PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2016-D9

PROVIDER –
UTMD Anderson Cancer Center

Provider No.: 45-0076

vs.

MEDICARE CONTRACTORS –
Cahaba Safeguard Administrators, LLC and Novitas Solutions, Inc.

HEARING DATE –
December 14 – 15, 2011

Cost Reporting Periods Ended –
August 31, 1999, August 31, 2003, August 31, 2004, August 31, 2005

CASE NOs.: – 04-1952, 06-2367, 08-1595, 08-1951

INDEX

ISSUES:

ISSUE 1 – Whether the Provider's request for adjustments to the TEFRA target amount shall be granted.[1]

ISSUE 2 – Whether the Medicare Contractor's adjustment to certain Company P expenses was proper.[2]

DECISION

After considering the Medicare law and program instructions, the evidence presented, and the parties' contentions, the Board makes the following findings:

ISSUE 1 – The Board finds that the Provider is not entitled to any additional adjustment to its TEFRA target amount for fiscal years ("FYs") 1999, 2003, 2004 and 2005. Accordingly, the Board affirms the Medicare Contractor's refusal to allow any additional TEFRA target adjustments for these fiscal years.

ISSUE 2 – The Board finds that the Medicare Contractor's adjustments at issue relating to Company P expenses for FY 2004 were proper. Accordingly, the Board affirms these adjustments.

INTRODUCTION:

The University of Texas M.D. Anderson Cancer Center ("UTMD Anderson" or "Provider") is located in Houston, Texas and is one of the nation's federally-designated comprehensive cancer centers. UTMD Anderson's designated Medicare contractor[3] during the time at issue was Trailblazers Health Enterprises ("Trailblazers") which was succeeded by Cahaba Safeguard Contractor ("Cahaba"). The Board will refer to Cahaba and Trailblazers collectively as the "Medicare Contractor."

As a cancer hospital, UTMD Anderson is exempt from the Medicare inpatient prospective payment system ("IPPS") for acute care hospitals. Instead, Medicare pays UTMD Anderson for allowable inpatient costs on a reasonable cost basis, subject to a ceiling on its rate of increase of operating costs as established by the Tax Equity and Fiscal Responsibility Act ("TEFRA").

UTMD Anderson timely appealed multiple issues resulting from Notices of Program Reimbursement ("NPRs") for FYs 1999, 2003, 2004 and 2005.[4] There are only two issues

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[1] *See* Transcript ("Tr") at 5, 7 (Dec. 14, 2011) (showing this issue pertains to Case Nos. 04-1952 (FY 1999), 06-2367 (FY 2003), 08-1595 (FY 2004) and 08-1951 (FY 2005)).

[2] *See id.* (showing this issue only pertains to Case No. 08-1595 (FY 2004)).

[3] The Board will refer to fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") as Medicare contractors.

[4] *See* Provider's Post Hearing Brief at 3-5, Addendum A (providing a summary of the procedural status of this issue for each fiscal year with cross references to the relevant exhibits including those exhibits containing copies of the relevant NPRs and RNPRs that were appealed).

remaining in these appeals.[5] The first issue concerns whether the Board should reverse the Medicare Contractor's denial of UTMD Anderson's requests for adjustments to its TEFRA target amount for FYs 1999, 2003, 2004, and 2005. UTMD Anderson also appealed the Medicare Contractor's adjustments to its FY 2004 cost report relating to the costs of certain capital projects referred to as "Company P" expenses.

The Board held a hearing on December 14 - 15, 2011. UTMD Anderson was represented by Christopher L. Keough, Esq. of Akin, Gump, Strauss, Hauer & Feld. The Medicare Contractor was represented by Bernard Talbert, Esq. of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS

ISSUE 1 - TEFRA TARGET ADJUSTMENT

In order to encourage Medicare-participating hospitals to render medical services more efficiently and economically, Congress established a ceiling on the rate of increase of inpatient operating costs through TEFRA. CMS calculates the ceiling, (known as the "TEFRA target amount") for a hospital's base year by dividing the allowable Medicare operating costs in a hospital's base year (net of certain expenses such as capital-related and direct medical education costs)[6] by the number of Medicare discharges in that year. CMS then updates the base year TEFRA target amount annually based on an inflation factor.

A hospital that incurs qualifying operating costs below the applicable TEFRA target amount in a given cost reporting year is entitled to reimbursement for its reasonable cost and an additional incentive payment.[7] However, a hospital that incurs operating costs above the TEFRA target amount may not be reimbursed above the target amount for a particular fiscal year unless the hospital requests, and receives CMS approval, for an "adjustment" to that fiscal year's TEFRA target amount or by requesting a permanent change in its TEFRA base year amount (known as "rebasing").[8]

The TEFRA target amount for UTMD Anderson was initially set using the base year of FY 1983. UTMD Anderson's base TEFRA target amount has been updated each year by the annual inflation adjustment factor.

UTMD Anderson requested that CMS make certain adjustments to its TEFRA target rate for FYs 1999, 2003, 2004 and 2005.[9] CMS denied UTMD Anderson's request for rebasing but granted some of the requested adjustments to the TEFRA target amounts. CMS granted adjustments for intensive care unit, anesthesiology services, physical therapy services and clinical services for

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[5] In particular, UTMD Anderson withdrew the following two issues from this appeal: (1) Medicare Contractor's denial of its request for a new TEFRA base year from the appeal; and (2) its payment to cost ratio ("PCR") for purposes of the hold harmless payment under the outpatient prospective payment system. *See* Provider's Post Hearing Brief, Addendum A at 3, 3n.1, 7 (showing #1 was withdrawn prior to the hearing and #2 following the hearing).

[6] *See* 42 CFR § 413.40 (a)(3).

[7] *See* 42 CFR § 413.40(d)(2).

[8] *See* 42 C.F.R. § 413.40(b)(1) and (e).

[9] *See* Medicare Contractor Exhibit I-6 (FY 2005); Provider's Post-Hearing Brief at 4, Addendum A.

FY 1999 and for increased physical therapy services, increased clinical services, and new radiology PET (Positron Emission Tomography nuclear imaging) services for FYs 2003, 2004, 2005.[10] However, for FYs 1999 and 2003 to 2005, CMS denied an adjustment based on increases in UTMD Anderson's case mix index ("CMI"), *i.e.*, increased patient acuity, and adjustments for the cost of certain new services including new drugs not included in the FY 1983 base year.[11] The only TEFRA target adjustment requests that are at issue in this appeal are those based on CMI and new drugs.[12]

For purposes of the hearing on this issue, the parties have agreed that the FY 2005 appeal, Case No. 08-1951, would serve as the representative case. Accordingly, the Board generally has focused on the FY 2005 data as it relates to this issue.[13]

ISSUE 2 - COMPANY P EXPENSES

UTMD Anderson established a cost center known as "Company P" to capture all capital and operating expenses associated with the development of several types of project costs during FY 2004.[14] One type of the Company P project costs involved salary costs for capital improvements to facilities; the other type involved the internal development costs of three software projects.

In the Company P cost center for its FY 2004 cost report, UTMD Anderson classified $769,750 in salary costs for four employees working on the capital improvement projects as operating costs.[15] During the initial audit, the Medicare Contractor agreed with this classification and did not adjust it in the FY 2004 NPR.[16] However, the Medicare Contractor subsequently reopened this NPR and reclassified these costs as capital costs instead of administrative overhead.[17] UTMD Anderson objected to this reclassification arguing that these salary costs were project management expenses, not directly involved in the production or increase in the value of the relevant capital assets.

The second aspect of the Company P issue has to do with cessation of further development of three software projects in FY 2004 before they were fully completed. On its FY 2004 cost report, UTMD Anderson included $3,802,152 as operating costs related to internally-developed software projects that became impaired or were abandoned.[18] The Medicare Contractor rejected this classification saying that these costs were not "related to patient care" as required by 42 C.F.R. § 413.9(b). The Medicare Contractor also maintains that UTMD Anderson should have claimed the costs at issue on the FY 2003 cost report rather than in the FY 2004 cost report because UTMD Anderson abandoned each of the three software projects during FY 2003.[19]

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[10] *See* Medicare Contractor Exhibits I-7, I-8 (FY 2005); Provider's Post-Hearing Brief at 4, Addendum A.
[11] *See* Provider's Post-Hearing Brief at 4, Addendum A.
[12] *See id.* at 10-14. *See also supra* note 5 (highlighting some of the issues withdrawn from this appeal).
[13] *See* Provider's Post-Hearing Brief, Addendum A at 3.
[14] *See* Provider's Final Position Paper (FY 2004) at 9.
[15] *See* Provider's Post-Hearing Brief at 89.
[16] *See id.* at 91.
[17] *See* Provider Exhibit P-54 (FY 2004); Provider's Final Position Paper (FY 2004) at 1.
[18] *See* Medicare Contractor's Final Position Paper (2004) at 12; Provider's Final Position Paper (FY 2004) at 9.
[19] *See* Tr. at 18-22 (Dec. 15, 2011).

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

ISSUE 1 - TEFRA TARGET ADJUSTMENT

UTMD Anderson claims that, for FYs 1999, 2003, 2004, and 2005, it is entitled to an adjustment to its TEFRA ceiling for its increased operating cost for two independent reasons: (1) a substantial increase in case mix as compared to the FY 1983 base year; and/or (2) the cost of new drugs introduced since the FY 1983 base year.[20] UTMD Anderson maintains that federal regulations recognize each of these factors as a valid basis for an adjustment.[21] The Board discusses UTMD Anderson's arguments with respect to each factor in more detail below. For purposes of the hearing on this issue, the Board has generally focused on the FY 2005 data because the parties have agreed that the FY 2005 appeal, Case No. 08-1951, would serve as the representative case for this issue.

A. Discussion Related to Increase in Case Mix and Service Intensity

UTMD Anderson contends that the record before the Board demonstrates that its patient acuity and case mix increased substantially in FY 2005 as compared to the FY 1983 base year and, as a result, it is due a TEFRA target adjustment for distortion. UTMD Anderson argues that, in FY 1983, a large percentage of patients with early stage cancers were hospitalized for lengthy periods of chemotherapy or for relatively simple surgeries.[22] In contrast, UTMD Anderson maintains that, as of FY 2005, cancer treatment has evolved significantly with new technologies, new drugs, and new therapies, and that the bulk of those patients with profiles similar to the FY 1983 patients (including even their surgeries) had shifted to the outpatient setting by FY 2005, leaving only the sickest individuals and most complex cases as inpatients during FY 2005.[23]

As a result, UTMD Anderson argues that the volume and intensity of services per inpatient discharge increased its operating costs for FY 2005 well above its TEFRA target rate.[24] In support, UTMD Anderson cites to the following as examples: (1) patients transferred from other hospitals' intensive care units to UTMD Anderson because of its advanced treatment methods; and (2) patients admitted to its routine floors where they receive care from specialists treating particular cancer types.[25] Finally, UTMD maintains that, in comparison to the FY 1983 base year, it performed complex surgeries during FY 2005 typically involving multiple surgeons with different specialties, resulting in longer surgeries involving multiple procedures.[26]

In support of its appeal, UTMD Anderson proffered extensive statistical data to support its argument related to increases in acuity and concurrent cost increases. In particular, UTMD

[20] *See* Provider's Post-Hearing Brief at 10.
[21] *See id.* at 8, 45.
[22] *See* Provider's Post-Hearing Brief at 11, 18; Tr. at 337-338 (Dec. 14, 2011).
[23] *See* Provider's Post-Hearing Brief at 11; Tr. at 329-330;170-174 (Dec. 14, 2011).
[24] *See* Provider's Post Hearing Brief at 45-46.
[25] *See* Tr. at 360-361 (Dec. 14, 2011).
[26] *See* Provider's Post-Hearing Brief at 15.

Anderson calculated its CMI for FY 2005[27] and compared it to the CMI for every year from FY 1983 (the base year) to FY 2005 to establish a CMI increase of 68 percent (*i.e.*, from 1.0584 to 1.7822).[28] UTMD Anderson argues that CMI is relevant to UTMD Anderson's analysis of increases in patient acuity and treatment practices (and their related increased cost) because CMS uses it and it is the best available, published and objective measure to account for increases in severity of illness and patient acuity.

In support of its assertion that the severity of its patients' conditions increased between FYs 1983 and 2005, UTMD Anderson also submitted data showing: (1) increases in the average number of surgery hours per case between FYs 1991 and 2005; (2) increases in the number of inpatient and outpatient operating room procedures between FYs 1991 and 2005;[29] (3) increases in the number of ICU days between FYs 1983 and 2005; and (4) an increase in the number of diagnoses per Medicare claim (*i.e.*, medical conditions as defined by DRG) between FYs 1995 and 2005.[30] To further illustrate the greater acuity of its patients during FY 2005 as compared to FY 1983, UTMD Anderson also submitted data to highlight increases in costs of certain core services between FYs 1995 and 2005, including nursing staff hours per Medicare patient day,[31] radiology services,[32] and physical therapy.[33] Similarly, UTMD Anderson submitted data to show the increase in its costs for outpatient clinic services between FYs 1987 and 2005.[34]

UTMD Anderson contends that this data demonstrates that it has met the criteria established in 42 C.F.R. § 413.40(g)(3) for a TEFRA target adjustment based on changes in service volume and intensity because: (1) increased patient acuity (*i.e.*, case mix) led to additional costs that caused UTMD Anderson to exceed its TEFRA target in FY 2005; and (2) these additional costs were extraordinary costs beyond its control that resulted in a significant distortion in costs between the base year and FY 2005. UTMD Anderson also used CMI to quantify how much the TEFRA target should be adjusted. Specifically, UTMD Anderson "calculate[d] what the projected cost per discharge would be in [FY] 2005, stated in [FY] 1983 dollars, based on the 68 percent change in CMI between [FYs] 1983 and 2005." Because UTMD Anderson's actual cost per discharge, adjusted to 1983 dollars, was 36 percent lower than the projected cost, UTMD Anderson concludes that it is entitled to a TEFRA target adjustment to cover all of its excess costs based on the acuity of its patients and complexity of care required as provided in 42 C.F.R. § 413.40(g)(3)(ii)(D).

42 U.S.C. § 1395ww(b)(4)(A)(i) requires the Secretary to provide for an adjustment to the method for determining the amount of payment to a hospital where "events beyond the hospital's control or extraordinary circumstances, including changes in case mix of such hospital create a distortion in the increase in costs for a cost reporting period…." Significantly, the statute does not address how the Secretary should calculate such an adjustment.

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[27] *See* Provider's Post Hearing Brief at 34-35. UTMD Anderson used CMS' calculation for case mix for 1983-2004. CMS did not publish a case mix index for 2005 but UTMD Anderson used the same methodology as CMS to calculate the 2005 index for purposes of this appeal.

[28] *See id.* at 35. *See also* Provider Exhibit P-3 (FY 2005).

[29] *See* Provider Exhibits P-5, P-36 (FY 2005).

[30] *See* Provider Exhibits P-14, P-15 (FY 2005).

[31] *See* Provider's Exhibit P-4 (FY 2005); Tr. at 180-181 (Dec. 14, 2011).

[32] *See* Provider Exhibit P-35 (FY 2005) at 2.

[33] *See* Provider Exhibit P-26 (FY 2005) at 2.

[34] *See* Provider Exhibit P-4 (FY 2005).

The Secretary's regulations implementing this statutory provision are located at 42 C.F.R. § 413.40(g). As a general rule, § 413.40(g)(1)(ii) specifies that the Secretary may make a TEFRA target adjustment "only to the extent that the hospital's operating costs are reasonable, attributable to circumstances specified separately, identified by the hospital and verified by the intermediary." These regulations also outline the three separate bases for a TEFRA target adjustment; however, only one is relevant to this appeal, namely an adjustment for distortion pursuant to § 413.40(g)(3)(i).[35] In this regard, the Board notes that the preambles to the final rules published on August 22, 1990 and August 30, 1991 ("the 1990 Final Rule" and "the 1991 Final Rule" respectively) confirm that an adjustment for distortion encompasses situations such as changes in case mix and the addition of new services.[36]

Section 413.40(g)(3)(i) allows the Secretary to adjust TEFRA target amount "to take into account factors that would result in a significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits." Section 413.40(g)(3)(ii) contains a nonexclusive list of the factors that may result in a significant distortion of the operating costs and, of these, the following factors are relevant to this appeal:

> (D) Increases in service intensity or length of stay attributable to changes in the type of patient served.
>
> (E) A change in the inpatient hospital services that a hospital provides….such as an addition or discontinuation of services or treatment programs.[37]

The preamble to the 1991 Final Rule confirms that increases in service intensity attributable to changes in the type of patient served encompasses TEFRA target adjustment requests based on increases in CMI. As explained in the preamble to 1990 Final Rule, CMS makes TEFRA target adjustments for distortion only when the factor(s) causing the distortion are established and the impact of the factor(s) on operating costs are "explicitly documented":

> The most common adjustment to the target amount is to correct for cost distortions between the base year and the year the target amount is applied under § 413.40(h)…. *If there are significant changes during the course of a cost reporting period that create a* ***cost distortion*** *in comparison to the base year, an adjustment will be made to remove the effects of the* ***distortion***. There are a variety of factors that could create distortions and result in the non-

[35] The Board recognizes that 42 C.F.R. § 413.40(g)(2) addresses an adjustment for extraordinary circumstances by allowing the Secretary to adjust TEFRA target amounts "to take into account unusual costs…due to extraordinary circumstances beyond the hospital's control." However, this section defines "extraordinary circumstances" as "include[ing], but . . . not limited to, strikes, fire, earthquakes, floods, or similar unusual occurences with substantial cost effects." Accordingly, the Board finds that neither changes in case mix nor the addition of new services qualifies as an "extraordinary circumstance and that the adjustment for extraordinary circumstances is not relevant to this appeal.

[36] *See* 55 Fed. Reg. 35990, 36004 (Sept. 4, 1990); 56 Fed. Reg. 43196, 43231-43232 (Aug. 30, 1991).

[37] 42 CFR § 413.40(g)(3)(ii).

> comparability of cost reporting periods; however, in order for HCFA to approve an adjustment, these factors must be linked to direct patient care services and *their impact on operating costs per case must be **explicitly** documented*. We approve an adjustment for only a particular cost reporting period if the circumstances creating the cost distortion are temporary or prone to fluctuation from year to year, such as a change in average length of stay. If the change is permanent, such as the addition or deletion of a service, a permanent adjustment is made to the target amount.[38]

The Board finds that UTMD Anderson has not met the requirement of distinguishing the effect of patient acuity and case mix from other concurrent inflationary (or deflationary) factors on operating costs per case in order to quantify the effect of the increased patient acuity on its operating costs. Although UTMD Anderson supplied numerous statistics and significant data, it is not clear that this data demonstrates that the increased case mix "create[s] a distortion in the increase in costs" as required by 42 U.S.C. § 1395ww(b)(4)(A)(i).

For example, UTMD Anderson provided a comparison of operating room procedures performed in FYs 1991 and 2005 in order to demonstrate the increased intensity of services.[39] UTMD Anderson argued that one of the reasons for increased costs was the switch from inpatient to outpatient services, leaving only the most seriously ill individuals as inpatients in the hospital. Yet, this chart indicates that the total number of inpatients receiving operating room services actually fell from 83.6 percent to 57.3 percent between FYs 1991 and 2005 while the number of outpatients receiving surgical procedures grew from 15.4 percent in FY 1991 to 42.7 percent in FY 2005.[40] This data demonstrate a move from surgeries being performed more frequently as an

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[38] 55 Fed. Reg. at 36004 (emphasis added). As part of the 1991 Final Rule, CMS deleted the then-existing adjustment for changes in case mix and noted that an adjustment for changes increase in service intensity attributable to changes in the type of patient served encompasses TEFRA target adjustment requests based on increases in CMI. Significantly, in the preamble to the 1990 Final Rule, CMS confirmed that, similar to that required for an adjustment for distortion, the then-existing adjustment for increases in case mix required "supporting documentation as to how the change [in case mix] affected specific costs." *See* 55 Fed. Reg. at 36004. Similarly, the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 3004(C) provides the following guidance on TEFRA target adjustments for increases in the costs of direct patient care services:

> A variety of factors can cause an increase in the cost per patient day of direct patient care services as compared to the base year. Serving a different patient population than in the base year may require the delivery of more services per patient, the hiring of additional staff, an upgrading of staff skill level, or the addition of new services. The change in the patient population must be documented and its effect on the hospital's inpatient operating costs must be quantified.

In the preamble to the 1991 Final Rule, CMS also provides the following examples of situations where TEFRA target adjustments would be denied:

> Some requests for an adjustment to the target amount do not contain sufficient justification and documentation to support a favorable decision. For example, a request for an adjustment may set out the circumstances that caused the cost distortion to occur but fail to quantify the effect of those circumstances on the hospital's costs. In other cases, the increased costs may be appropriately documented but the application does not link the increases to changes in patient care services.

56 Fed. Reg. at 43231.

[39] *See* Provider Exhibit P-5 (FY 2005).

[40] *See* Provider Exhibit P-5 (FY 2005) at 17.

outpatient than inpatient but does not demonstrate that those remaining inpatients have greater acuity.

UTMD Anderson did an "Analysis of Increase in Intensity for Services for Operating Room CC37.00" between FYs 1995 and 2005.[41] However, there are 10 service codes listed in FY 2005 that apparently were not used in FY 1995. If the "weighted units" of these services (service codes 2400933 through 2406898)[42] are removed from the listing for FY 2005 and the adjusted remaining weighted units are divided by the number of Medicare discharges (Column "C" divided by "Medicare Discharges (D)"), the FY 2005 "No. of Services Per Beneficiary" drops to 4.823—which is less than the FY 1995 "No. of Services Per Beneficiary" listed as 5.17.[43] It suggests that the "increase in intensity" for operating room services may be more attributable to the addition of 18 service codes that did not exist in FY 1995 than to any actual increase in intensity in procedures used in FY 2005 or, at least, UTMD Anderson has not explained sufficiently what the addition of service codes tells the Board about either increased intensity of services or its relationship to patient acuity or case mix.

Next, UTMD Anderson cites the increased number of diagnoses per claim between FY 1995 and FY 2005 to illustrate the greater acuity of its Medicare inpatients.[44] While the data clearly suggests an increase in the number of diagnoses per claim between FY 1995 and FY 2005, UTMD Anderson provides no link to demonstrate that the increased number of diagnoses is related to a change in case mix or patient acuity. There could be several alternate explanations for the increased number of diagnoses per claim, including changes in the code definitions or improved accuracy in coding of conditions by UTMD Anderson's staff between FYs 1983 and 2005 (*i.e.*, 22 years).[45] UTMD Anderson failed to tie a change in case mix is directly related to increases in the number of diagnoses per claim.

Further, UTMD Anderson argued that the cost of new services demonstrates that it is due an adjustment for distortion based on increased service intensity attributable to changes in the type of patients served between FYs 1983 and 2005. These new services include respiratory therapy, drugs charged to patients, therapeutic radiology and clinic services.[46] However, when you compare the year-to-year cost of these services,[47] it appears that these services increased during some years, decreased during others. For the purposes of this appeal, however, therapeutic radiology services increased significantly from FYs 2000 to 2001—from $9,367,494 to $13,022,194 in FY 2001, and again increasing to $19,369,440 in FY 2002—but these years were not part of this appeal. Beginning in FY 2003, the second year in this appeal, therapeutic radiology services increased slightly to $19,827,421, but then decreased in FYs 2004 and 2005

[41] *See* Provider Exhibit P-37 (FY 2005).
[42] *See id.* at 1.
[43] *See id.* at 2.
[44] *See* Provider Exhibit P-14 (FY 2005).
[45] *See, e.g.*, 72 Fed. Reg. 47130, 47175 (Aug. 22, 2007) (discussing three different factors that affect a hospital's CMI as well as CMS' observations regarding general changes to CMI since the implementation of IPPS in 1983).
[46] *See* Provider Exhibit P-7 (FY 2005). The Board notes that, for purposes of this appeal, UTMD Anderson is not claiming that a TEFRA target adjustment should be made based solely on the addition of any new services other than drugs which is discussed in the next subsection. Rather, UTMD Anderson presents evidence of these new services to support its claim that the changing patient acuity (as reflected by the increased CMI) increased the intensity of patient services. *See* Provider's Post-Hearing Brief.
[47] *See* Provider Exhibit P-6 (FY 2005).

the last two years under appeal, to $18,905,381 and $17,922,366. UTMD Anderson provides no explanation for why it believes it is entitled to an adjustment for distortion for FYs 1999, 2003, 2004 and 2005 based on increased costs of new therapeutic radiology services that happened, for the most part, in years outside the specific years under appeal.

Finally, the Board notes that, in determining the "impact" of changes in intensity of services on operating costs, it necessarily means that certain costs could decrease while others increase. UTMD Anderson has failed to explain why it did not offset any decrease in costs due to efficiencies achieved through an increase in intensity of services between FYs 1983 and 2005. In this regard, UTMD Anderson admits the following in its Post-Hearing Brief:

> The real question is why M.D. Anderson's costs have not increased even more than they did [sic]? The answer is that M.D. Anderson has managed to contain costs to a rate of increase that is markedly less than the rate of increase in case mix since 1983. In large part, that gain in efficiency was achieved by reducing lengths of stay (even as case mix, and patient acuity, increased) and through sound fiscal management. In addition, dramatic improvements in new drugs and other therapies permit a higher intensity and volume of treatments to be compressed into shorter stays even for sicker patients.[48]

These efficiencies are borne out in the data UTMD Anderson submitted on length of stay ("LOS") showing decrease in LOS from 12.45 in FY 1983 to 7.83 in FY 2005.[49]

These examples illustrate the Board's general observation that UTMD Anderson failed to persuade it that the change in case mix for inpatient services led to increases in cost per discharge, an increase in operating room procedures or new services. Nor did UTMD Anderson identify the unique, discreet and specific impact these changes had on specific operating costs. In this case the Board finds that UTMD Anderson was not able to directly link the changes in case mix to increases in specific costs for which a TEFRA target adjustment could be granted. UTMD Anderson has not demonstrated that the change in case mix or the cost of new or additional services has distorted the operating costs of its inpatient hospital services sufficiently to receive an adjustment in its TEFRA target amount.

B. Discussion Related to Cost of New Drugs

UTMD Anderson also contends that it is entitled to an adjustment based on the net cost of new drugs that were neither available in the FY 1983 base year nor had a therapeutic equivalent in the FY 1983 base year because these new drugs caused a dramatic distortion in operating costs for FY 2005 when compared with the FY 1983 base year. UTMD Anderson argues that, not only is the cost of drugs much higher in FY 2005 than that in FY 1983, new drugs allow for new therapies and greater intensity in the use of old drugs which further increase the overall costs.[50]

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[48] Provider's Post-Hearing Brief at 11.
[49] *See* Provider Exhibit P-4 (FY 2005).
[50] *See id.* at 53-54.

Specifically, UTMD Anderson contends that actual data reveals that the net cost of new drugs increased UTMD Anderson's Medicare inpatient operating costs for FY 2005 by $11.8 million.[51] According to its analysis, the additional cost of new drugs by itself accounts for most of the excess cost over the TEFRA target and that, even if there were any savings from the replacements of old drugs or increased efficiency in providing other services, they were "negligible" – about 4 percent of the cost of the new drugs.[52] UTMD Anderson concludes that the cost of new drugs is an extraordinary circumstance beyond its control that has caused a distortion in operating costs for inpatient hospital services between the base year and the subsequent cost reporting periods.[53]

Similar to its analysis of the request for a TEFRA target adjustment for case mix, the Board finds that 42 C.F.R. § 412.40(g)(3)(i) addressing TEFRA target adjustments for distortions is the regulation that governs UTMD Anderson's request for an adjustment based on new drugs. The Board further finds that UTMD Anderson has not adequately documented how much costs of new drug technologies for FY 2005 exceed the comparable costs of drugs and services included in the FY 1983 base year. The Board acknowledges that many new cancer drugs were introduced between FYs 1983 and 2005 and that UTMD Anderson's drug costs increased significantly for FY 2005 when compared to the FY 1983 base year.

However, the Board finds that UTMD Anderson has not adequately quantified increases or decreases between FYs 1983 and 2005 in the cost of drugs relating to specifically new drug technology—reformulating or repackaging of the drugs, cost increases, discounts or rebates or drug handling fees, for example, which would affect the overall comparable cost of the drugs between FYs 1983 and 2005 and that would have no effect on (nor be affected by) case mix, intensity of treatment or length of inpatient stays. In particular, the Board notes that UTMD Anderson "identified the total number of charges in 1995, for service codes that were later inactivated, and as a matter of calculating a cost [UTMD Anderson] identified the charges, identified the costs for fiscal year 1995, rolled that back to 1983, to take out the inflation factors, and then rolled it back to 2005, to calculate the cost of inactivated service codes in 2005, dollars."[54] However, it is unclear to what extent the roll back of a FY 1995 drug cost is really reflective of FY 1983 drug costs because relative cost of a specific cost that was in use in FY 1983 may have been much higher in FY 1983 than in FY 1995, particularly if the drug was still in its period of FDA exclusivity during FY 1983. Further, it is unclear whether UTMD Anderson has addressed and accounted for Medicare coverage of certain experimental drugs (*i.e.*, pre-FDA approval) in its cost analysis, particularly since Medicare National Coverage Determinations Manual, CMS Pub 100-03 ("MNCDM 100-03"), §110.2 confirms that Medicare does cover certain cancer drugs for terminally ill patients prior to full FDA approval.[55]

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[51] *See* Provider's Final Position Paper (FY 2005) at 45.

[52] *See id*. at 47; Provider's Post-Hearing Brief at 32. *See also* Provider Exhibits P-46, P-47 (FY 2005) (includes comparison of the FY 1983 cost of certain drugs in use during FY 1983 with the FY 2005 cost of new drugs identified as replacing the FY 1983 drugs); Provider Exhibits P-22, P-23 (FY 2005) (includes list of drugs inactivated prior to FY 2005 but not before FY 1995).

[53] *See* Provider's Post-Hearing Brief, at 59.

[54] Tr. at 219 (Dec. 14, 2011).

[55] The Board raised this concern during the hearing and asked UTMD Anderson to address it post-hearing; however, it was not addressed. *See* Tr. at 285-297 (Dec. 14, 2011). MNCDM 100-03 § 110.2 was previously located at Medicare Coverage Issue Manual, HCFA Pub. 6, § 45.16 (effective for services furnished on or after Oct. 1, 1980)

This uncertainty in cost drivers is demonstrated by UTMD Anderson's own witness, Mr. Anderson. When discussing the increases in the patient's severity of illness and the higher number of diagnoses per Medicare claim, UTMD Anderson's counsel asked Mr. Anderson to explain the discrepancy between relative weight of the chemotherapy DRG increasing from 0.7172 to 1.1684, a 63 percent increase, and the 300 percent increase in average per patient increase in chemotherapy drug costs in the following exchange:[56]

> Q. To what would you attribute the difference in the increase in cost?
>
> A. There actually are a couple of things that could be contributing to that. One could be an increased intensity of the particular drugs that were provided earlier in the year, an increase in price of the drugs or the cost that we have to pay for those drugs.[57]

Counsel goes on to extensively inquire about the increase in intensity but fails to ask anything further to explain, and eliminate, any other possibilities for the significant cost increase in chemotherapy drugs.

Similarly, UTMD Anderson argues that new drugs allowed UTMD Anderson to supplant or take the place of other ancillary services that had been formerly provided to inpatients in 1983.[58] Using various exhibits, UTMD Anderson demonstrated that both routine and ancillary costs continued to increase between FYs 1983 and 2005 despite the use of new drugs.[59] However, the recitation of these increased costs shows no direct relationship with new drugs. UTMD Anderson asserts that new drugs intensifies and fundamentally changes the nature of cancer services but it has not addressed or quantified this relationship between new drugs and the other routine and ancillary costs. As recognized by UTMD Anderson, this relationship can impact operating costs both positively and negatively through volume and decreased lengths of stay: "[D]ramatic improvements in new drugs and other therapies permit a higher intensity and volume of treatments to be compressed into shorter stays even for sicker patients."[60] Consistent with its earlier discussion,[61] the Board finds that 42 C.F.R. § 413.40(g) requires UTMD Anderson to quantify the effect of each individual cost factor addressed by UTMD Anderson, and to distinguish the effect of each factor from other concurrent inflationary (or deflationary)

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and it states that "a Group C drug and the related hospital state are covered if all other applicable coverage requirements are satisfied." *See also* FDA Information Sheet entitled "Treatment Use of Investigational Drugs" (last updated Jan. 19, 2016) (as of Apr. 4, 2016, *available at*: http://www.fda.gov/RegulatoryInformation/Guidances/ucm126495.htm) (recognizing that Group C drugs are investigational).

[56] *See* Tr. at 185-188 (Dec. 14, 2011).

[57] *Id.* at 188.

[58] *See* Tr. 213-216 (Dec. 14, 2011).

[59] *See id.* at 217.

[60] In its Post-Hearing Brief at 11.

[61] *See also* PRM 15-1 § 3004.2 (stating "[w]hen a variety of factors have caused the hospital's Medicare inpatient operating costs to exceed the target amount, the hospital's request must address each of these factors"). *See also* Medicare Coverage Issues Manual § 45-16

factors. The Board concludes that UTMD Anderson has not demonstrated that the increases in operating costs justify a TEFRA target adjustment.[62] As UTMD Anderson did not meet the criteria, the Board concludes that the Medicare Contractor's denial of UTMD Anderson's request for an adjustment to the TEFRA rate-of-increase ceiling was proper.

ISSUE 2 – COMPANY P EXPENSES

The Company P expenses at issue involves two different types of expenses for FY 2004: (1) salary expenses relating to four capital construction projects; and (2) the software projects denoted as P2810139, P2810489 and P2810529. The Board discusses each of the Company P expenses at issue by each of these project types.

A. Discussion Relating to Salary Expenses for Four Capital Construction Projects

The FY 2004 salary expenses for the four capital constructions projects relate to the replacement, renovation or additions to various facilities.[63] UTMD Anderson explains that these salary expenses involve only employees who were part of the Capital Planning & Management Department and specifically included the following positions: Senior Facilities Project Manager, Facilities Project Manager, Senior Facilities Planner/Designer, and Coordinator Construction Project.

The Medicare Contractor maintains that the salary costs for these employees are capital-related costs and, accordingly, should be capitalized. UTMD Anderson disagrees. UTMD Anderson recognizes that it apportioned salaries between the Company P projects but maintains that this apportionment is an unsubstantiated estimate meant for internal tracking purposes only. Rather, UTMD Anderson argues that these salary costs should be classified as operating costs because the employees at issue were serving solely in an administrative capacity managing the relationship between UTMD Anderson and the construction contractors and providing project management services. UTMD Anderson maintains that, in contrast to the services provided by an architect or an engineer involved in the actual construction of the building, the services of the employees at issue did not directly increase the value of the asset being developed and their salaries, therefore, should not be considered as capital costs.[64]

UTMD Anderson further argues that the salary costs at issue are not capital-related costs because 42 C.F.R. § 413.130(a) provides an exclusive list of capital-related costs and salary costs attributable to administrative personnel who have worked on a capital project are not included in

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[62]The Board notes that. even if it would conclude that UTMD Anderson had demonstrated a distortion in its operating costs, the preamble to the 1990 Final Rule appears to limit an adjustment "for only a particular cost reporting period *if the circumstances creating the cost distortion are temporary or prone to fluctuation from year to year*, such as a change in average length of stay. If the change is permanent, such as the addition or deletion of a service, a permanent adjustment is made to the target amount." 55 Fed. Reg. 35990, 36004 (Sept. 4, 1990) (emphasis added). The Board concludes that the new drug costs should most likely be considered a permanent change in the nature of the treatment of cancer patients. Under the preamble language a rebasing may be more appropriate than a TEFRA target adjustment in this case. However, UTMD Anderson withdrew its appeal for a rebasing in the case as part of an agreement for rebasing in a later fiscal year, so the Board makes no finding on this issue.

[63] *See* Provider's Post Hearing Brief at 89.

[64] *See id.* at 12-14.

this regulatory list.[65] Finally, UTMD Anderson maintains that the arbitrary assignment of employees' administrative salary expenses to particular depreciable assets would improperly distort the averaging principle that underlies the step-down allocation of administrative and general costs based on statistical proxies for usage.[66]

The Board finds that the Medicare Contractor correctly classified the salary costs at issue as capital costs because they met the applicable criteria for capital costs and failed to meet the criteria for operating costs. The Board examined the submitted job descriptions for the employees at issue.[67] The project directors oversee the completion of the design, construction, activation, move-in, and close-out of the project. Their functions/work products include Construction Drawings and Bid Specifications, Document Design Reviews, Design/Bid/Build Documents and Contracts, Project Inspections and Documentation, Concept Floor Plans, Stacking Diagrams, Pre-Design Reports, and Specifications. The education requirements for these positions include a degree in Construction Management, Construction Science, or other construction related Architectural/Engineering fields, and a degree with major course work in Interior Design, Space Planning and/or Architecture.[68] Further, the record demonstrates that the salary costs at issue relate to completed capital improvement projects.[69]

Contrary to UTMD Anderson's position, the Board finds that the salary expenses at issue do fall within the categories of capital-related expenses listed at 42 C.F.R. § 413.130(a). Specifically, based on the testimony, the job descriptions provided, and the internal accounting of the salary expenses at issue, the Board finds that the salary costs at issue are "costs of betterments and improvements" per 42 C.F.R. § 413.130(a)(4) and, accordingly, are capital-related costs.[70] As such, the Board affirms the Medicare Contractor's adjustments to treat certain Capital Planning & Management Department salary costs as capital-related costs.

B. Discussion Related to the Abandonment of Internally-Developed Software Projects

The internally developed software projects at issue relate to the software projects denoted as P2810139, P2810489 and P2810529. UTMD Anderson argues that it accounts for these expenses consistent with how it accounts for all of its internally-developed software. As an agency of the State of Texas, UTMD Anderson follows guidance on specific accounting standards issued by the Governmental Accounting Standards Board ("GASB"). In particular, GASB 51 requires that the costs of internally developed software in the pre-development or "Analysis & Planning" stage, be treated as operating costs because the materialization of a capital asset is too uncertain. Once the project moves to the development or "Execution &

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[65] *See* Provider's Final Position Paper (FY 2004) at 12. *See also id* at 15-16 (citing support to the following cases: *St. Charles Gen. Hosp. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 99-D7 (Nov. 24, 1998), *declined review*, Adm'r (Jan. 13, 1999); *Mercy Hosp. v. Shalala*, 823 F. Supp. 1, 4 (D.D.C 1993)).

[66] *See id.* at 14 (citing to *Charter Peachford Hosp., Inc. v. Bowen*, 803 F. 2d 1541, 1547 (11th Cir. 1986)).

[67] *See* Provider Exhibit P-53 (FY 2004) at 9-27.

[68] *See id.*

[69] *See* Provider's Final Position Paper (FY 2004) at 12-13.

[70] The Board's finding is consistent with its decision in *St. Charles Gen. Hosp. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 99-D7 at 19 (Nov. 24, 1998), *declined review*, Adm'r (Jan. 13, 1999).

Control" phase, GASB 51 requires these development costs to be treated as capital costs because, at that point, there is sufficient certainty that a capital asset will indeed be created.[71]

UTMD Anderson explains that it followed this policy with regard to Project P2810139 which was intended to improve UTMD Anderson's then-existing internal computer systems to allow electronic entry of chemotherapy orders for patients. Consistent with GASB 51, UTMD Anderson moved the project from the Analysis & Planning phase to the Execution and Control phase and UTMD Anderson began accumulating costs on the balance sheet for capitalization per its Institutional Policy.[72]

In July and August of 2003, UTMD Anderson moved the project back to the Analysis & Planning phase when it determined that problems with the project would prevent its completion. At that time, UTMD Anderson evaluated and reclassified the Company P costs for this software project from capitalized costs to operating costs[73] but did not make the final determination of which expenses were operating expenses until FY 2004. Accordingly, UTMD Anderson asserts, these expenses should be allowable in the FY 2004 cost-reporting period.[74] The Medicare Contractor counters that UTMD Anderson had ample time to claim these costs on its FY 2003 cost report which was not due until the end of January 2004.[75]

UTMD Anderson explains that it terminated the two other software projects at issue, P2810489 and P2810529, in FY 2004 and that it had claimed these costs as operating costs in FY 2004.[76] The Medicare Contractor disallowed all costs related to these projects because the projects were abandoned and should be considered as an investment loss which is not an allowable expense under the Medicare program.[77] Further, the Medicare Contractor argues that these costs were not related to the cost of care for beneficiaries as allowed by regulation.[78]

UTMD Anderson disagrees stating that, while UTMD Anderson never put these two software programs into use, its patients did receive a benefit from UTMD Anderson's work on the projects and that these project costs are akin to abandoned "planning" costs which the Board and federal courts have upheld as operating costs.[79]

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[71] *See* Provider's Post-Hearing Brief at 93-94.

[72] *See* Provider's Final Position Paper (FY 2004) at 16.

[73] *See* Medicare Contractor Exhibit I-5 (FY 2004) at 7, 44.

[74] *See id*. at 16-17.

[75] *See id.* at 16-18.

[76] *See* Provider's Final Position Paper (FY 2004) at 18.

[77] *See* Medicare Contractor's Final Position Paper (FY 2004) at 20-21. The Medicare Contractor notes that the cost in question for Project P2810489 includes costs for Milestone #2 Acceptance in Phase IV and Milestone #4 Delivery in Phase IV. Likewise for Project P2810529 the vast majority of the cost in question is for professional services, training and consulting.

[78] *See id.* at 20.

[79] *See* Provider's Final Position Paper (2004) at 19 (citing to the Board's decision in *See also id* at 15-16 (citing support to the following cases: *St. Charles Gen. Hosp. v. Mutual of Omaha Ins. Co.,* PRRB Dec. No. 99-D7 (Nov. 24, 1998), *declined review*, Adm'r (Jan. 13, 1999) and to PRM 15-1 § 2154.4 to advance an argument that the software projects at issue were used as part of a decision-making process that yielded a benefit to patients).

With respect to FY 2004 cost related to Project 2810139, the Board finds that, had UTMD Anderson adequately documented them, UTMD Anderson should have expensed them in FY 2003 when UTMD Anderson moved the project back to the Analysis & Planning phase. 42 C.F.R. § 413.24(e) requires that providers' costs be reported in the appropriate cost reporting period, using the accrual basis of accounting. Based on the evidence in the record, the Board finds that UTMD Anderson acknowledged that, beginning in June 2003, it was not going to further develop Project 2810139 and that it accrued the costs as operating costs in FY 2003. Accordingly, the Board finds that the Project P2810139 costs at issue should have been reported on the FY 2003 cost report and affirms the Medicare Contractor's FY 2004 adjustments related to Project P2810139.

With respect to the FY 2004 costs related to Projects 2810489 and 2810529, the Board finds no evidence to demonstrate that the Projects P2810489 and P2810529 were ever placed into use for patient care and, accordingly, finds that these costs cannot be treated as operating costs. Medicare regulations at 42 C.F.R. § 413.9(a) require that "[a]ll payments to providers of services must be based on the reasonable cost of services covered under Medicare and *related to the care of beneficiaries*."

The Board rejects UTMD Anderson's argument that the costs should be considered planning costs related to patient care and, thereby, treated as operating costs. Both parties agree that UTMD Anderson stopped the further development of these two projects. UTMD Anderson did not submit any evidence to support its position that these costs should be considered planning costs. In particular, UTMD Anderson did not submit evidence to demonstrate that the software projects contributed to the development of any other internal software that was fully developed and utilized. Accordingly, the Board finds that the costs for these two projects were development costs related to an abandoned project rather than planning costs and that the Medicare Contractor properly disallowed these costs as an investment loss.

DECISION:

After considering the Medicare law and program instructions, the evidence presented, and the parties' contentions, the Board makes the following findings:

ISSUE 1 – The Board finds that the Provider is not entitled to any additional adjustment to its TEFRA target amount for FYs 1999, 2003, 2004 and 2005. Accordingly, the Board affirms the Medicare Contractor's refusal to allow any additional TEFRA target adjustments for these fiscal years.

ISSUE 2 – The Board finds that the Medicare Contractor's adjustments at issue relating to Company P expenses for FY 2004 were proper. Accordingly, the Board affirms these adjustments.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty, Chairman
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: April 8, 2016