PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D5

PROVIDER –
Chippewa Dialysis Services
Sault St. Marie, Michigan

Provider No. 23-2557

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
United Government Services, LLC -WI

DATE OF HEARING -
January 22, 2003

CASE NO. 01-0741

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ISSUE:

Did the Centers for Medicare and Medicaid Services ("CMS")[1] correctly deny Chippewa Dialysis Services' request for an exception to the end stage renal disease ("ESRD") composite rate?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Chippewa Dialysis Services ("Provider") is an independent, free-standing, dialysis facility located in Sault St. Marie, Michigan. The facility is jointly owned and operated by Northern Michigan Hospital, Chippewa County War Memorial Hospital and the Sault St. Marie Tribe of Chippewa Indians. Pursuant to the provisions of §1881(b) of the Social Security Act and the regulations at 42 C.F.R. §413.170 et seq., hospital-based and free-standing ESRD facilities are reimbursed for outpatient dialysis services under the "composite rate" system. Under this system, a provider of dialysis services receives a prospectively determined payment for each dialysis treatment that it furnishes. An ESRD facility must accept the composite prospective payment rate established by CMS as payment in full for covered outpatient dialysis. During certain periods of time generally referred to as exception windows, an ESRD provider may request an exception to its composite rate in accordance with the procedures established under 42 C.F.R. §413.180. Such an exception window was opened by HCFA commencing on March 1, 2000. The Provider submitted a timely exception request to the composite rate for maintenance dialysis services ($123.96 per treatment) to United Government Services, LLC – WI ("Intermediary").[2] The Provider sought an exception in the amount of $31.85 per treatment on the basis of atypical service intensity and additional nursing service and administrative costs. Following a review of the exception request, the Intermediary forwarded the request to HCFA and recommended approval of a base hemodialysis rate of $155.81.[3]

HCFA denied the Provider's exception request based on its determination that the Provider did not satisfy the criteria for atypical patient mix as specified in 42 C.F.R. §413.184. HCFA further stated that the Provider failed to justify any increased costs based upon the Provider's claim of atypical patient population.[4] The Provider timely appealed HCFA's denial to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §413.194 and has met the jurisdictional requirements set forth in 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Jefferey A. Lovitky, Attorney at Law. The Intermediary's representative was Bernard M. Talbert, Esquire, Associate General Counsel, Blue Cross Blue Shield Association.

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[1] CMS was known as the Health Care Financing Administration ("HCFA") at the time denial actions were taken. This decision will refer to the name of the agency as CMS unless otherwise required by context.
[2] See Provider's Exhibit P-1 to Provider's Final Position Paper.
[3] See Provider's Exhibit P-2 to Provider's Final Position Paper.
[4] See Provider's Exhibit P-3 to Provider's Final Position Paper.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA properly denied the Provider's exception request pursuant to the governing regulation at 42 C.F.R. §413.184. Under the regulation, a provider must demonstrate that its per treatment costs in excess of its composite rate are reasonable, allowable and directly attributable to the servicing of an atypical patient mix. Since the Provider did not substantiate an atypical patient mix nor demonstrate the provision of atypical nursing and administrative services, it failed to meet the specific exception requirements under 42 C.F.R. §413.184. The Intermediary states that its position is best reflected in HCFA's denial letter and supporting workpapers.[5]

Based on its review of the Provider's documentation submitted in support of its request for relief from the composite payment rate, HCFA's denial letter included the following determinations:

> Atypical Patient Mix
>
> Medicare regulation 42 C.F.R. §413.182 requires that a provider demonstrate that its per treatment costs in excess of its composite rate are reasonable, allowable, and directly attributable to the servicing of an atypical patient mix as specified in 42 C.F.R. § 413.184. The documentation requirements in support of an atypical services exception are set forth in §413.184(b)(1), which states as follows in pertinent part:
>
>> A facility must submit a listing of all outpatient dialysis patients (including home patients) treated during the most recently completed fiscal or calendar year. . .
>
> The above regulatory requirement that a provider submit documentation in connection with its patient mix for its most recently completed fiscal or calendar year (depending upon its cost reporting period) applies because an atypical services exception is prospective in nature. As specified in section 2725.1.A of HCFA Pub.15-1:
>
>> This exception is limited to those situations where the facility can demonstrate that it expects to incur higher than average per treatment costs which are directly related to a substantial number of treatments to be furnished to patients who, because of their complex medical needs require more intense care, special dialysis procedures or supplies

[5] See Intermediary's Exhibit I-3.

> during an outpatient maintenance dialysis session. . . .
>
> Emphasis added.

[The Provider] is not certified to provide a home program of renal dialysis services. All of its patients are on hemodialysis. Attachment 1 of Provider Exhibit 1 contains a list of the Provider's 26 hemodialysis outpatients for the FYE 12/31/99 cost reporting period. . . . The Provider has prepared profiles of its patient population, both including and excluding transients (those with less than 12 treatments per year). The Provider's presentation reveals that of its 26 patients, 14 or 53.8% were aged (65 or over), and 11 or 42.3% were diabetic. . . . The corresponding figures excluding 4 transients were 59.0% (based on 13 of 22 patients), and 50.0% (based on 11 of 22 patients), respectively. The national averages based on HCFA 1997 data, the latest available, are 36.7% and 33.0%, respectively. The Provider computed the average length of stay for its 11 patients requiring inpatient admissions at 7.64 days (Exhibit 11). However, the Provider incorrectly included both the day of admission and day of discharge in computing the length of stay for each patient. Excluding the day of discharge, the correct average is 6.64 days, substantially less than the HCFA national average of 8.30 (based on 1994 data). Although page 3 of the narrative portion of [the Provider's] exception request references mortality information contained in Exhibit 8, that exhibit contains no mortality information whatsoever. We note from attachment 1 of Exhibit 1 that 3 of the Provider's 26 patients or only 11.5% had a diagnosis of hypertension. The national average based on HCFA 1997 data is 25.0%. The average age of the Provider's patient is 61.4, close to the national average of 62.4. Based on the totality of the Provider's presented evidence, we do not believe that [the Provider] has substantiated an atypical patient mix in accordance with 42 C.F.R. §413.184(b)(1).

Cost Justification

Notwithstanding the Provider's failure to demonstrate an atypical patient mix, we noted the Provider's argument that it furnishes an atypical number of nursing hours per treatment. The Provider states on page 5 of its narrative:

> We believe the staffing schedules are a more accurate indicator of hours worked since they reflect what work was actually done. Thus, for

> each dialysis treatment which lasts for roughly four patient hours we must invest an average of 3.6 hours of staff time.

Enclosure 1 based on Worksheets B-1 and C from the Provider's FYE 12/31/98, 12/31/99, and projected FYE 12/31/00 cost reports reveals that the Provider's average number of direct patient care hours per treatment was 2.29 in FYE 12/31/98, 2.82 in FYE 12/31/99, and forecasted to be 2.90 in FYE 12/31/00. A provider with an atypical patient mix based on data for ESRD outpatients treated during its most recent cost reporting period must also demonstrate that it furnishes atypical nursing services based on the number of direct patient care hours per treatment in accordance with section 2725.1 of HCFA Pub. 15-1.

National audited data for 1988 and 1991, the latest available, show that average direct patient care hours, excluding social workers and dieticians, were 3.00 hours per treatment. Thus, not only is the Provider's patient mix not atypical, its nursing hours per treatment were not atypical. Accordingly, even if the Provider had demonstrated an atypical patient mix, its exception request must still be denied, as it has not shown that it furnishes atypical nursing services.

Administrative and General Expense

The Provider reasons that because it believes it has justified atypical labor expense due to the provision of atypical services, then it should automatically be entitled to an exception allowance for atypical administrative and general ("A&G") expense because of higher accumulated costs, the prescribed cost finding statistic for allocation of A&G expense. . .

Because the Provider has neither justified an atypical patient mix nor demonstrated that it furnishes atypical nursing services, its argument with respect to entitlement to incremental A&G expenses based on atypical nursing costs its moot. However, we wish to respond to the Provider's argument.

A&G expenses are allocated on the basis of accumulated costs. Therefore, if the direct costs of a facility are higher, it follows that the A&G cost allocated to all treatment modalities will also be higher. However, that does not mean that the higher allocated costs are specifically and directly attributable to the atypical patients. The accounting protocols used for cost reporting may or may not be appropriate in identifying cost directly attributable to

atypical patients. For example, if a provider incurred additional nursing costs (overtime hours) because of treating atypical patients, there might be no additional costs incurred at all with regard to data processing, a home office, employee health insurance, purchasing, or telephones. True, the additional direct nursing costs would result in an increased allocation of those overhead costs, but it does not necessarily follow that the increased A&G allocation represents costs that are attributable to the atypical patients. Costs do not become directly attributable merely because of the use of a particular statistic as an allocation basis. Medicare regulation 42 C.F.R. §413.182 states as follows in pertinent part:

> HCFA may approve exceptions…if the facility demonstrates… that its per treatment costs in excess of its payment rate are <u>directly attributable</u> to…
>
> (a) Atypical service intensity (patient mix)…
>
> Emphasis added.

The requirement that overhead costs be directly attributable to the special needs of atypical patients for purposes of consideration under the atypical services exception criteria is further set forth in section 2725.1B.4 of HCFA Pub. 15-1 which states as follows:

> 4. <u>Overhead Costs</u>. – There are infrequent instances, (e.g., hepatitis) when an isolated area is required and when higher overhead cost may be justifiable. For these costs to be considered under this exception criteria (<u>sic</u>), documentation must be submitted that identifies the basis of higher overhead costs, the specific cost components to be impacted, and the incremental per treatment costs. General statements regarding a facility's higher overhead costs are not acceptable in meeting the criteria.

We reject the Provider's argument that it should be entitled to an exception allowance for higher allocated A&G costs simply because of a proportional increase in those costs solely due to atypical labor costs. Because the Provider has not demonstrated an atypical patient mix or shown that it furnishes atypical nursing services, it has not justified that its higher overhead costs are

directly attributable to the special needs of atypical patients in accordance with 42 C.F.R. §§413.182, 413.184, and section 2725.1.B.4 of HCFA Pub.15-1.

Worksheet S-1of the Provider's FYE 12/31/99 cost report reveals that [the Provider] has 5 renal dialysis machines regularly available for use and operating 6 days per week or 312 days per year. The number of days dialysis is furnished, number of machines, and number of treatments furnished per day are entirely within a provider's discretion. The Provider's maximum operating capacity is 4,680 treatments (5 machines X 3 treatments X 312 days). Based on the reported number of 2,817 treatments in FYE 12/31/99, adjusted to exclude 11 inpatients treatments as reported in Exhibit 26, [the Provider's] outpatient dialysis utilization rate was:

$$\frac{2{,}817 \text{ minus } 11}{4{,}680} = 60.0\%$$

We believe the Provider's high overhead costs per treatment are in large part due to its significant excess idle capacity of 40.0%. They are particularly disturbing because overhead costs are not directly related to patient care.

Other Issues

Section 2723.3 of HCFA Pub. 15-1 reveals that salaries and employee benefits comprise $47.00 of the composite rate. The Provider's combined salary and employee health and welfare expense per treatment in FYE 12/31/99 was $48.73 (Enclosure 2), close to the amount included in the composite rate, and hardly reflective of atypical nursing costs due to the provision of atypical nursing services. . . .

In addition, Exhibit 26 reveals that the Provider furnished 11 dialysis treatments to inpatients in FYE 12/31/99 and forecasted 17 treatments to inpatients in FYE 12/31/00. Renal related services to hospital inpatients are reimbursed under the hospital prospective payment system, not the ESRD composite rate. However, the FYE 12/31/99 cost report neither reveals a Worksheet A-2 adjustment excluding the direct and indirect costs for inpatient renal treatments, nor the establishment of a non-reimbursable cost center for the exclusion of costs associated with renal related inpatient services. . . .

Conclusion

> The Provider has neither substantiated an atypical patient mix, nor demonstrated the provision of atypical nursing services. Accordingly, its request for an atypical services exception covering additional nursing service cost and incremental A&G expense is denied in its entirety.

At the hearing before the Board , the Intermediary's witness was the CMS Health Insurance Specialist who was assigned the exception request at issue and was the author of the denial letter. This witness testified that the primary basis for denying the Provider's request was that the Provider did not exceed the national average of 3.0 hours per treatment.[6] As to the source of the 3.0 hours per treatment standard, the witness testified that he discussed this matter with his technical advisor and another analyst who had firsthand knowledge of the data used and the methodology employed. It was his testimony that the data was primarily obtained from audited cost reports of freestanding ESRD facilities for fiscal years 1988 and 1989. The data was selected based upon a stratified random sample that was statistically representative of freestanding facilities in the United States.[7]

In support of the 3.0 hours per treatment standard, the Intermediary's witness referred to various governmental reports (See Intermediary's Exhibits I-4, I-5 and I-6) to demonstrate that the contemporary standard for the duration of a dialysis session had increased to 3.5 hours. Based on his analysis of these reports, it was his conclusion that the average dialysis time of 3.5 hours was a more realistic standard, and that the application of the 3.0 hours threshold in denying the Provider's exception request was a very generous and liberal standard.[8]

In summary, it is the Intermediary's conclusion that the Provider has not met its burden of proof that it is providing atypical services. Accordingly, the Board should uphold CMS' denial of the Provider's exception request.

PROVIDER'S CONTENTIONS:

The Provider contends that it satisfied the atypical service intensity criteria set forth in 42 C.F.R. §413.184 and §2725.1 of the Provider Reimbursement Manual ("CMS Pub. 15-1"). The applicable regulations state in pertinent part:

> A facility must demonstrate that a substantial proportion of the facility's outpatient maintenance dialysis treatments involve atypically intense dialysis services, special dialysis procedures, or supplies that are medically necessary to meet special medical needs of the facility's patients.

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6 Tr. at 165-166, 203, 278-279.
7 Tr. at 168-169.
8 Tr. at 183-193.

42 C.F.R. §413.184(a)(1)

The Provider argues that its exception request provided solid evidence that its level of patient acuity was higher than the national average. In support of this position, the Provider refers to HCFA's denial letter which the Provider describes as correctly pointing out the following striking variations between the Provider's patient population and the national norm:

- 53.8 percent of the Provider's patients are 65 years or older as opposed to a national average of 36.7 percent.

- 42.3 percent of the Provider's patients are diabetic as compared to a national average of 33 percent.

The Provider further points out that, when transient patients are excluded, its percentages increase to 59 percent for patients over 65 and to 50 percent for diabetic patients.[9] The Provider believes the exclusion of transient patients is more appropriate because it eliminates the statistical anomaly that results when such patients are compared to its regular patient population who receive multiple treatments throughout the entire year.

The Provider contends that patients who are 65 years of age or older, as well as diabetic patients, present far more acute medical conditions than are present in younger and non-diabetic populations. Such patients require additional nursing and staff assistance and clearly satisfy the criteria for atypical service intensity. In denying the Provider's claim that its patients were atypical, HCFA relied on certain other indicators (i.e., hypertensive patients, morbidity factors and average length of stay) which did not exceed national averages. The Provider argues that HCFA's action reflects a misunderstanding of the regulatory requirements in that a provider need not demonstrate atypicality with respect to each and every characteristic of its patient population. The Provider concludes that it clearly demonstrated that its patient population varied in significant respects from the national norms, thereby resulting in additional costs.

The Provider also contends that it furnished ample cost justification in support of its exception request. The manual provision at CMS Pub. 15-1 §2725.1 authorizes an exception on the basis of significantly increased nursing hours per treatment. In its denial letter, HCFA determined that the Provider's average direct patient care hours for the fiscal year ended ("FYE") December 31, 1998 were 2.29 per treatment; 2.82 per treatment for the FYE December 31, 1999; and were forecasted to be 2.90 for the FYE December 31, 2000. In denying the Provider's request, HCFA's denial letter stated in pertinent part the following:

> National audited data for 1988 and 1991, the latest available, show that average direct patient care hours, excluding social workers and dieticians, were 3.00 hours per treatment. Thus, not only is the

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[9] The Provider defines a transient patient as a patient who requires 11 or less dialysis treatments per year.

> Provider's patient mix not atypical, its nursing hours per treatment were not atypical.

In response to its discovery request, the Provider obtained copies of the "national audited data" which HCFA relied upon in calculating the 3.0 hours per treatment standard.[10] Using the identical data relied upon by HCFA, the Provider's consultant calculated average direct patient care hours, including social workers and dietitians, as equaling 3.07 hours per treatment. If social workers and dietitians are excluded, average direct patient care hours equaled 2.86 hours per treatment.[11] Contrary to the terms of HCFA's denial letter, the Provider contends there is no 3.0 hours per treatment standard. Moreover, the Intermediary's witness admitted during his testimony before the Board that he was unable to arrive at the 3.0 hours per treatment figure based upon the data available.[12]

The Provider points out that there are other deficiencies with the data used by HCFA in calculating its average hours per treatment standard. For example, it appears that the sample used to develop the 3.0 hours per treatment figure excluded home-based or peritoneal patients. Since home patients generally require less nursing assistance, the exclusion of such patients from the sample would inflate the average time per treatment, thereby making it more difficult to qualify for an exception.[13] The Provider also notes that the sample was based upon a survey of 63 out of a total of 1,819 ESRD facilities (3.5 percent of the aggregate). The Provider's consultant testified that the sample was not large enough to ensure its statistical reliability,[14] and the Intermediary's witness testified that he was unable to form any opinion as to the size of the sample.[15] Other deficiencies in the HCFA sample noted by the Provider included the skewed geographic distribution, no breakdown between rural and urban facilities, and the age of the data, as it was derived from fiscal years 1988 and 1989.

The Provider contends that HCFA's failure to produce any evidence supporting the statistical reliability of its study is of overriding importance. HCFA produced no documentation as to the method of randomization of the facilities selected, justification for the sample size, or how it was determined that the sample size was statistically reliable. Without such documentation, the Provider insists that there is no way to audit the study or verify its results. Based on the above noted deficiencies, the Provider concludes that there is no statistical support for HCFA's 3.0 hours per treatment standard.

In addition to denying the Provider's exception request based on atypical patient mix, HCFA also denied the request on the basis that the Provider's combined salary and employee benefits were roughly equivalent to the national average of $47.00 per treatment. Based on the information furnished by CMS in response to the Board's subpoena,[16] the Provider argues that there is no support for the average cost per treatment

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[10] See Provider's Exhibit P-15.
[11] See Provider's Exhibit P-27.
[12] Tr. at 176-178.
[13] Tr. at 70-74, 253-255.
[14] Tr. at 76-77.
[15] Tr. at 237-240.
[16] See Provider's Exhibits P-4 and P-6.

figures contained in CMS Pub. 15-1 §2723.3. In its response, CMS believed that 1983 and 1984 data were used in developing the cost per treatment figures, but conceded that the data no longer existed. With regard to the hours per treatment standard, no documentation was produced as to whether or how a randomized sample of facilities was selected, or how the size of the sample selected was justified. Accordingly, it is not possible to place any credence in the cost per treatment figures contained in the manual. Moreover, such data does not take into consideration the enormous increases in productivity over the past twenty years.

In denying the Provider's request for overhead exception relief, HCFA stated: "Because the Provider has not demonstrated an atypical patient mix or shown that it furnishes atypical nursing services, it has not justified that its higher overhead costs are directly attributable to the special needs of atypical patients . . ." The Provider argues that the test applied by HCFA misconstrues the requirement as it pertains to indirect expenses. Such costs increase proportionately as the direct cost of rendering dialysis treatment increases. As to HCFA's inference that increased costs were linked to the Provider's idle capacity, the Provider points out that it must maintain sufficient dialysis capacity to accommodate the surge requirements of tourist periods. Therefore, any idle capacity is clearly justified by the unique and particular circumstances attributable to the Provider.

In summary, it is the Provider's conclusion that HCFA improperly used overall national averages as the yardstick to measure its costs. The regulation at 42 C.F.R. §413.184(a)(2) states the following:

> (2) The facility must demonstrate clearly that these services, procedures, or supplies and its per treatment costs are prudent and reasonable when compared to those of facilities with a similar patient mix.

42 C.F.R. §413.184(a)(2).

The Provider argues that the record is devoid of any indication that HCFA made any such comparison in adjudicating its exception request. Instead, HCFA used an overall average of 3.0 hours per treatment and a cost for salary and benefits of $47 per treatment as the bases for denying the Provider's request. Neither value is representative of other facilities with "similar patient mix" to the Provider as required by the applicable regulation. The Provider believes it has fully justified its claim based upon atypical service intensity and submitted ample justification of its costs and that the Board should grant its exception request in its entirety without regard to the averages relied on by HCFA.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and Program instructions, the parties' contentions, and evidence presented, finds and concludes as follows:

The Board finds that CMS properly denied the Provider's request for an exception to the ESRD composite rate because the Provider failed to meet its burden of proving that it rendered atypical services to its ESRD patients as required under the controlling regulatory provisions of 42 C.F.R. §413.184. In order to qualify for an exception based on atypical service intensity, the regulation states:

> A facility must demonstrate that a substantial proportion of the facility's outpatient maintenance dialysis treatments involve atypically intense dialysis services, special dialysis procedures, or supplies that are medically necessary to meet special medical needs of the facility's patients….

42 C.F.R. §413.184

The Provider sought an exception to the composite rate for atypical nursing and administrative and general costs based on its contention that it served an atypically more acute patient population than the national norms. Pursuant to the regulation at 42 C.F.R. §413.182, CMS may approve such an exception request if the facility demonstrates by convincing objective evidence that: (1) its total per treatment costs are reasonable and allowable under the relevant cost reimbursement principles, and (2) its per treatment costs in excess of its payment rate are directly attributable to atypical service intensity. Accordingly, the Provider is responsible for justifying and demonstrating to CMS' satisfaction that the requirements and criteria for an exception request are met in full. It is the Board's conclusion that the Provider has not furnished evidence to support its atypical services exception request or that its excess costs were directly attributable to this factor.

In support of its argument that its facility had an atypical patient mix, the Provider dealt only with its composition of aged and diabetic patients. While the Provider's patient population did reflect a higher percentage than the national averages in these categories, the Board notes that the variations did not reflect a substantial deviation from the national norms.[17] Moreover, the Provider did not take into consideration other factors in its patient mix analysis which CMS addressed in reviewing the exception request (i.e., mortality rate, length of stay for patients requiring inpatient admission, average age of patient population, and individual patient diagnosis). Given the fact that the Provider's own patient analysis did not demonstrate a significant deviation from the national averages, the Board is not able to make a clear determination that the Provider had an atypical patient mix which justified the incurrence of additional costs per treatment.

Despite the Board's finding that the Provider failed to meet the threshold requirement of patient atypicality, the Board nevertheless analyzed the Provider's cost data. The primary argument presented by the Provider in support of its exception request based on atypical service intensity was that it furnished an atypical number of nursing hours per treatment. Based upon its analysis of the data presented in the Provider's exception request, CMS

[17] The Board also took into account the exclusion of transient patients which the Provider believes is more appropriate.

determined that the Provider's average number of direct patient care hours per treatment was less than the national average of 3.0 hours per treatment.

While the Provider did not dispute CMS' recalculation of the number of direct patient care hours per treatment for its facility, the Provider did challenge the validity of the standard applied by CMS in determining that the Provider had not shown that it furnished atypical nursing services. Although the Provider cited various deficiencies in the data and methodology employed by HCFA in establishing the 3.0 hours per treatment standard, the Board notes that the Provider did not present alternative data which would support the use of another standard. By contrast, CMS did present additional governmental reports which demonstrated that a more realistic contemporary standard for the duration of a dialysis session may have increased to 3.5 hours.[18] Accordingly, the Board concludes that CMS applied an appropriate standard to measure the Provider's atypical service intensity and properly denied the Provider's exception request that was based upon the criterion.

The Board also finds that because the Provider has not demonstrated that it had an atypical patient mix or that it furnished atypical nursing services, the Provider has not shown that its higher overhead costs were directly attributable to the special needs of atypical patients. The argument that the Provider should be entitled to an exception allowance for higher allocated administrative and general costs because of a proportional increase in those costs due solely to atypical labor costs is therefore rejected.

The Board also concurs with CMS' contention that the Provider's high overhead costs per treatment were in large part due to its significant excess idle capacity (40%).

DECISION AND ORDER:

CMS correctly denied the Provider's request for an exception to the ESRD composite rate in accordance with the regulatory provisions of 42 C.F.R. §413.184. CMS' denial is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.

FOR THE BOARD

[18] See Intermediary's Exhibits:
I-4 - Report to Congress: Medicare Payment Policy
I-5 - HCFA 2000 Annual Report ESRD Clinical Performance Measures Project
I-6 - CMS 2001 Annual Report ESRD Clinical Performance Measures Project

DATE: December 22, 2003

Suzanne Cochran
Chairman