# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D21

**PROVIDER –**
San Joaquin Community Hospital -SNF
Bakersfield, CA

Provider No.: 05-0455

**vs.**

**INTERMEDIARY -**
BlueCross BlueShield Association/
First Coast Service Options, Inc.

**DATE OF HEARING -**
October 30, 2008

Cost Reporting Period Ended -
December 31, 1995

**CASE NO.:** 97-2425R

**INDEX**

**ISSUE:**

Whether the Secretary's failure to reclassify costs in the peer group construction was arbitrary, capricious or plainly erroneous?[1]

**MEDICARE STATUTORY AND PROCEDURAL HISTORY:**

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended (Act),[2] to provide health insurance to the aged and disabled. The Centers for Medicare and Medicaid Services (CMS),[3] is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries (FIs) and Medicare administrative contractors (MACs). FIs and MACs[4] determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS.[5]

Cost reports are required from providers on an annual basis with reporting periods based on the provider's fiscal or accounting year. A cost report shows costs incurred during the relevant fiscal year and the portion of those costs to be allocated to the Medicare program.[6] The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider

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[1] The Board notes that this statement of the issue is the one agreed to by the parties. However, as reflected in the following excerpt from the district court decision that resulted in the remand of this case to the Board, the district court has retained jurisdiction over this issue and remanded to the Board only the sub-issue of "the effect of the Secretary's failure to reclassify costs in the peer group construction on the amount [of] San Joaquin's exceptions reimbursement":

> A finding by the PRRB must be made as to the effect of the Secretary's failure to reclassify costs in peer group construction on the amount [of] San Joaquin's exceptions reimbursement before it can be determined whether the Secretary's decision not to reclassify costs in the peer group was arbitrary, capricious, or plainly erroneous manner inconsistent with the PRM. . . .
>
> Decision on the parties motions for summary judgment on the issue [of] reclassification costs cannot be made *pending a finding by the PRRB* as to the effect of the Secretary's failure to reclassify costs in peer group construction on the amount of San Joaquin's exceptions reimbursement.
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> This case is remanded to the PRRB to make a finding as to the effect of the Secretary's failure to reclassify costs in peer group construction on the amount [of] San Joaquin's exceptions reimbursement.

*San Joaquin Comty. Hosp. v. Thompson*, No. CIV-F-01-5733-OWW-DLB, 2002 WL 34596496 at *22-*23 (E.D. Cal. Aug. 13, 2002) (emphasis added). To this end, the Board's decision is limited to this sub-issue as well as the additional issue included in the Administrator's remand order (*see infra* note 24 and accompanying text) and it does not address the larger issue as presented by the parties.

[2] 42 U.S.C. Ch. 7, Subch. XVIII.

[3] Prior to 2001, CMS was called the Health Care Financing Administration (HCFA). For simplicity, CMS will be utilized to refer to the agency.

[4] FIs and MACs are hereinafter referred to as intermediaries.

[5] *See* §§ 1816 and 1874A of the Act, 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

[6] *See* 42 C.F.R. § 413.20.

and issues the provider a Notice of Program Reimbursement (NPR).[7] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the receipt of the NPR.[8]

SNF Exception Request Background

The Medicare program reimbursed eligible hospital-based skilled nursing facilities (HB-SNFs) and freestanding skilled nursing facilities (FS-SNFs) on a per diem basis for the "reasonable cost" of covered services provided to Medicare beneficiaries. "Reasonable cost" is defined in § 1861(v)(1)(A) of the Act[9] as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services."

Further, § 1861(v)(1)(A) specifies that the reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services." In establishing how "reasonable cost" is determined under these regulations, § 1861(v)(1)(A) allows CMS to "provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or estimates of the costs necessary in the efficient delivery of needed health services." In developing these regulations, § 1861(v)(1)(A) prohibits what is referred to as "cross-subsidization." Specifically, § 1861(v)(1)(A) states:

> Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) *in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs . . . .*[10]

Consistent with the definition of "reasonable cost," § 1888(a) of the Act[11] directs CMS to establish to establish Routine Cost Limits (RCLs) for the routine service costs of extended care services furnished by SNFs. CMS has characterized these limits as "a presumptive estimate of reasonable costs."[12] In addition, § 1888(c) allows CMS to grant exceptions to the RCLs .[13] CMS promulgated regulations delineating the circumstances under which exceptions to RCLs

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[7] 42 C.F.R. § 405.1803.

[8] *See* § 1878(a) of the Act, 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.

[9] 42 U.S.C. § 1395x(v)(1)(A).

[10] (Emphasis added.)

[11] 42 U.S.C. § 1395yy(a).

[12] Provider Reimbursement Manual (PRM) Part I § 2530.1.

[13] *See* 42 U.S.C. § 1395yy(a).

may be provided. During the time at issue, these regulations were located at at 42 C.F.R. § 413.30(f) which stated, in pertinent part:

> (f) *Exceptions*. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) of this section. An adjustment is made only to the extent that the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.
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> (1) *Atypical services*. The SNF or HHA can show that the—
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> (i) Actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified; and
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> (ii) Atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.[14]

In July 1994, CMS issued Transmittal No. 378 which published a new Chapter 25 of Part I of the Provider Reimbursement Manual (PRM). The new Chapter 25 set forth detailed written instructions for the submission and adjudication of SNF exception requests and was effective for all exception requests submitted on or after July 20, 1994. As a result of Transmittal No. 378, PRM Part I § 2534.5 provides, in pertinent part:

> In determining reasonable cost, the provider's per diem costs in excess of the cost limit are subject to a test for low occupancy and are compared to per diem costs of a peer group of similarly classified providers.
>
> A. *Low Occupancy.* -- . . .
>
> B. *Uniform National Peer Group Comparison.* --The uniform national peer group data are based on data from SNFs whose costs are used to compute the cost limits. The peer group data are divided into four groups: Urban Hospital-based, Urban Freestanding, Rural Hospital-based, and Rural Freestanding. For each group, an average per diem cost (less capital-related costs) is computed for each routine service cost center (direct and indirect) that the provider reported on its Medicare cost report. For each cost center, a ratio is computed as to the average per diem cost. Those cost centers not utilized on the Medicare cost report must be eliminated and all ratios are revised based on the revised total per diem cost. *If indirect costs are directly assigned* (e.g. nursing administration (indirect cost) assigned to the direct cost center), *the*

[14] 42 C.F.R. § 413.30(f) (Oct. 1, 1996 edition) (emphasis in original.) (as amended by 60 Fed. Reg. 45778, 45849 (Sept. 1, 1995)).

> *indirect cost elements must be identified and reassigned, for the purpose of constructing the peer group, to the indirect cost center identified with the type of cost incurred.* The ratios are then based on the averages for the cost centers reflecting the reassigned costs ....
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> ... For each hospital-based group ... the ratio is applied to 112 percent of the group's mean per diem cost (*not the cost limit*), adjusted by the wage index and cost reporting year adjustment factor applicable to the cost reporting period for which the exception is requested. The result is the provider's per diem cost is disaggregated into the same proportion of its peer group mean per diem cost for each cost center.
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> The SNF's actual per diem cost ... is compared to the appropriate component of the disaggregated cost limit or 112 percent of the hospital-based mean per diem cost. If the SNF's per diem cost exceeds the peer group per diem cost for any cost center, the higher cost must be explained. Excess per diem costs which are not attributable to the circumstances upon which the exception is requested and cannot be justified may result in either a reduction in the amount of the exception or a denial of the exception.[15]

Thus, in the exception process, the comparison of a provider-applicant's costs to the uniform national peer group costs is not made in the aggregate. Rather, those costs are disaggregated into specific "cost centers." While there are several "indirect" cost centers, there is only a single "direct" cost center.

The amount of a provider-applicant's exception is then determined by comparing a provider-applicant to the uniform national peer group. Specifically, the amount of a provider's exception for the direct cost center and each of the indirect cost centers is determined by subtracting it from the corresponding uniform national peer group direct and indirect cost centers. Significantly, prior to making the comparison of the provider-applicant to the uniform national peer group, PRM Part I § 2534.10(A) requires that providers identify any indirect costs reported in their direct cost centers and reclassify them into the appropriate indirect cost center.

The controversy in this case concerns whether the direct cost centers of each of the urban HB-SNFs in the uniform national peer group of urban HB-SNFs contained a significant amount of indirect costs that were not otherwise reclassified into an indirect cost center. If so, the average cost for the direct cost center of the uniform national peer group would be inflated in comparison to the provider-applicant because the exception process requires a provider-applicant to identify and remove indirect costs from its direct cost center prior to comparing it to the uniform national peer group. In sum, the resulting comparison has the effect of lowering, in an alleged improper manner, the amount the provider-applicant receives for the exception to the direct cost center.

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[15] (Emphasis added.)

## STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

San Joaquin Community Hospital (Provider) operates a 21-bed Medicare certified hospital-based SNF in Bakersfield, California.

This case concerns the Provider's fiscal year ending December 31, 1995 (FY 1995). For this fiscal year, the Provider exceeded all of the benchmarks established by CMS to determine whether it provided atypical services. The Provider had:

1. An average length of stay of 13.11 days compared to a national average of 132.34;
2. Medicare utilization of 97.88 percent compared to a national average of 52.39 percent; and
3. Medicare SNF ancillary per diem costs of $230.52 compared to a national average of $62.73.[16]

A lower than average length of stay, combined with a higher than average Medicare utilization and Medicare SNF ancillary costs point to the provision of atypical services to higher acuity patients.

The Provider's intermediary, Blue Cross of California, which was later replaced by First Coast Service Option, Inc. (Intermediary) issued the NPR for FY 1995 on March 31, 1997. Pursuant to 42 C.F.R. § 413.30(f)(1), the Provider submitted a request for an atypical services exception for FY 1995 to the Intermediary. Both the Intermediary and CMS recognized that the Provider had provided atypical services during FY 1995 and granted first an interim and then a final atypical services exception request.[17] Later, the Intermediary reopened the Provider's cost report for FY 1995 to reclassify directly expensed nursing management cost from the routine cost centers to the nursing administration cost center and, on April 2, 1999, issued a revised Notice of Program Reimbursement (NPR). Based on this revised NPR, a new final exception amount of $92.92 was determined and communicated to the Provider by the Intermediary's letter of September 7, 1999.[18] The Provider filed a timely appeal to the Board.

In 2000, the Board heard this case and issued a decision in favor of CMS.[19] In that decision, the Board found the following with respect to the instructions for reclassifying the Provider's costs from direct to indirect cost centers and the construction of the peer groups:

> The Board finds that the Intermediary properly followed the instructions for reclassifying the Provider's costs pursuant to the instruction in HCFA Transmittal 378. The Board notes that the Provider did not provide sufficient evidence to prove that HCFA improperly developed the peer groups.

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[16] *See* Exhibit P-16.

[17] *See* Exhibits P-15 – P-18.

[18] *See* Exhibit P-19.

[19] *San Joaquin Comty. Hosp. v. Blue Cross and Blue Shield Ass'n,* PRRB Hearing Dec. No. 2001-D17 (April 17, 2001), CMS Administrator declined review (June 11, 2001).

> The Board notes that HCFA Pub. 15-1 §§ 2534.5.B and 2534.10 provide that a provider's directly assigned indirect expenses be reassigned to the appropriate indirect expense cost center in the peer group identified with the type of cost incurred. These costs are then compared with the respective peer group costs in order to determine if an exception is warranted.
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> The Provider indicates that HCFA constructed its peer groups using settled cost report data. The Provider claims that directly assigned costs were not reassigned in those cost reports. As a result, HCFA's peer group costs include substantial amounts of unreclassified costs and therefore represent an unfair comparison group. The Provider points out that California law requires direct assignment of costs and that California providers represent at least 10 percent of the group making up the peer group. The Intermediary asserted that the data was from settled cost reports and did not contain widespread misclassification of costs as claimed by the Provider. Although the Board agrees that it may be appropriate to make adjustments to correct classification of data used to create the national peer groups, the Board did not find any evidence in the record that they were constructed in an erroneous manner. The Board finds no specific documentary evidence as to the extent to which data used to construct the national peer groups actually contained unreclassified costs.
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> The Board finds that the Intermediary properly calculated the Provider's exception and that sufficient proof that the national peer groups was improperly constructed was not presented.[20]

The U.S. District Court of the Eastern District of California ("District Court") reviewed the Board's decision and held that:

> The Secretary tacitly admits no reclassification was made in the construction of peer groups as required by Transmittal No. 378. The PRRB found "that it may be appropriate to make adjustments to correct classification of data used to create the national peer groups," AR at 26, but it made no finding as to the effect of the Secretary's failure to reclassify costs in the construction of the peer groups. Without a finding by the Board as to the extent to which San Joaquin's exceptions reimbursement was affected by the Secretary's failure to reclassify costs, the Secretary's position that the effect was minimal and its decision not to reclassify costs in the construction of the peer groups was not arbitrary and capricious cannot be assessed.[21]

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[20] *Id.* at 21 (footnote omitted).

[21] *San Joaquin Comty. Hosp.*, 2002 WL 34596496 at *22.

The District Court, by order dated September 4, 2002, remanded the case to the Board "as it relates to the reclassification of costs issue . . . for [the Board] to make a finding as to the effect of the Secretary's failure to reclassify costs in peer group construction on the amount of San Joaquin's exceptions reimbursement."[22] The CMS Administrator implemented the remand by order dated January 8, 2003 and directed the Board to determine "the effect of the Secretary's failure to reclassify costs in the peer group construction on the amount of San Joaquin's exceptions reimbursement" and, after having made that finding, to "issue a decision with respect to Issue No. 1 of the PRRB Decision No. 2001-D17 on whether the Intermediary properly reclassified certain of the Provider's direct costs to indirect cost centers in processing the exception request."[23]

On February 13, 2003, the Board sent notice to the parties that the Board had reopened this case, set a hearing for the case on June 12, 2003, and required the parties to file position papers within 60 days. The Provider submitted a timely position paper on April 10, 2003. The Intermediary requested additional time to develop its position paper and the Board requested the Intermediary prepare a position paper by January 30, 2004. The Intermediary did not submit a position paper by the Board's deadline. The Board rescheduled the hearing and set a second hearing date of March 15, 2005.

On January 21, 2005, the Provider requested a subpoena to compel the deposition of certain CMS witnesses with information related to the remand issue prior to the hearing. These CMS witnesses included both current and former CMS employees. The Board denied the Provider's request because the Provider did not identify the specify facts it wished to establish and had not established that the information it sought was available through other means of discovery.[24] On February 10, 2005, the Provider requested that the Board reconsider its order denying the subpoena for discovery depositions. The Provider asserted that CMS had not complied with discovery requests and had not submitted a position paper and, as a result, it could not prepare for the hearing.[25] The Board again denied the Provider's request because the Provider still had not identified the matter it wished to question the parties about and had not properly served the subpoena requests to the Office of General Counsel for CMS (CMS OGC).[26]

CMS subsequently declined to make any of the CMS witnesses (current or former employees) available for a deposition because CMS was not a party to the appeal.[27] In a letter dated August 9, 2005, the Provider suggested an alternative method to obtain testimony from CMS by having the Board hearing for this case conducted in two stages. At an initial evidentiary hearing, the Provider would be given an opportunity to call witnesses to obtain information that was not provided during discovery. Based upon the facts learned during the initial evidentiary hearing, the Provider then would be permitted to obtain further witnesses and documents to present at a later hearing for the presentation of full evidence. The Provider, noting that the CMS OGC did

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[22] *See* District Court Remand Order, Sept. 4, 2002.

[23] *See* CMS Order, Jan. 8, 2003.

[24] *See* Board Letter, Jan. 31, 2005.

[25] *Id.*

[26] *See* Board Letter, March 23, 2005.

[27] *See* CMS OGC letter, July 5, 2005.

not object to the production of documents, submitted a request for production of documents in its August 9, 2005 letter.

In a letter dated August 26, 2005, CMS OGC continued to object to producing deposition testimony because it was not a party to the case. CMS OGC also indicated that since it was not a party to the case, it would produce all record information that the Provider requested through CMS' Freedom of Information Act office.[28]

On July 18, 2006, the Board reset the case for hearing on March 23, 2007. On October 6, 2006, the Provider submitted to the Board a request for a pre-hearing conference and a request for two hearing dates where the first hearing would be for production of documents and the testimony of CMS witnesses and the second hearing would be for the presentation of full evidence. In addition, the Provider also sought the issuance of hearing subpoenas for production of documents and a number of CMS witnesses. In a letter dated October 26, 2006, CMS OGC explained that it was responding to the Provider's request for documents through FOIA and requested additional time to respond to the Provider's other requests.

On February 22, 2007, the Provider submitted its witness list for the case which included five CMS witnesses for which it previously had requested subpoenas. On February 26, 2007, the Board sent a letter to CMS OCG requesting that it complete its response to the Provider's requests by March 15, 2007. The Board also requested that CMS OGC address the status of the Provider FOIA request which had been referred to CMS FOIA office; address the Board's authority to subpoena witnesses under 42 C.F.R. §§405.1843(b) and 405.1857; state its position regarding the subpoena of former CMS employees; and explain how it reconciles CMS' refusal to respond to discovery with the Court's remand to the Board to make findings where CMS has sole custody of evidence needed to make those findings.

On March 1, 2007, CMS OGC submitted a brief in opposition to the Provider's requests for hearing subpoenas for the production of documents and testimony. CMS OGC first objected because the Provider's request exceeded the limits of the Court's remand order and were not relevant. CMS further indicated that the request for discovery should proceed under FOIA and that the Board does not have the authority to issue or enforce administrative subpoenas against federal agencies, including CMS. And finally, that CMS is not a party to the appeal and the Board rules concerning motions to compel are limited to parties and therefore CMS's policy of treating the request under FOIA is consistent with Board procedures.

On March 15, 2007, CMS OGC also wrote separately to the Board to address the issues raised in the Board's letter of February 26, 2007. CMS OGC stated that CMS's FOIA office was searching for documents that the Provider had requested. They further stated that they expected FOIA to complete its search within a matter of weeks and that to date no responsive documents had been discovered. CMS OGC again reiterated that the documents being requested and all of the testimony were not relevant to the narrow issue remanded by the Court. On June 5, 2007, the Board inquired about the progress of the outstanding FOIA request. On June 12, 2007, CMS OGC informed the Board that the inquiry was not complete but again noted that no responsive documents had been uncovered.

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[28] *Id.*

On June 26, 2007, the Board sent a letter to the parties and CMS OGC. The Board expressed concern with the failure to uncover any records of this significant Medicare process despite a comprehensive search over an extended period of time. The Board indicated that the lack of any documentation strongly suggested that testimony of the individuals directly involved in the development of the process was necessary and that this testimony might lead to discovery of evidence and it could obviate the need for further testimony at the hearing. The Board noted that despite CMS' position that it is insulated from the Board's authority to compel discovery or testimony at a hearing, it had a statutory responsibility to develop the record on procedural and substantive grounds so that conflicts could be resolved in the appellate courts. Based on these facts, the Board granted the Provider's request for issuance of subpoenas for the depositions of current and former CMS employees and production of documents.

On September 10, 2007, the Provider informed the Board about discussions with CMS OGC concerning discovery and testimony of current and former CMS employees. While CMS OGC still objected to deposition subpoenas issued by the Board, it agreed to produce three current CMS employees to testify at the Board hearing and would not object to the Board hearings occurring in two stages so that testimony of CMS witnesses could be given on one date and the parties could return to the Board for a continuation hearing after an opportunity to analyze the CMS testimony and present their remaining witnesses. With regard to former CMS employees, CMS OGC did not object to their testifying at a Board hearing but would consider them under the Department's regulations at 45 C.F.R. Part 2. CMS OGC also reported that it would indicate whether any requested documentation had been found. The Provider also requested a pre-hearing conference to address a number of other procedural matters.

A pre-hearing conference was held on September 11, 2007. The Board prepared a summary of the discussion at the prehearing conference in a letter to the parties dated September 14, 2007. At the prehearing conference, CMS OGC confirmed that CMS had not identified any information responsive to the FOIA request regarding the peer groups used to calculate the Routine Cost Limits and that CMS' FOIA officer would issue a letter to this effect. Progress was obtained on obtaining testimony from current and former CMS employees. It was noted that CMS would not object to producing previously identified current employees for an evidentiary hearing on or before December 15, 2007. Also, by September 30, 2007, CMS would notify the Provider and the Board as to which individuals, previously identified, it would provide to testify at the evidentiary hearing. For those individuals whose appearance may be opposed, the Board will issue a subpoena.

By letter dated September 28, 2007, CMS OGC informed the Board that it voluntarily agreed to make two witnesses requested by the Provider available at the evidentiary hearing as well as another CMS employee not previously requested. With respect to the three former CMS employees, CMS OGC informed the Board that one former employee had agreed to voluntarily testify but that two former CMS employees had declined to voluntarily testify before the Board. Also attached to CMS OGC's letter was a September 14, 2007 letter from the CMS FOIA office confirming that they were not able to identify any records responsive to the Provider's FOIA request.

On October 22, 2007, the Provider confirmed that, after consulting with CMS OGC, three current CMS employees would testify voluntarily. With respect to former CMS employees, the

Provider only sought testimony from one witness. As this witness had not agreed to testify voluntarily, the Provider requested that the Board issue a subpoena for this former CMS employee.

On November 14, 2007, the Board scheduled an evidentiary hearing for January 15 and 16, 2008. On December 17, 2007, the Board issued a subpoena duces tecum for the former CMS employee who had not agreed to voluntarily testify.[29] The Board held the evidentiary hearing on January 15 and 16, 2008.[30] While the three current employees testified at the evidentiary hearing, the subpoenaed former CMS employee was unable to attend the evidentiary hearing, and the Provider did not pursue obtaining the subpoenaed former CMS employee's testimony at a later time.

Subsequent to the evidentiary hearing, the Board held a hearing for the full presentation of evidence on October 30, 2008.[31]

The Provider was represented by Frank P. Fedor, Esq., of Murphy Austin Adams Schoenfeld LLP. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

**PARTIES' CONTENTIONS:**

The Provider continues to assert that the correct interpretation of HCFA transmittal 378 requires that there be a two-step process to determine exceptions reimbursement under the Medicare program. Specifically, the Provider maintains that, when the Intermediary reclassifies the Provider's direct costs to one or more indirect cost centers, it also has to reclassify a proportional amount out of the uniform national peer group. The Provider refers to this interpretation as the "Corresponding Reclassification Method" or CRM.[32] In support of its CRM interpretation, the Provider refers to the following excerpt from PRM Part I §2534.5(B):

> If indirect costs are directly assigned (*e.g.* nursing administration (indirect cost) assigned to the direct cost center), the indirect cost elements must be identified and reassigned, for the purpose of constructing the peer group, to the indirect cost center identified with the type of cost incurred. The ratios are then based on the averages for the cost centers reflecting the reassigned costs.[33]

The Provider also maintains that a CMS letter dated September 29, 1997 to another intermediary

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[29] The Board's subpoena was returned with it marked refused on January 14, 2008. The Board also received a January 17, 2008 note from the former employee indicating that he was on an extended trip and did not receive the notice until after the hearing. The former employee further asserted that the matter under contention occurred over ten years ago and that he did not recall details about it.

[30] Reference to the transcript for the evidentiary hearing will hereinafter be cited as "EH Tr.," followed by the date of the evidentiary hearing, either "1/15/08" or "1/16/08," and the transcript page (*e.g.*, EH Tr. 1/15/08 at 1).

[31] Reference to the transcript for the full hearing will hereinafter be cited as "FH Tr." and the transcript page (*e.g.*, FH Tr. at 1).

[32] *See* Provider's Final Position Paper at 3.

[33] *See* Provider's Final Position Paper at 12 (quoting PRM Part I § 2534.5(B) as stated in HCFA Transmittal No. 378 (July 1994)).

supports its CRM interpretation.[34] This letter reads in pertinent part:

> In accordance with a memorandum dated March 13, 1995 from HCFA Central Office to all HCFA Regional Offices, an exception for direct salary costs is computed as the provider's direct salary per diem cost in excess of the peer group direct salary per diem cost. The peer group direct salary per diem cost is determined by dividing the provider's actual percent of salary costs by total direct costs and applying this percentage to the peer group direct per diem costs. No exception is allowed for the non-salary direct cost per diem. However, if the provider can disaggregate the items included as non-salary direct costs into another cost center in the peer group, e.g. central services and supply, it could combine these costs with costs already included in that cost center. The portion of the peer group amount for non-salary direct costs associated with costs that were redistributed to the other cost center of the peer group would also need to be combined with the peer group amount for that cost center. This could result in an additional exception amount for some of the provider's costs previously categorized as non-salary direct costs. Any non-salary direct costs that can not be redistributed into a different cost center on the peer group will be left in the peer group as non-salary direct costs and no exception is allowed for these costs.[35]

The Provider asserts that step two of the two-step CRM process is necessary to maintain the integrity of the uniform national peer group which is used for comparison. The Provider notes that the uniform national peer group was constructed using settled cost report data from providers with urban HB-SNFs for the fiscal years ending in 1988 and 1989. In using this data, the Provider also notes that there was no reason for the intermediaries settling the 1988 and 1989 cost reports to make the type of reclassifications that the Intermediary made in this case as part of the exception determination process.

Further, the Provider maintains that the evidence in the record before the Board confirms that no reclassifications occurred before the uniform national peer groups were constructed, including the uniform national peer group of urban HB-SNFs at issue.[36] The Provider acknowledges that CMS disagrees with the Provider's interpretation that HCFA Transmittal 378 requires a two-step CRM process; however, the Provider points out that CMS has acknowledged that, in constructing the peer groups, CMS did not take any steps to reclassify any directly-assigned indirect costs. Specifically, CMS confirmed this fact in a February 2, 2000 memorandum to one of its intermediaries.[37] The Provider also alleges that CMS merely assumed that providers were correctly reporting costs on their cost report, and that CMS based this assumption on the fact that

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[34] *See* Provider's Final Position Paper at 12-14.

[35] Provider's Exhibit 2 for the Evidentiary Hearing. The Provider's Exhibits for the Evidentiary Hearing Exhibits will hereinafter be cited as "EH Exhibit" followed by the exhibit number preceded by "P-" (*e.g.*, EH Exhibit P-2).

[36] *See* Provider's Final Position Paper at 2.

[37] *See* EH Exhibit P-7 at 1.

most of the providers were reporting costs in the employee health and welfare cost center.[38] Thus, it is clear that the national uniform peer group of urban HB-SNFs created by CMS utilized the direct and indirect cost originally reported by the providers filing their cost reports, without any reclassification.

The Provider contends that the data used by CMS to create the national uniform peer group contained substantial amounts of misclassified indirect cost in the direct cost center because a substantial number of providers utilized "responsibility accounting" in submitting their cost reports. The Provider maintains that "responsibility accounting," whereby non-salary costs are assigned to the direct cost center, is followed by the majority of HB-SNFs that constitute the urban HB-SNF uniform national peer group.[39] Further, the Provider asserts that CMS was aware of the general use of responsibility accounting by providers as demonstrated by the following excerpt from a proposed rule published on March 19, 1980:

> Under the current reimbursement system, hospitals usually report their revenue and expenses according to the organizational units that produce the revenue and incur the expense (i.e., a "responsibility" reporting system). Each hospital is organized differently; therefore the costs are organized differently. Since each hospital has some flexibility in determining what costs form a particular cost center (a set of activities or functions for which costs are reported), cost centers cannot be accurately compared. Further, there are no uniform definitions of what costs can be included in a particular cost center. There is no adequate way to determine the cost per unit of services in a hospital or to compare the cost per unit of service across hospitals because the cost centers may include data which are not comparable.[40]

The Provider presented testimony[41] on the manual *Chart of Accounts for Hospitals: An Accounting & Reporting Reference Guide* as published by the Healthcare Financial Management Association (HFMA Chart of Accounts) to explain the concept of "responsibility centers" as organizational units that make up a hospital.[42] Specifically, this manual states:

> 1.12 Thus, the hospital entity is composed of organizational units. Each unit is a *responsibility center*. The individual in charge of each responsibility center is given the authority, within prescribed policies and practices, to take actions and make decisions necessary to effective management of the activities of the center. With such authority, that individual accepts responsibility for the achievement of the center's established objectives.

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[38] FH Tr. at 269-270.

[39] Provider's Post Hearing Brief at 4.

[40] Exhibit P-61 at 2 (CCH ¶ 30,373 reprinting 45 Fed. Reg. 17894 (March 19, 1980)).

[41] *See* FH Tr. at 162-168. *See also* FH Tr. at 148-151.

[42] Exhibit P-54 at 8 (L. Vann Seawell, Healthcare Financial Management Association, Chart of Accounts for Hospitals: An Accounting & Reporting Reference Guide (exhibit copy is undated)).

> 1.13 All responsibility centers incur expenses; some responsibility centers also generate revenues. Centers that do not generate revenues are referred to as *expense centers* or *cost centers*. (They also may be called *overhead*, or *support*, *centers*.) Those centers that generate revenues are called *revenue centers* or *profit centers*. In a *responsibility accounting system*, expenses are recorded and reported according to the centers responsible for the incurrence of the expense; revenues are recorded and reported according to the centers whose activities produced the revenues. The classification of revenues and expenses by responsibility center facilitates the process of managerial planning and control.[43]

"Responsibility centers" are the units underlying a system of "responsibility accounting" in which department managers report and control costs.[44]

The Provider is located in California. The Provider maintains that under California state law all hospitals operating in California (including HB-SNFs such as the Provider) are required to use "responsibility accounting" and, as a result, the original classification in the direct cost center of its costs is an outgrowth of its compliance with this state law.[45] In support of this assertion, the Provider introduced excerpts from the HFMA Chart of Accounts which support the direct assignments of the indirect costs that the Intermediary reclassified. Further, the Provider asserts that the impact of the California requirement is significant because California accounts for approximately 10 percent of the hospital population.[46]

The Provider acknowledges that Medicare does not have similar requirements for adherence to a "responsibility accounting" system. However, the Provider maintains that it is the regular practice of hospitals to report costs to the Medicare program using this accounting system.[47] The Provider explains that, under Medicare cost reporting rules, providers were allowed to maintain the accounting system they already had in place (*e.g.*, responsibility accounting) in submitting their Medicare cost reports[48] and that CMS was aware that some hospitals were permitted to report their costs to the Medicare program in this manner.[49] Thus, the Provider maintains that the Provider had properly assigned these indirect costs to the direct cost center consistent with the principles of responsibility accounting for purposes of submitting Medicare cost reports[50] and that it only reclassified the indirect costs from its direct cost center to various indirect cost

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[43] *Id.* (emphasis in original).

[44] FH Tr. at 60.

[45] *See* FH Tr. at 148-149. *See also* Cal. Code Regs tit. 22, §§ 97015, 97018; California Office of Statewide Health Planning and Development, *Accounting and Reporting Manual for California Hospitals, Second Edition* (March 2009) (*available at* http://www.oshpd.ca.gov/hid/Products/Hospitals/AnnFinanData/ Manuals/index.html)

[46] *See San Joaquin Comty. Hosp.*, PRRB Hearing Dec. No. 2001-D17 at 6.

[47] FH Tr. at 66.

[48] *See* FH Tr. at 165. *See also* 42 C.F.R. § 413.20.

[49] *See* FH Tr. at 255.

[50] *See* Exhibit P-19 at 4; FH Tr. at 45-46.

centers as part of its preparation of the exception request at issue in order to comply with the instructions provided in the PRM, Part I, Chapter 25.[51]

The Provider explains that CMS' failure to complete the two-step process consistent with the Provider's interpretation of HCFA Transmittal No. 378 distorts the peer group comparison to the disadvantage of the Provider. Removing the Provider's directly-assigned indirect costs without making a corresponding reclassification in the peer group does not allow for a proper comparison. What was a comparison of apples to apples, before any reclassification occurred, became a comparison of apples to oranges. An appropriate comparison can only be restored to one of like qualities (apples to apples) if the second step of also reclassifying directly-assigned indirect costs in the peer group is taken.

The Provider contends that CMS' assertion that the uniform national peer group does not contain direct costs of the type reclassified by the Intermediary (*i.e.*, directly-assigned indirect costs in the direct cost center) is unconvincing. The Provider notes that CMS maintained a data base of selected cost report information for hospitals and other providers known as the Health Care Cost Report Information System (HCRIS).[52] The Secretary used HCRIS data in developing the base per diem amounts for the uniform national peer group at issue pursuant to the PRM Part I, Chapter 25 peer group SNF exception methodology. However, the version of HCRIS used by CMS at that time did not identify the percentage of costs in the direct cost center that were non-salary costs.[53] As a result, the Secretary knew that the direct cost centers for the uniform national peer group at issue contained both nursing and non-nursing salary costs and non-salary costs.[54]

CMS witnesses gave testimony on the incidence of directly-assigned indirect costs in the direct cost center. The Provider characterizes this testimony as vague and conclusory because they each testified that, in their experience, the incidence of directly-assigned indirect costs in the direct cost center was limited to a few SNFs, in a few cost centers, and in small amounts.[55] The Provider asserts that the best source of such data to confirm this incidence would be CMS' records of adjudicated SNF exception requests because the adjudicated exception requests would identify the precise amount of directly-assigned indirect costs that were reclassified out of the

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[51] FH Tr. at 42-47.

[52] *See* EH Tr. 1/15/08 at 25.

[53] *See* EH Tr. 1/16/08 at 28. *See also* EH Exhibit P-7 (CMS memorandum dated Feb. 2, 2000). EH Exhibit P-7 states on page 2: "[T]he automated data system (Healthcare Cost Report Information System ) in use to construct the peer group could not identify what portion of net direct expense on Worksheet A was salary related and what portion was other than salary."

[54] EH Tr. 1/16/08 at 18-21. *See also* EH Exhibit P-7 (CMS memorandum dated Feb. 2, 2000). EH Exhibit P-7 states on page 2: "The peer group per diem amounts in Column A of the appendices in the Manual came from the certified SNF line of Worksheet B Part 1 of the Medicare costs reports less capital related costs divided by inpatient days. These costs originate from Worksheet A the first column of which is titled salaries, the second column of which is titled other, the third column is the sum of the first two columns, the next three columns include reclassifications and adjustments to arrive at the net expenses which flow to Worksheet B Part 1. The net direct expense which flows from the certified SNF line on Worksheet A to Column 1 of Worksheet B Part 1 thus includes salaries, other costs and any applicable upwards or downwards reclassifications and adjustments."

[55] *See* EH Tr. 1/15/08 at 6-62 and 218-221; EH Tr. 1/16/08 at 20-21 and 30.

direct cost center of the requesting provider. Unfortunately, CMS' witnesses did not know where this data is currently located.[56]

The Provider claims that, since 1994, CMS had information showing that material amounts of directly-assigned indirect costs were in the direct cost center and that these costs were material for a majority of HB-SNFs. The Certus Corporation (Certus) is a consulting group located in California that specializes in SNF exception requests. Based on information obtained from Certus, the Provider conducted several studies to estimate the average percentage of direct costs that are directly-assigned indirect costs during federal fiscal years (FFYs) 1995, 1996, 1997 and 1998.[57]

From a total sample population of 373 SNFs, the Provider determined that, as part of the HB-SNF exception application process for all HB-SNFs (urban and rural) for FFYs 1995 to 1998, 15.56 percent of each HB-SNF's total direct costs were on average directly-assigned indirect costs.[58] When only the SNF exception applications for urban HB-SNFs were reviewed for this same time period, this percentage increased to 15.72 percent.[59]

The Provider also presented a study using HCRIS cost report data to compare a sample of HB-SNFs with the entire population of HB-SNFs for FFYs 1997 and 1998.[60] The Provider asserts that this study confirms that its sample of 373 SNFs from FFYs 1995 to 1998 is representative and that the15.56 percent of the total direct costs identified as directly-assigned indirect costs in the four-year average noted above was accurate.

The Provider asserts that CMS could have conducted studies on this issue using adjudicated exception requests as early as 1995 and subsequent years. However, despite five years experience of material incidences of directly-assigned indirect costs occurring in these adjudicated exception requests, CMS rejected the facts that formed the basis of the CRM it claims exists in the PRM Part I, Chapter 25, in the 1997 policy letters and the advice and practice of some fiscal intermediaries, and applied a one-sided reduction method despite the clear evidence that there were material amounts of indirect costs in the direct cost center used to create the uniform national peer group.

The Provider contends that the CRM will not result in a windfall for providers because the Provider showed that the CRM will result in a lower amount of exception payments than would have occurred from an initial reclassification of the peer group data. In addition, the PRM Part I, Chapter 25 "cap" and "gap" methodologies limit the exception amount that an HB-SNF may receive.

The Provider presented data from all of the HB-SNFs that Certus represented that include this reclassification issue.[61] The Provider asserts that this report shows that, had CMS reclassified

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[56] EH Tr. 1/15/08 at 35-36 and 226-228; EH Tr. 1/16/08 at 32-34.

[57] *See* Exhibits P-40 – P-44

[58] *See* Exhibit P-44 Revised at 1.

[59] *Id.* at 3.

[60] *See* Exhibits P-45, P-46 and P-47; FH Tr. at 189 and 212.

[61] Exhibit P-49 FH Tr. at 219-220.

the indirect cost in the direct cost centers of the peer group to start, CMS would owe $7,265,447 on the 93 appeals.[62] Whereas, the amount that CMS would owe under the CRM would be $7,049,744. The similarity of the result shows that the CRM is a fair measure of the reclassification that should have taken place when the peer groups were compiled. The Provider also extrapolated its findings from the study and claims that by not adjusting the peer group by the CRM, CMS has underpaid hospitals with high Medicare utilization approximately $95 million annually.[63] The Provider also points out that these savings would be folded over into the Prospective Payment System rates.[64]

The Provider asserts that using the CRM, on the other hand, does not result in a windfall to the Provider because under the PRM Part I, Chapter 25 method its costs are limited by the "cap" and other rules that limit the amount that its actual costs may exceed numerous indirect cost centers. In addition, the Provider's reimbursement is also limited by the "gap" method in PRM Part I, Chapter 25 which only allows HB-SNFs to recover costs that are over 112% of their peer group mean.

The Provider contends that in refusing to apply the CRM, CMS acted arbitrarily, capriciously and not in accordance with law because: (1) CMS failed to consider its own data that shows the incidence of material amounts of directly-assigned indirect costs in the direct cost center of the peer group; and (2) it constitutes an inconsistent application of CMS rules regarding directly-assigned indirect costs and other non-salary costs.

The Intermediary indicates that the purpose of HCFA Transmittal 378 was to develop a uniform national peer group for SNFs to use to adjudicate exceptions and to identify a baseline amount in each relevant cost center to use when exceptions are being reviewed.[65] These were divided into four categories – hospital based SNFs in urban and rural areas and freestanding SNFs in urban and rural areas. CMS did this by using cost information from 1,000 cost reports available to it at that time (*i.e.*, the 1988/1989 HCRIS cost report data) to calculate the average cost for the direct cost center, which contained costs for the nursing and support staff that delivered hands-on care to patients, and also for 12 additional indirect cost centers which go to support the direct costs of delivering direct care. These average costs are the amounts listed in the HCFA Transmittal 378 appendixes in Column A which form the basis for adjudicating exception requests.

The Intermediary acknowledges that the averages are based on the assumption that providers used the cost reporting definitions or conventions widely in use and were reporting direct and indirect costs in their proper categories.[66] The Intermediary notes that the Provider has asserted that some providers had permission to directly assign certain indirect costs to the direct patient care area and others had miscalculated costs in the settlement of their cost reports. Despite these concerns, the Intermediary maintains that the majority of providers follow the typical cost reporting scheme and that using averages based on the majority of the contributing hospitals is an accurate and reasonable starting point to use in the exception review process.

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[62] Exhibit P-49 at 3.

[63] *See* Provider's Post Hearing Brief at 20.

[64] FH Tr. at 222.

[65] FH Tr. at 21-29.

[66] EH Tr. 1/15/08 at 18-30.

The Intermediary points out that the methodology in Transmittal 378 uses the baseline averages in Column A to develop relative weights for each of the cost centers in Column B and then applies these relative weights to spread the new cost limits in future years to the various cost centers in Column C. The methodology then compares each individual provider's costs in each of the various cost centers to the new peer group amounts in Column C. The Intermediary further indicates that since it assumed that the original peer groups were constructed using data that was properly reported in the various cost centers, providers requesting exceptions are required to correct, or reclassify, any indirect costs that they may have included in the direct cost center. In this way, they can assure that there is a proper comparison of the provider's costs with those of the uniform national peer group.

The Intermediary contends that the Provider's interpretation, the so-called CRM, is not a correct interpretation of the methodology in HCFA Transmittal 378. It is counter to the premise upon which the uniform national peer groups were constructed in the first place. The Intermediary points out that under the Provider's approach, the more a provider's costs differed from those of the peer group, the more the peer group would have to be revised, which would result in an overcorrection for that individual provider. The Intermediary claims that there needs to be a uniform consistently developed peer group that applies to all providers and that the decision, to utilize the cost reporting data as it was when the peer groups were constructed, is the best that could be done.

## FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has reviewed and considered the Medicare law and guidelines, the parties' contentions, testimony and other evidence presented. Set forth below are the Board's findings and conclusions.

### *District Court's Concern*

This case was remanded to the Board by the District Court to determine the effect of the failure to remove misclassified costs from the data used to create the uniform national peer groups on the Provider's exception request. In remanding this case, the District Court described an area of the record that was unclear:

> The Secretary contends the Medicare reports upon which the peer groups are constructed, "taking [into account] the fact that some providers might over report in a particular cost center, [and] the fact that it's an average," are sufficiently accurate to use in calculating exceptions. *See* AR at 148. The record is unclear as to the extent to which the settled reports which make up the peer groups incorporate reclassified costs. *See* AR at 162.[67]

Because of the lack of information in the record concerning the extent to which the data used to create the uniform national peer groups may have contained improperly classified costs and the

[67] *San Joaquin Comty. Hosp.*, 2002 WL 34596496, at *21 (italics and brackets in original and underline added).

effect of those costs on the amount of the Provider's exception, the District Court remanded the case to the Board for the following specific purpose:

> [T]he PRM requires national peer groups to be constructed using properly classified costs. The parties do not dispute that no reclassification of data took place from [*i.e.*, within] settled cost reports used to construct the national peer groups against which San Joaquin's exceptions reimbursement was calculated. . . . The PRRB's conclusion "that the Intermediary properly calculated the Provider's exception," . . . cannot be supported on the record. *A finding by the PRRB must be made as to the effect of the Secretary's failure to reclassify costs in peer group construction on the amount [of] San Joaquin's exceptions reimbursement before it can be determined whether the Secretary's decision not to reclassify costs in the peer group was arbitrary, capricious, or plainly erroneous manner inconsistent with the PRM.*[68]

Further, the above excerpt confirms that the District Court found that the language in HCFA Transmittal 378 required CMS to use "properly classified costs" in the creation of the uniform national peer groups but that no reclassification of potentially misclassified costs took place. The CMS position was that it did not reclassify any costs in the creation of the uniform national peer group because providers were, for the most part, correctly reporting their data on the cost reports making this reclassification unnecessary. On the other hand, the Provider asserts that there were significant amounts of misclassified costs in the uniform national peer group because substantial numbers of providers were utilizing responsibility accounting.

The Board notes that, in its earlier decision in this case, it found that the Intermediary properly followed the instructions in HCFA Transmittal 378. PRM Part I §§2534.5B and 2534.10, as amended by HCFA Transmittal 378, provide that a provider's directly-assigned indirect expenses be reassigned to the appropriate indirect expense cost center in the uniform national peer group identified with the type of cost incurred and that these costs then be compared with the respective cost centers in the uniform national peer group.[69] The Board again finds that the methodology used by the Intermediary to determine the Provider's exception request was proper under HCFA Transmittal 378. The Board finds that the purpose of HCFA Transmittal 378 was to establish a uniform national peer group against which providers could be compared and that the CRM methodology, as proposed by the Provider, is not supported by the text of HCFA Transmittal 378. In addition, the Board agrees with the Intermediary's contention that modifying the uniform national peer group to match the level of reclassification in each provider's cost report would undermine the concept of having a single benchmark for all providers and would result in a windfall for providers that had high levels of indirect costs reclassified compared to those that did not.

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[68] *Id.* at *22 (citations omitted) (emphasis added).

[69] The Board has more recently made a similar finding in *Parkview Mem. Hosp. v. Blue Cross Blue Shield Ass'n*, PRRB Case No. 2005-D20 (Jan. 7, 2005), CMS Administrator declined review (Feb. 14, 2005).

***Lack of Direct Evidence on the Extent of Improperly Classified Costs in the Uniform National Peer Groups***

The parties and the Board expended considerable efforts to locate and obtain the data or programs that CMS used to create the uniform national peer group at issue as well as any other documentation concerning CMS' analysis of the data in the database. In particular, the Board notes that considerable effort was made to obtain evidence pertaining to the extent of improperly classified costs in the data used to create the uniform national peer group at issue.[70] As these efforts were unsuccessful, the Board concludes that CMS did not retain this information.

While the actual data could not be obtained, the record does contain testimony from three then-current CMS employees who were involved in the development of the uniform national peer groups and the adjudication of provider exception requests. This testimony addresses the nature of the data used and the steps taken to ensure that this data did not have improperly classified costs (*e.g.*, directly-assigned indirect costs in direct cost centers).[71]

CMS employee testimony confirmed that CMS created the original uniform national peer group using cost report data from HCRIS.[72] As previously discussed, HCRIS contains data from the electronic cost reports submitted by a large number of providers.[73] CMS employee testimony indicated that, even though CMS developed the specification or formulas to create the cost limits[74] and ran the programs against the database, due to the passage of time, no records could be found or produced despite efforts to find the supporting documentation as part of the discovery request which CMS treated as a Freedom of Information Act (FOIA) request.[75] Further inquiry revealed that, even though CMS may have retained some HCRIS cost reporting data from providers from this time period, the specific files used to create the uniform national peer group no longer exist.[76] Further, the HCRIS data file used to create the uniform national peer group at issue cannot be reconstructed because HCRIS files are updated as cost reports are audited or changed due to re-openings and any current version of the HCRIS would not match the "snapshot" of HCRIS that CMS used to create the uniform national peer group at issue.[77]

Despite the lack of any documentation concerning the creation of the uniform national peer group at issue, CMS employees testified that they were aware that providers, subject to intermediary approval, could report their costs in different ways and, specifically, that some providers were directly reporting indirect costs in the direct cost center.[78] CMS employees also acknowledged that, from the data they used to create the uniform national peer group, they could not determine whether there were any indirect costs in the direct cost center.[79] The Board notes

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[70] *See* Background, *supra*.

[71] *See* EH Trs. 1/15/08 and 1/16/08; FH Tr.

[72] EH Tr. 1/15/08 at 26.

[73] EH Tr. 1/15/08 at 27 and 148.

[74] EH Tr. 1/15/08 at 29.

[75] EH Tr. 1/15/08 at 34-38; September 14, 2007 FOIA letter.

[76] EH Tr. 1/15/08 at 39.

[77] EH Tr. 1/15/08 at 50-54, 146-7, 154-157.

[78] EH Tr. 1/15/08 at 60, 68 and 69.

[79] EH Tr. 1/15/08 at 70, 151-2 and 155; FH Tr. at 268.

that the record also contains a February 2, 2002 memorandum that a CMS employee prepared for one of its intermediaries that purported to explain CMS' position with respect to the creation of the uniform national peer groups.[80] A portion of this document states:

> While directly assigning various indirect expenses may be permitted for cost reporting purposes, HCFA was not able to estimate either the number of providers in its peer group which did this or the per diem effect of doing this.[81]

CMS employees testified that this statement was correct and that data it used to create the uniform national peer group did not permit them to know how many providers did or did not directly assign indirect costs to the direct cost center. The CMS employees further testified that, even if CMS were to locate the data that was used, one still would not be able to determine if any of the providers were directly assigning indirect costs to the direct cost center.[82] Finally, the CMS employees did not recall the specifics of the program that was developed to run using the HCRIS data (including the program formula, algorithm, and methodology) for purposes of creating the national uniform peer group benchmarks.[83]

CMS employee testimony also indicated that, prior to using HCRIS data that was ultimately used to create the uniform national peer group, CMS did not conduct any special audits or other analysis to try to make the data uniform with regard to reclassification.[84] CMS employees explained that the only way to answer the question would be to obtain additional information from each hospital's financial records.[85]

CMS employees testified that they believed that the 1988/1989 HCRIS cost report data used to create the uniform peer group did not have a substantial amount of directly-assigned indirect costs in the direct cost center. The basis of that determination was their review of whether a significant number of providers in the sample were reporting costs in the employee health and welfare line of the cost report.[86] This belief appears to be based, in part or in whole, on CMS' historical experience in reviewing SNF exception requests.[87] However, the Board notes that other than this general statement concerning the CMS employee's assumption regarding the 1988 and 1989 data and their historical experience in reviewing SNF exception requests, no evidence was presented or identified to support this assumption. Furthermore, CMS employees admitted that they could not determine if providers had reported all or just a portion of their employee health and welfare costs in that cost center.[88]

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[80] *See* EH Exhibit P-7; EH Tr. 1/15/08 at 72.

[81] EH Exhibit P-7 at P-07.0001.

[82] EH Tr. 1/15/08 at 72 and 73.

[83] *See* EH Tr. 1/15/08 at 37-38, 32-41 generally, 85-86, 108. 195-196.

[84] EH Tr. 1/15/08 at 148.

[85] EH Tr. 1/15/08 at 157-8.

[86] FH Tr. at 269-70.

[87] EH Tr. at 72-73.

[88] FH Tr. at 272.

The Board agrees with the CMS employee testimony that the HCRIS cost report data used to create the uniform national peer groups at issue does not contain the data elements that would have permitted CMS to determine whether providers were reporting directly-assigned indirect costs in the direct costs center. The Board agrees with CMS employee testimony that the only way to correctly determine the extent of directly-assigned indirect costs in the direct cost center would be to obtain additional information from each provider's accounting records from the fiscal years used to create the national uniform peer group at issue.[89] Given the number of hospitals in the national HCRIS data base, the Board finds it would have been impractical to commission a special audit merely to determine the extent of directly-assigned indirect costs in the direct cost center for all providers in the HCRIS data base. At the same time, the Board finds that there is no evidence in the record on which to base a determination concerning the extent of directly-assigned indirect costs in the direct cost center in these fiscal years and that, due to the passage of time, the detailed accounting information needed to make this determination is unlikely to be available.[90]

The Board finds that the evidence in the record and the methodology that CMS employees described being used to create the uniform national peer group at issue neither corroborates nor disproves CMS employees' assertions regarding the extent of improperly classified costs in the data used to create that uniform national peer group at issue. The Board did not find any evidence in the record that shows the extent, if any, of directly-assigned indirect costs in the direct cost center in the 1988 to 1989 fiscal year data used to create the uniform national peer group at issue.

The Provider contends that many SNFs and other health care providers utilize "responsibility accounting" as a method of accounting and that under this method many indirect costs are directly assigned to the cost center responsible for incurring those costs and that this practice resulted in significant amounts of indirect costs being assigned to the direct cost center. The Provider further noted that some states, including California where the Provider is located, require hospitals to classify as direct costs many of the costs that were reclassified as indirect in requesting an exception under Transmittal 378. The Provider further points out that because Medicare cost reporting does not require uniform reporting of costs, providers who were using responsibility accounting were allowed to submit their cost reports with significant amounts of indirect costs in the direct cost center. The Intermediary indicated that it was aware of the fact that some providers may have been using responsibility accounting in reporting their costs reports,[91] but indicated that they did not believe significant amounts of indirect costs were reported in the direct cost center.[92]

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[89] EH Tr. 1/15/08 at 157; EH Tr. 1/16/08 at 29 and 72; FH Tr. at 268. *See also* Exhibit P-58 (General Ledger responsibility report).

[90] Even though there is no evidence in the record describing the program used to run against the 1988/1989 HCRIS cost report data to create the uniform national peer group benchmark at issue (*see supra* note 84 and accompanying text), it is the Board's understanding that CMS generally cleans data sets prior to using them for reimbursement purposes. As a result, it is unclear whether CMS may have cleaned the data at issue (*e.g.*, remove certain outliers ) prior to using it calculate the urban HB-SNF benchmark at issue and, if so, whether that cleaning could have minimized some or all of the impact of improperly classified costs potentially remaining in the data set.

[91] EH Tr. 1/15/08 at 60.

[92] FH Tr. at 269 – 272.

While the Board generally agrees with the Provider's assertions that some providers were using responsibility accounting at the time the uniform national peer group at issue was developed and were permitted to report their costs in that manner on their cost reports, the Board notes that the Provider did not present any definitive evidence quantifying the extent to which this issue affected the construction of the uniform national peer group at issue.[93] There was no definitive evidence presented concerning which states, other than California, required providers to use responsibility accounting in the 1988 fiscal year, and the percentage of providers that might represent. In addition, the Board notes that, even if certain providers were required to use responsibility accounting *for state purposes*, they were not required to report their costs in this same manner on their Medicare cost reports and, as a result, may have reported their costs differently.[94] And finally, as discussed more fully in the next subsection, the Board notes that a substantial portion of the providers in the Provider's data were from California where responsibility accounting was required and, the Board ultimately finds that this data cannot be used as a sample because it is not representative of the providers in the country as a whole and, thereby, is fatally flawed.

***Potential Indirect Evidence Concerning the Extent of Improperly Classified Costs***

Absent any definitive evidence about the extent of improperly classified costs in the actual data used to create the uniform national peer group at issue, the Provider suggested that the amount of misclassified costs in the 1988 costs reports could be estimated by examining the amount of misclassified costs in all provider exception requests filed with CMS under the new exception request procedures. The Provider pointed out that, under the new exception request procedures in Transmittal 378 that were effective in 1994, providers were required to identify the amount of directly-assigned indirect costs and reassign those costs to the appropriate indirect cost center prior to the comparison to the cost centers in the uniform national peer group. Since both the Intermediary and CMS carefully review provider exception requests, it was asserted that the amount of indirect costs in the direct cost center in these requests would be accurate.

The Board agrees that the examination of HB-SNF exception requests could indicate the extent to which indirect costs have been reported in the direct cost center. However, it is not clear if one can use this information to determine the extent to which, if any, the uniform national peer group at issue was improperly constructed. First, the Board notes that one cannot determine if those seeking exception requests have a similar amount of misclassified costs as SNFs that did not request exception or by what amount (*i.e.*, determine whether some or all of those seeking exception requests represent outliers). Second, the potential data would only pertain to exception requests for fiscal years that started in 1994 well after the creation of the uniform national peer group at issue. As a result, one cannot determine if the percentage of SNFs reporting

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[93] *See Id.* at 149-150 (California requires responsibility accounting, but witness uncertain about New York state.) The Provider did not present any evidence confirming whether responsibility accounting is required in any state other than California.

[94] The Board notes that the Provider's study of SNF exception requests (*see* Exhibits P-40 to P-44) illustrate that, even if providers use responsibility accounting for state purposes, they may not have reported their costs in this same manner on their Medicare cost reports. Specifically, the Board observes from its review of this data that the reclassification percentage for providers located in California alone (where responsibility is required) varied significantly from virtually 0 percent to greater than 40 percent.

misclassified costs was greater or less than they were six to ten years earlier when the uniform national peer group at issue was created.[95]

In any event, these exception request records are not available from CMS. CMS employee testimony at the evidentiary hearing indicated that CMS only retained basic information concerning the amount of exception awards granted and did not retain the detailed information from the exception requests that would have included information about the amount of reclassified cost.[96]

Even though CMS did not retain its detailed SNF exception request records, the Provider was able to obtain a large number of exception request records from Certus Corporation (Certus), a health care consulting firm that assisted numerous providers, including the Provider, in preparing their SNF exception requests during fiscal years 1995 through 1998. The exception request information from Certus contained the detailed information about the amount of indirect costs that had to be reclassified from the direct cost center.

The Provider presented SNF exception data for 373 SNF providers (urban and rural) which breaks out as follows:

- 59 SNF providers in FFY 1995,
- 94 SNF providers for the FFY 1996,
- 111 SNF providers for the FFY 1997, and
- 109 SNF providers for the FFY 1998.[97]

For each FFY, the Provider presented a detailed analysis of the actual costs reclassified from the direct cost center to various indirect cost centers (or vice versa in some instances)[98] for each of these SNF providers.[99] The providers in the sample were principally from central and western states, particularly the State of California. However, there were 15 total states represented in the 1995 data, 19 total states in the 1996 data, 22 total states in the 1997 data, and 21 total states in the 1998 data.[100] The Provider also presented data which it asserts shows that the providers in its sample of urban and rural HB-SNFs closely represented the HCRIS data base for all urban and rural HB-SNFs in both FFYs 1997 and 1998.[101]

However, as the peer group at issue only pertains to those providers that are urban HB-SNFs, the Board must look at the sample as it pertains to urban HB-SNFs. There were 282 urban HB-SNFs and the representation of other states decreases significantly when only urban HB-SNFs are

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[95] The uniform national peer group was based on 1988 cost report data and the earliest exception information would be for 1994 cost reports.

[96] *See* EH Tr. 1/15/08 at 226-232.

[97] *See* Exhibits P-40 (FYE 1995), P-41 (FYE 1996), P-42 (FYE 1997) and P-43 (FYE 1998).

[98] For example, in the subset of the 1995 data pertaining to urban HB-SNFs, there are 16 providers in which certain costs were reclassified *into* the direct cost center (as opposed to being reclassified *out of* the direct cost center). *See* Exhibit P-40.

[99] *Id.*

[100] Exhibit P-44 Revised at 1.

[101] *See* Exhibit P-47 at 1.

considered. For example, state representation decreases to 8 in 1995 and 13 in 1996 when only urban HB-SNFs are considered.[102] Indeed, California and Texas tend to dominate and together comprise more than 60 percent of the urban HB-SNFs in the 1995 and 1996 sample.[103]

The Provider summarized its findings of the weighted average amounts of directly-assigned indirect costs that were reclassified from the direct cost center for urban HB-SNFs,[104] rural HB-SNFs[105] and all HB-SNFs[106] for each of the four years studied – 1995, 1996, 1997, and 1998. The table below summarizes the Provider's findings[107] on the weighted average amount of net costs that were reclassified from the direct cost center for all HB-SNFs and for the subset of urban HB-SNFs for each of the four years reviewed by the Provider:

| FFY | All HB-SNFs | Urban HB-SNFs |
|---|---|---|
| 1995 | -11.93 percent | -12.98 percent |
| 1996 | -15.75 percent | -15.18 percent |
| 1997 | -16.49 percent | -16.62 percent |
| 1998 | -16.27 percent | -16.44 percent |

The overall weighted average expressed as a percentage for all 373 HB-SNFs in all four years across the sample was -15.56.[108] Similarly, the overall weighted average expressed as percentage for all 282 urban HB-SNFs in all four years across the sample was -15.72.

The Board finds that the evidence presented by the Provider for this limited sample does show a significant number of providers consistently reporting a material percentage of indirect costs in their direct cost centers during a four year time period from FFY 1995 through FFY 1998. Although this data is suggestive that there could be a significant amount of directly-assigned indirect costs in the data that CMS used to develop the uniform national peer group at issue, the Board finds that it has no probative value because there is insufficient evidence to determine:

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[102] *See* Exhibit P-44 Revised at 3.

[103] The Board's review of the 1995 sample at P-40 suggests that the effective size of the urban HB-SNFs for 1995 was the 42 because even though 57 urban HB-SNFs are listed, the "N/A" notations for 15 of these SNFs suggests that records were not located for these 15 SNFs. Further, 15 of these 42 (approximately 36%) were located in California and 14 of these 42 (approximately 33%) were located in Texas. As a result, the Board's review suggests that approximately 69% of the 1995 sample as it pertained to urban HB-SNFs were from two states. The Board's review of the 70 urban HB-SNFs identified in the 1996 sample at Exhibit P-41 yielded similar results where more than 60% were located from those same two states.

[104] Exhibit P-44 Revised at 3.

[105] *Id.* at 2.

[106] *Id.* at 1.

[107] *Id.*

[108] *Id.* The Board notes that Exhibit P-38 includes a 14.21 reclassification percentage. However, it is unclear whether the Exhibit has any probative value relative to determining the extent of improperly classified directly-assigned indirect costs in the direct cost center. For example, unlike Exhibits P-40 to P-43, this table does not appear to represent a sample as it includes providers with fiscal years ending in 1993, 1994, 1995, and 1996. Further, the data that it does include is less detailed than Exhibits P-40 to P-43, and the data overlaps partially with the data in Exhibits P-40 and P-41 but, in some instances, Exhibit P-38 reports different amounts of reclassifications for the providers that overlap with P-40 and P-41.

1. Whether the sample is representative of all SNFs in general for the years sampled (*i.e.*, FFYs 1995 to 1998);[109] and
2. Whether the sample is representative of the SNFs at the time the uniform national peer group was created (*i.e.*, FFY 1988).[110]

The Board again observes that the exception request information is limited to providers that applied for exceptions, the data represents only a portion of the SNF providers that sought an exception request during fiscal years 1995 through 1998, the providers were predominately from the central and western portions of the country with California and Texas dominating the subset of urban HB-SNFs, and the data pertains to cost years long after the creation of the uniform national peer group.[111] The Board finds that the Provider has failed to present evidence to support a finding that, notwithstanding the large presence of California and Texas providers in the sample, the sample is representative of the country as a whole. As a result, the Board finds that this data is not representative of the providers in the country as a whole and, thus, is fatally flawed.[112]

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[109] In addition to concerns about the sample being disproportionately represented by California providers, it is unclear to what extent there may be outliers in the sample and whether the weighted average percentages put forward by the Provider are materially skewed in one direction or the other. For example, Providers 25, 42, 55, and 56 of the 1995 sample had the highest dollar amounts reclassified *out of* the direct cost center into indirect cost centers—$1,110,810, $905,256, $517,774, and $785,022 respectively. If these 4 providers are removed from the 1995 sample, then the 1995 urban HB-SNF percentage decreases over 40 percent from 12.98 to 7.61. Similarly, Provider 7 is a potential significant outlier in the other direction as this provider had $490,909 reclassified *into* the direct cost center. If Provider 7 is removed from the 1995 sample, then the 1995 urban HB-SNF percentage increases by almost 10 percent from 12.98 to 14.25.

[110] *See supra* notes 103 and 104 and accompanying text. In connection with the remoteness of time, the Board makes a distinction between costs and the manner in which costs are accounted. The Board recognizes that, in comparing the Provider's costs from FY 1995 to the costs of a uniform national peer group of urban HB-SNFs from FYs 1988 and 1989, CMS necessarily believed (and the Board accepts) that there is a sufficient relationship for purposes of comparison between urban HB-SNF costs for FY 1995 and urban HB-SNF costs from FYs 1988 and 1989. However, separate and apart from the Board's concerns regarding the representativeness of the Provider's information, the Board finds that there is insufficient information for the Board to move a step further to conclude that the frequency of urban HB-SNF use of responsibility accounting in FYs 1995 through 1998 can be extrapolated back onto the uniform national peer group of urban HB-SNFs for FYs 1988 and 1989. For example, the Provider's data suggests that average amount of reclassifications from the direct cost center increased over the four-year period studied by more than 25% (*i.e.*, increased from 12.98% to 16.44%). *See* Attachment to Provider's Post Hearing Brief at 3 (submitted to supplement Exhibit P-44).

[111] *See* Exhibits P-40 – P-43.

[112] The Board recognizes that the Provider conducted a study using HCRIS cost report data from FFYs 1997 and 1998 to compare the Certus sample of HB-SNFs with the entire population of HB-SNFs for those FFYs. *See* Exhibits P-45, P-46 and P-47; FH Tr. at 189, 191-192, 212. However, the Board finds that this study fails to rehabilitate the Certus sample. Even if the selected HCRIS data points for the HB-SNFs from the Certus sample were "comparable" to the corresponding HCRIS data points for the universe of HB-SNFs, it would not establish that the Certus sample was representative of the universe of HB-SNFs (*e.g.*, the HCRIS data does not address the Board's concern that the inclusion of a large number of California providers that are required to use responsibility accounting may improperly skew the Certus sample). Further, the Provider has asserted that the fact that over 75% of the hospitals in the HCRIS data had other direct costs that were more than 10% of total direct costs is the best available empirical data to contradict "CMS' assumption that only a small number of hospital-based SNF units would be affected by cost reclassifications and that its failure to make any reclassifications when constructing the Peer Group limits would be insignificant." *See* Exhibit P-39 at 3. The Board does not believe the HCRIS data supports this assertion because it is unclear, for example, the extent to which the HCRIS "other direct costs" data

With all of these limitations, the Board finds that the Provider's proposed approach cannot provide accurate information for a representative sample of SNFs in general and may not be representative of the level of misclassified costs in the year the uniform national peer group was created. Based on the data and other evidence in the record, there is no way for the Board to determine the extent to which there was indirect costs in the uniform national peer group.[113]

***Summary***

The Board finds that the Intermediary used the proper methodology to calculate the Provider's exception pursuant to the methodology specified in Transmittal 378 and that, notwithstanding the parties' efforts to identify evidence relevant to this case, there is insufficient evidence to reach a conclusion that the uniform national peer group of urban HB-SNFs was materially affected by urban HB-SNFs reporting indirect costs in the direct cost centers. In particular, the data presented by the Provider did not identify the number of providers using responsibility accounting during fiscal year 1988 or any other later year; was from a time period too remote from the fiscal year 1988 when the uniform national peer group at issue was constructed; and was not representative because the data only included providers that filed for exceptions and overly represented California and other western and central states.

## DECISION AND ORDER:

The Board finds that there is insufficient evidence to determine the effect of the Secretary's failure to reclassify costs in the peer group construction on the amount of the Provider's exception reimbursement. In particular, there is insufficient evidence that directly-assigned indirect costs in the construction of the uniform national peer group materially affected its use to limit the Provider's exception request was improper. Finally, the Board reaffirms its findings with respect to Issue No. 1 of the PRRB Decision No. 2001-D17 that "the Intermediary properly calculated the Provider's exception [pursuant to the instruction in HCFA Transmittal 378] and that sufficient proof that the peer groups was improperly constructed was not presented."

## BOARD MEMBERS PARTICIPATING:

Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
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may include other non-salary direct costs and does not consider the extent to which the directly-assigned indirect costs may be offset, in part or in whole, by direct costs being moved from an indirect cost center into the direct cost center for purposes of an exception request.

[113] Further, even if the Provider's approach were to produce accurate information, using it to the adjust the uniform national peer group benchmark at issue could result in an overcorrection because it is unclear to what extent, if any, CMS took steps to clean or adjust the raw 1988/1989 HCRIS cost reporting data prior to using it to calculate this benchmark.

**FOR THE BOARD:**

John Gary Bowers, C.P.A.
Board Member

Date: AUG 08 2012