CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
San Francisco Medical Center	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/94**
Provider	
vs.	**Review of:**
Mutual of Omaha Insurance Company	**PRRB Dec. No. 2005-D29** **Dated: April 8, 2005**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). Comments were received from CMS' Center for Medicare Management (CMM) and the Provider. The parties were then notified of the Administrator's intention to review the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

On April 21, 1994, the Provider submitted its 1994 exception request for the treatment of patients with end-stage renal disease (ESRD.) The Provider requested $476.15 in total reimbursement per treatment due to its atypical patient mix, an exception of $337.15 over and above the composite rate of $139.00. The Intermediary performed a review of the Provider's exception request and recommended that the Provider be granted a rate of $153.04. On May 11, 1994, the Provider's ESRD exception request was transmitted to CMS.[1] CMS made a final

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[1] Intermediary's Exhibit I-3.

determination of total reimbursement of $199.56 per dialysis treatment.[2] The Provider filed a timely appeal of CMS' partial denial of its 1994 exception request to the Board.

ISSUE AND BOARD'S DECISION

The issue is whether CMS' partial denial of the Provider's request for an exception to the ESRD composite rate based on atypical patient mix was correct.

LABOR COSTS

With respect to the labor component, the Board agreed with the Provider that CMS incorrectly determined the cost per treatment for nursing salaries. CMS used "nursing hours paid" and then multiplied that rate by "nursing hours worked" to determine the cost per treatment for nursing salaries. The Board concluded that by using "nursing hours paid" in the first part of the calculation and "nursing hours worked" in the second half of the calculation distorted the calculation by improperly disallowing the vacation, sick and holiday time the Provider paid to its nursing staff. Therefore, the Board held that "nursing hours worked" should be used in both parts of the calculation to determine the average nursing hour rate. This results in an exception amount of $62.13 for nursing salaries, $15.80 more per treatment than the $46.33 granted by CMS.

The Board also agreed with the Provider that CMS should have used the Provider's actual employee benefit percent rather than the "national average employee benefit percent" to calculate the exception for employee benefits. The Board found that there was no indication that the Provider's costs were unreasonable, therefore, with regard to employee benefits the Board granted the Provider an exception amount of $15.28 per treatment, $6.62 per treatment more than the $8.66 granted by CMS.

With respect to other labor, including nursing supervision, unit assistants and a physician medical director, the Board held that the Provider submitted sufficient documentation to support some of its claims. The Board held that the Provider's costs of a physician director was justified based on the acuity of the patients but was limited by the Reasonable Compensation Equivalent (RCE). The Board also held

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[2] Intermediary's Exhibit I-4. CMS partial approval of the Provider's exception request included salary costs of $46.33, employee benefit costs of $8.66 and supply costs of $5.57 plus the composite rate of $139 for the total approved exception amount of $199.56.

that, because of the high turnover rate, the Provider was justified in requesting $4.95 per treatment for administrative costs. The Board also noted that, 57 percent of the Provider patient population had severe nutritional deficiencies, which justified the additional direct labor and benefits costs of $1.55 per treatment for the services of a clinical dietician.

SUPPLY COSTS

With respect to supply costs, the Board held that the Provider presented specific evidence to support its increase in supply costs per treatment. The Board addressed each category of supply costs, as follows:

Subclavian Dressing Kits

The Board found that 57 percent of the Provider's patients required subclavian lines and that nurses were used to ensure that patients did not acquire a life threatening infection through the line. The Board rejected the Intermediary's argument that the $33 average cost per treatment for typical patient population included the cost for supplies. Accordingly, the Board granted the Provider its actual cost of $2.34 per subclavian dressing kit.

Dialyzers

The Board found that the Provider presented evidence that it is medically inappropriate and unsafe to sterilize and reuse hemodialyzers for its acutely ill and unstable patient population. The Board noted that the Provider treats a higher number of patients with hepatitis and other infections than typical facilities, which precluded dialyzer reuse. Thus, the Board granted the Provider's exception request.

Hypertonic saline

The Board found that the Provider presented sufficient evidence that typical dialysis facilities rarely use hypertonic saline, but that the Provider's patients often require infusions to stabilize their blood pressure during dialysis. The Board noted that the Intermediary only granted $0.40 cost per treatment for the solution. The Board found that the Provider justified its request for the additional costs of $.94 for this supply.

Gloves

The Board noted that the Provider demonstrated that it uses seven times more gloves than are used in a typical dialysis facility. The Board found that the Provider

incurred a high cost for gloves due to the volume of gloves used for its atypical patients and granted the additional costs for this supply of $1.60.

Bicarbonate and Acid Dialysis Concentrate

The Board found that the Provider justified the additional costs for this supply of $4.69 CPT. The Board noted that the Provider used special Bicart on-line dialysis solution because of the unstable and acutely ill patients it treats to decrease the rises of bacterial contamination. The Provider demonstrated that Bicart dialysis solution costs two to three times more per treatment than the manual method used in a typical dialysis facility. Thus, the Board granted the additional amount.

Wound Dressing and Cleaning Supplies

The Board found that the Provider demonstrated that typical ESRD units do not perform wound dressing and cleaning services and that an exception in the amount of $.98 CPT is warranted. Thus, the Board granted the additional amount.

OVERHEAD COSTS

With respect to overhead, the Board determined that it is not possible to link overhead costs directly to a particular service, that the Provider presented evidence that its overhead costs were related to its atypical patient mix, and that there is no such incremental requirement in the Medicare regulations and Manual provisions. The Board determined that when the Provider incurs and CMS approves incremental direct and indirect costs, appropriate overhead costs should be applied. The Board determined that a 56.65 percent overhead factor should be allowed on all other costs approved in their decision.

SUMMARY OF COMMENTS

The Provider submitted comments requesting that the Administrator grant an exception rate equal to the full amount of its original request. Specifically, the Provider requested that the Administrator uphold the Board's decision on the merits with respect to the lead nurse salary and employee benefits, and modify the Board's decision with respect to the amount of overhead costs allowed by the Board. The Provider argued that all the regulations require are that the Provider demonstrate its services are of an atypical intensity, its costs were determined in accordance with Medicare reimbursement principles, and its costs are in line for such costs to be included in the Provider's rate upon the granting of an exception.

Although the Provider agreed with the Board's determination that the Provider was entitled to an exception amount with respect to overhead costs, the Provider disagreed with the amount of the exception that the Board granted. The Provider argued that it should be reimbursed the full amount of its overhead costs allocable to ESRD services since the Board has already granted $105.20. The Provider requested and additional $122.46 in overhead costs. The Provider contended that there is no justification to determine a provider's allowable overhead costs based on a national average, particularly where there is no showing that the Provider's overhead costs are unreasonable or substantially out of line or were computed incorrectly and where there is no showing as to how the $47 national average was developed.

CMM submitted comments requesting that the Administrator review the exceptions granted by the Board. As to labor costs and employee benefits, CMM argued that, to maintain consistency in accounting, the labor calculation should use nursing hours worked and nursing hours paid and that employee benefits are always limited to the national average of 18.7 percent of any additional amounts approved for labor. As to supply costs, the CMM argued that the Provider failed to provide an explanation for the significant increase in supply costs and was therefore only entitled to additional supply costs of $5.57 per treatment. With regard to overhead costs, the CMM argued that the Board's calculations were irrelevant because the Provider only offered narrative explanations to justify its incremental overhead costs, and the Provider did not comply with the regulations regarding the submission of and explanation of its incremental cost analysis.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Under §1881(b) of the Social Security Act and 42 C.F.R. 413.170(b) of the regulations approved providers of renal dialysis services are reimbursed on a prospective payment basis. Under 42 C.F.R. 413.170(b) (2), "[a]ll approved ESRD facilities must accept the prospective payment rates established by [CMS] as payment in full for covered outpatient maintenance dialysis." The regulations, as mandated by §1881(b) of the Act, also provide for the granting of exceptions to these rates. The criteria for granting an exception are contained at 42 C.F.R. 413.170(g), and the criteria for the specific exception at issue in this case, namely, the exception for atypical service intensity/patient mix, are set forth in subparagraph(1) of §413.170(g). The regulation states, in pertinent part that:

> [CMS] may approve exceptions to an ESRD facility's prospective payment rate if the facility demonstrates with convincing objective evidence that its total per treatment costs are reasonable and allowable under §413.174, and that its per treatment costs in excess of its payment rate are directly attributable to….
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> (1) *Atypical service intensity (patient mix)*. A substantial proportion of the facility's outpatient maintenance dialysis treatments involve atypically intense dialysis services, special dialysis procedures, or supplies that are medically necessary to meet special medical needs of the facility's patients. The facility is able to demonstrate clearly that these services, procedures or supplies and its pretreatment costs are prudent and reasonable when compared to those of facilities with a similar patient mix. Examples that may qualify under this criterion are more intense dialysis services that are medically necessary for patients such as:
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>> (i) Patients who have been referred from other facilities on a temporary basis for more intense care during a period of medical instability, and who return to the original facility after stabilization;
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>> (ii) Pediatric patients, who require a significantly higher staff-to-patient ratio than typical adult patients; or
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>> (iii) Patients with medical conditions that are not commonly treated by ESRD facilities, and that complicate the dialysis procedure.

The regulation at 42 C.F.R. §413.170(f) (5) states that a provider has the burden of proving that it qualifies for an exception to the ESRD composite payment rate.[3] To meet this burden, the provider must also satisfy the documentation requirements of 42 C.F.R. §413.17(f) (6) which states in part:

> If requesting an exception to its payment rate, a facility must submit to [CMS] its most recently completed cost report … and whatever … [other information is] determined by [CMS] to be needed to determine if an exception is approvable…. The materials submitted to [CMS] must:

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[3] See also, infra, n. 3, regarding general Medicare documentation and record keeping requirements of providers.

> (i) Separately identify elements of costs contributing to costs per treatment in excess of the facility's payment rate;
> (ii) Show that all of the facility's costs, including those costs that are not directly attributable to the exception criteria, are allowable and reasonable under the reasonable cost principles set forth in this part;[4]
> (iii) Show that the elements or excessive costs are specially attributable to one or more conditions specified by the criteria set forth in paragraph (g) of this section; and
> (iv) Specify the amount of additional reimbursement per treatment the facility believes is required in order to recover its justifiable excess costs.

In addition, the Provider Reimbursement Manual (PRM) at Chapter 27 provides instructions for filing ESRD exception request. Consistent with the regulation, section 2720.1 of the PRM states that:

> Criteria For Approval of Exception Requests.—[CMS] may approve an exception to an ESRD facility's composite rate payment if the facility demonstrates with convincing evidence (See 42 CFR 413.170(f)(5)) that its total estimated per treatment costs are reasonable and allowable in accordance with Medicare reasonable cost principles and §2717,….

In addition, §2721 of the PRM requires that a facility, in filing an exception request:

> [I]s responsible for justifying and demonstrating to [CMS] that the requirements and criteria listed in the instructions are met in full. That is,

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[4] Section 1861(v) (a) (A) of the Act provides that the reasonable costs of any services "shall be the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services…." A basic tenet of cost based reimbursement, under §1814 of the Act, is that no payment shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due the provider. Consistent with the statute, the regulation at 42 C.F.R. §413.20 states that the principles of cost reimbursement require that providers maintain sufficient financial record and statistical data for proper determination of costs payable under the program. Moreover, 42 C.F.R. §413.24 states that providers receiving payment on the basis of reimbursable costs must provide adequate cost data.

> the burden of proof is on the facility to show that one or more of the criteria are met, and that the facility's costs, in excess of its composite rate, are justified under cost reporting principles.

Importantly, §2721.B of the PRM states that:

> The facility must provide written justification for supporting the facility's higher costs. The fact that a facility projects costs higher than its composite rate payment is not adequate documentation for granting an exception. The facility must provide [CMS] with supporting material documenting the reasons that may justify its costs in excess of its composite payment rate.

The Administrator finds that, in this case, the record supports the finding that the Provider serves an atypical patient mix population under the criteria of the regulations. However as noted, supra, in addition to demonstrating that it serves an atypical patient mix, the Provider must also demonstrate, inter alia, that the costs are reasonable and that the elements of excessive costs are specifically attributable to the Provider's atypical patient mix.

Nursing Salary Labor Costs

With respect to labor costs, the Administrator disagrees with the Board determination that CMS incorrectly determined the cost per treatment for nursing salaries. The Administrator finds that CMS has consistently used "nursing hours worked" to determine the average nursing hours per treatment and "nursing hours paid" to determine the average hourly rate for an ESRD unit. There is nothing inherently inconsistent in this methodology as the average nursing hour per treatment is a measure of nursing hours worked per treatment. Conversely to determine the average hourly rate which was paid for those hours worked per treatment, CMS reasonably used nursing hours paid. CMS has applied the same methodology for all ESRD exception requests including the Provider; the Provider is only entitled to an exception of $46.33 for nursing salaries.

Employee Benefits

With respect to employee benefits costs, the Administrator disagrees with the Board's conclusion that, absent a finding that the Provider's benefits rate was unreasonable or substantially out-of-line, CMS improperly denied the Provider's full exception for excess employee benefits costs. In this case, although the Provider meets the "atypical service intensity" criterion of the regulations, the Administrator finds that the Provider is not

entitled to the amount of the exception to the Provider's ESRD composite payment rate granted by the Board based on excess employee benefits.

Notably, in allowing the higher direct patient care salary costs, under the exception process, a related higher fringe benefit amount is recognized through the application of the 18.7 percent fringe benefit rate to the increased direct patient care salary exception amount. An allowance of higher direct salary costs, under the exception process, results in a direct proportional increase in fringe benefits amounts. Thus, in this instance, the Provider has received a proportional increase of its fringe benefit allowance corresponding with the allowed increase in direct salary costs. Although, as noted by the Board, the regulation does not limit an employee's fringe benefit rate to a national average, the PRM provides that CMS will use national data in evaluating the reasonableness of a provider's component costs.[5] Use of a national-salary-benefits fringe average is a reasonable exercise of the agency's discretion with respect to the determination of reasonable costs. It is not an abuse of discretion for CMS to compute the Provider's fringe benefit increase based on a percentage to which nursing benefits are directly reflective of nursing fringe salaries. Rather, tying the fringe benefits increase to the nursing salary increase effectively indicates that the fringe benefits are an integral part of the labor costs for an atypical patient mix.

Significantly, the 18.7 percent fringe benefit rate is not an absolute ceiling to reimbursement of costs over that amount. A provider may warrant an increase above that amount if documentation showing all expenditures incurred for employee benefits is submitted and the costs are linked to the provider's atypical patient mix. Contrary to the Board's finding, CMS, both in allowing the direct patient care salary amount above that included in the composite rate, i.e., the Provider's "actual" salaries, and in denying the employee benefits amount in excess of the 18.7 percent fringe rate, consistently required the Provider to demonstrate that the excess costs were attributable to its atypical patient mix. However, as the Board failed to recognize, unlike the allowed direct patient care salary costs, the Provider failed to demonstrate that its costs in excess of the national average benefits rate were attributable to its patient population. As reflected by the record, the Provider's exception request is absent of documentation which links the excessive employee benefits costs above the 18.7 percent granted by CMS to its atypical patient mix.[6]

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[5] PRM §2723.3.D. ("In addition to the peer comparison submitted by the intermediary, [CMS] uses national data and general program statistics in evaluating the reasonableness of a facility's component costs shown in its exception request.")

[6] Notably, the Court in University of Cincinnati v. Shalala, Civ No. C-93-841 (S.D. Ohio, March 15, 1995), found that the Provider was not entitled to fringe benefits allowance greater than the national, salary-to-benefits average. The Court stated that:

Accordingly, with respect to the Provider's fringe benefit costs in excess of the 18.7 percent national average, the Administrator finds that the Provider failed to demonstrate that the excess fringe benefit costs are attributable to the Provider's atypical patient mix. Since the Provider has not demonstrated that its benefit costs in excess of the national average is a result of its provision of atypical services, the Administrator finds that the Provider failed to justify and exception to the composite rate for its excess fringe benefit costs.

Other Additional Labor Costs

With respect to other labor costs, the Administrator disagrees with the Board's determination. The Board held that the Provider submitted sufficient documentation to support some of its claims. The Board found that the Provider's costs of a physician director was justified based on the acuity of the patients but was limited by the Reasonable Compensation Equivalent (RCE). The Board also determined that because of the high turnover rate the Provider was justified in requesting $4.95 per treatment for administrative costs. The Board also noted that 57 percent of the Provider patient population had severe nutritional deficiencies which justified the additional direct labor and benefits costs of $1.55 per treatment for the services of a clinical dietician.

The Administrator finds that while the Provider identified its actual and projected costs the Provider failed to identify or document the incremental costs associated with the additional items or services rendered. As stated above §PRM §2721.B.

> In remanding this case back to HCFA, this court is not stating that HCFA must come up with a fringe benefit rate which is higher, lower, or the same as the 18.7 percent originally utilized. Nor is the court holding that HCFA must determine a fringe rate that is facility-factor-specific, geographic-specific, or urban-rural specific. All this court is doing is remanding the national, benefits-to-salary, question to HCFA in order for HCFA to make a documented, non-arbitrary, noncapricious fringe benefit rate calculation.

University, at n. 3.

In response, CMS documented that the 18.7 percent fringe benefit rate was statistically valid and consistent with the rate reflected by contemporaneous data. CMS' calculation of the average fringe benefit rate for the past ten years reflects a consistent national average of 18.7 percent, which was the standard that CMS used in reviewing this Provider. See also Palomar Medical Center, Admin. Dec. No. 97-D87; The Hospital of the University of Pennsylvania, Admin. Dec. No. 97-D53.

states a facility must provide written justification for supporting its higher costs which the Provider failed to do here.

Supply Costs

With respect to supply costs, the Administrator agrees with the Board's determination. The Provider's ESRD exception request for supply costs was based on additional costs incurred for six (6) particular types of supplies: Subclavin Dressing Kits, Dialyzer, Hypertonic Saline, Gloves, Bicarbonate and Acid Dialysis Concentrate, and Wound Dressing and Cleaning Supplies. The Board held that the Provider presented specific documentation to support its increases in supply costs and that the additional costs were directly attributable to its atypical patient mix. In this case, CMS had compared the actual costs incurred two years prior (1992) to the budgeted cost period (1994-1995) instead of FYE 1993. The PRM at §2721.F states that a provider must "provide an explanation of any significant increase or decrease in budgeted costs and data compared to actual cost and data reported on the latest filed cost report."

The Administrator finds that there was no significant increase or decrease in the budgeted costs compared to actual cost and data reported on the latest filed cost report. The record shows that for FYE 1994-1995 the budgeted cost for supplies was $51.82 and for FYE 1993 the actual cost was $49.42; an increase of 4.9 percent. Accordingly, the Administrator affirms the Board's determination with respect to specific supply costs.

Overhead Costs

The Administrator disagrees with the Board's decision with respect to its allowance of excess costs for overhead. Under the regulations at 42 C.F.R. §413.170(g) and §2720.1 of the PRM, a provider must demonstrate "with convincing evidence" that its per treatment costs are reasonable and "directly attributable" to the basis upon which an exception has been granted.[7] In supporting an atypical patient mix exception request for excess overhead costs, the PRM at §2725.1.B.4 specifically states:

> Overhead Cost. —There are infrequent instances, (i.e., hepatitis) when an isolated area is required and where higher overhead costs may be justifiable. For these costs to be considered under this exception criteria, documentation must be submitted that identifies the basis of higher overhead costs, the specific cost components to be impacted and the incremental pretreatment costs. General statements regarding a facility's

[7] See The Hospital of the University of Pennsylvania, Admin. Dec. No. 97-D53, aff'd by Civ No. 97-2027 (D.D.C. March 26, 1999).

> higher overhead costs are not acceptable in meeting the criteria. (Emphasis added).

As indicated in the record, the Provider failed to substantiate its claims that excess overhead costs relate to the Provider's atypical patients. The Administrator finds that the Provider's general contention that certain overhead costs must follow higher direct costs is contrary to the specific requirements of the regulations and manual and likewise is not supported by the record. Contrary to the specific regulatory requirements and PRM instructions, the Provider offered no documentation, other than general statements, to identify its higher overhead costs and the link to its atypical patient mix. Simply because the Provider has an atypical patient mix does not demonstrate that its overhead costs are "directly attributable" to the provision of atypical services.

Accordingly, for reasons indicated above, the Administrator finds that the Provider has not submitted convincing evidence, in conformity with the specific ESRD requirements of the regulation, PRM, the general documentation, or record keeping requirements of the Medicare regulations, to satisfy its burden of proof and substantiate its exception request for excess overhead costs.

DECISION

The decision of the Board is modified, consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION
OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 6/7/05

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services