ 737.22	119
1990	$ 5,822.11	$ 6,656.18	$ 1,483.26	103
1991	$ 6,087.48	$ 8,744.52	$ 2,657.04	63
1992	$ 6,973.77	$ 8,310.57	$ 1,336.80	108
1993	$ 7,523.13	$ 8,642.73	$ 1,119.60	102

From 1986 to 1987, the actual cost per discharge rose by 15 percent. The Intermediary acknowledges that this can be fairly described as substantial. The move occurred in the 10th month of the fiscal year. The Intermediary asserts that it is too soon to label the increase permanent. From 1987 to 1988, costs per discharge rose another 16.2 percent. Again, the data supports the Provider's argument. However, in 1989 and 1990, the cost per discharge fell just as dramatically as it rose. In fact, the 1989 and 1990 cost per discharge was less than in 1988. In 1991, the costs per discharge increased by 31 percent over 1990. The costs per discharge dropped slightly in 1992 and 1993.

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[18] See Intermediary Hearing Exhibit 1.

[19] See Provider Exhibit 27.

The Intermediary's conclusion from looking at the Provider's cost history is that the TEFRA overruns in 1992 and 1993 were most likely driven by something that happened between 1990 and 1991. Any cost rise due solely to the impact of the move was minimized by 1989. Looking at the chart, the cost per discharge increase from 1987 to 1988 may be a function of a drop in discharges rather than a pure increase in costs.

The hospital has simply not causally linked its costs over its limits in 1992 and 1993 to the impact of the move five years earlier. The regulation requires "substantial and permanent" change. There may have been a substantial increase in costs in the first full year of operation after the move as compared to prior to the move. However, the increase was temporary, as shown by the previous schedule.

The Provider indicated that CMS' denial was superficial and weak. The Intermediary noted that the denial was certainly brief or terse but that it did raise the causation question and/or lack of linkage. The extended time financial analysis shows that there was no substantial and permanent increase attributable to the change in physical plants.

The Intermediary asserts that after a move like the Provider made, a permanent and substantial increase in costs is not a given or an automatic entitlement to a rebasing. The Intermediary states that the move did not create the 1992 and 1993 TEFRA overruns, so a rebasing is not a cure. The rejection of the request for a new TEFRA base year was appropriate and should be affirmed.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395f(b) et seq. - Amount Paid to Provider

§ 1395x(v)(1)(A) - Reasonabl

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§ 1395ww(a) - Limits on Operating Costs for Inpatient Hospital Costs

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

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

§ 405.1835-.1841 - Board Jurisdiction

§ 413.30 - Limitations on Coverage of Costs: Charges to Beneficiaries If Cost Limits are Applied to Services

§ 413.40 et seq. - Ceiling on the Rate of Increase in Hospital Inpatient Costs

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

§ 3005.3 - Inclusion of ndirect Costs in a New Base Period

4. Cases:

Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993).

5. Other:

Administrative Procedure Act, 5 U.S.C 501 et seq.

Social Security Amendments of 1983, P. L. No. 98-21

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

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 case is unusual because the Provider existed in a temporary facility for an extraordinary number of years and did not move into its rebuilt facility until after the establishment of the TEFRA base year. The Board notes that the regulation provides for the establishment of a new base year if it is more representative of the reasonable and necessary costs of furnishing inpatient services and other criteria are met. 42 C.F.R. § 413.40(i). The Board finds that the differences between the capabilities and cost structure of the new facility and the temporary facility are large and permanent and therefore warrant the establishment of a new base year versus an adjustment.

The Board notes that this Provider's original facility was an 888-bed facility that was so extensively damaged by an earthquake in 1971 that it had to be demolished and rebuilt. The Board notes that the Provider temporarily moved to a 113-bed facility that was not even licensed to provide inpatient psychiatric care and that it had to lease 22 psychiatric beds from two other facilities. Because this number of psychiatric beds was insufficient, the Provider converted part of the 113-bed facility to provide additional inpatient psychiatric care. In total, the Provider had 50 PPS exempt psychiatric beds in 1985, which was the base year for TEFRA purposes. The Board notes that the Provider did not resume operation in its rebuilt 377-bed facility until 1987. The rebuilt facility's psychiatric unit was double the size of the temporary facility[20] and had 80 licensed beds.[21] Although the parties have addressed the inordinate delay in rebuilding the Provider's facility, the Board agrees with the parties that the length of the delay is not relevant to the case. Rather, the Board finds that the issue centers around the comparability of the reasonable and necessary costs in the temporary facility used to establish the TEFRA base year rate and the costs in the rebuilt facility that the Provider now occupies.

The Board notes that the regulations at 42 C.F.R. § 413.40(i) allow a new base year to be established if it would be more representative of the reasonable and necessary costs of furnishing inpatient services and other criteria are met. The other criteria require that the Provider's allowable inpatient costs exceed the TEFRA target amount, that the Provider document that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base year, and that other types of adjustments would not result in recognition of the reasonable and necessary costs of providing inpatient services. 42 C.F.R. § 413.40(i)(A), (B) and (C).

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[20] Tr. at 107 and 200-201.

[21] Tr. at 108.

The Board notes that there is no dispute that the Provider exceeded its TEFRA cost limits. The Board further notes that the Provider presented considerable evidence that the services provided at its temporary facility, both at the hospital level and within the psychiatric unit, were not representative of the pre-earthquake facility or the rebuilt facility, and that the costs in the rebuilt facility were substantially and permanently higher. The Board observes that the rebuilt facility had the following new services: open heart surgery,[22] newborn and maternity service, labor and delivery rooms, birthing rooms and a neonatal intensive care unit;[23] a higher grade emergency service;[24] additional ancillary, diagnostic and treatment capabilities, including a cardiac catheterization suite, a laminar airflow surgical unit, a neurology lab, a laser surgery unit and an oral surgery unit.[25] The Provider indicated that these new services and equipment were available and commonly used by its psychiatric patients and in general resulted in additional overhead costs.[26] With regard to the psychiatric services, the Provider added a 12-bed adolescent psychiatric service and expanded emergency psychiatric service with increased levels of staffing.[27] The Board finds evidence in the record related to the cost figures for 1985 versus 1988 that clearly show that overhead costs of the rebuilt facility as a whole had increased markedly.[28] This is supported by information in the record that demonstrates increased

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[22] Tr. at 180.

[23] Tr. at 120.

[24] Tr. at 120.

[25] Tr. at 122.

[26] Tr. at 129-130 and Provider Exhibits 4 and 22.

[27] Tr. at 126-127.

[28] See Provider Exhibit 22.

capability and increased LOS, for which an adjustment was made, and increased staffing for which not adjustment was made. The Board concludes that the increased capability of the rebuilt facility and the higher associated overhead costs related to providing this enhanced level of care are substantial and permanent. The Board finds that the Provider meets the requirements of the regulation at 42 C.F.R. § 413.40(i)(1)(A) and (B) . The Board also finds that a one time adjustment for start-up costs will not suffice to cover the permanent higher costs inherent in the rebuilt facility. Id. at (C).

The Board notes that the Intermediary argues that the Provider's costs should have gone up every year after it entered the new facility. The Board notes that the Provider's costs did increase every year except for one year in which the Provider experienced a particularly high utilization rate. The Board believes that this fluctuation in costs due to variance in census should not prohibit the Provider from recovering, on a permanent basis, for its changes in capability and associated overhead costs. The Intermediary did not address the fact that the Provider's new facility was different in capability and cost structure from the temporary one that was used to establish its base period, and one time adjustments will not recognize this permanent change.

The Board also agrees with Provider that CMS Pub. 15-1 § 3005.3, which limits inclusion of indirect costs in the new base period, was not effective until August 29, 1994 and therefore not applicable to the cost years at issue in this case.

In summary, the Board finds that the differences between the capabilities and cost structure of the new facility and the temporary facility are large and permanent and therefore warrant the establishment of a new base year versus an adjustment that includes both direct and indirect costs.

DECISION AND ORDER:

The Intermediary and CMS denial of the Provider's request for a new base year was improper. The Intermediary should assign FYE June 30, 1988 as the Provider's new TEFRA base year and recalculate and apply the appropriate new TEFRA target amounts for each of the years following FYE June 30, 1991 still subject to reopening.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett

Date of Decision: March 20, 2003

FOR THE BOARD:

Irvin W. Kues
Chairman