PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D20

PROVIDER -
Burke Rehabilitation Hospital, Inc.
White Plains, New York

Provider No. 33-3028

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Empire Blue Cross and Blue Shield

DATE OF HEARING -
May 20, 1999

Cost Reporting Period Ended -
December 31, 1991

CASE NO. 94-2879

INDEX

ISSUE:

Was HCFA's partial denial of the Provider's request for a TEFRA[1] target rate adjustment proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Burke Rehabilitation Hospital, Inc., ("Provider") is a general, short-term hospital located in White Plains, New York. It is a rehabilitation hospital that is licensed for 150 beds. It was established in 1912 and provides a broad range of physical rehabilitation services for patients with various diagnoses, including spinal cord injuries, head trauma, stroke, neurological disorders, orthopedic surgeries, and cardiovascular/pulmonary disease. The Provider also furnishes a full range of outpatient therapy services. Its Medicare utilization is approximately sixty six and two thirds percent.

The Provider's fiscal intermediary is Empire Blue Cross and Blue Shield. In this case, the decision to deny the TEFRA adjustment was made by the Health Care Finance Administration ("HCFA") and not the Intermediary. The Intermediary's only witness at the hearing was Ms. Linda Hite, a HCFA employee who presented the basis for the TEFRA adjustment request partial denial.

The Provider's base year for its TEFRA target rate is 1985. The Provider's target rate base year was 1985, rather than 1982 as for most other excluded hospitals in the country because New York state had a waiver in place in 1982. Between 1985 and 1990 the Provider was essentially able to operate under its TEFRA target rate, exceeding the TEFRA target rate only in 1990 and then only by a small amount of $90,000 or $110 per case.[2]

The Provider requested an adjustment to its TEFRA target ceiling rate for calendar year ended December 31, 1991, by letter of October 1, 1992.[3] The Provider was notified by the Intermediary in a letter dated March 11, 1994, that HCFA denied in part its adjustment. The HCFA letter dated March 4, 1994[4] denied in substantial part the Provider's request for adjustment relief although it did grant an adjustment in the amount of $76,006 on matters not in dispute in this appeal. This reflected an adjustment for increased speech pathology services in the amount of $63,002 and increased medical supplies charges to patients in the amount of $12,984. With respect to the principal issue for which adjustment relief had been requested--increased cost resulting from a Medigap insurers' change in

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[1] TEFRA is the Tax Equity and Fiscal Responsibility Act of 1982.

[2] Transcript ("Tr.") at 40, Provider Exhibit 1.

[3] See Provider Exhibit B of Provider's Final Position Paper.

[4] See Provider Exhibit A of Provider's Final Position Paper.

policy so as to require their insured to exhaust Medicare lifetime reserve days prior to the Medigap insurer assuming full coverage--HCFA denied relief. In relevant part, HCFA's letter stated:

> New York's adaptation of Medicare secondary insurance coverage policies is not an issue covered by section 413.40(g) of the Medicare regulations. Health care facilities nationwide, as well as in the state of New York, must assess local and national market factors when evaluating staffing, overhead, and cost containment needs.

Id.

The Provider believes that the data shows that it is entitled to an adjustment of its TEFRA target rate in the amount of approximately $1 million because the number of Medicare lifetime reserve days increased from 1,780 in 1990 to 3,991 in 1991. This more than doubled the number of lifetime reserve days covered by Medicare, resulting in significant increased costs to the Provider. The Provider believes that it is entitled to an adjustment according to the specifications listed in Provider Reimbursement Manual, HCFA Pub. 15-1 ("HCFA Pub. 15-1") §3004 because:

1. The length of Medicare covered stays increased;

2. The cost of Medicare covered stays increased;

3. The number of Medicare lifetime reserve days increased significantly from 1990 to 1991, the first year when Medigap insurers changed their coverage policy and the number of lifetime reserve days was not comparable to the Provider's base period which caused the Provider to exceed its target rate by approximately $1 million;

4. The amount by which the Provider's costs were increased by the sharp increase in the number of lifetime reserve days can be readily identified and calculated; and

5. The Provider's cost are reasonable.

In 1991, the Provider continued to decrease its overall average length of stay. The Medicare length of stay increased by 2.3 days from 1990.[5] The Provider's total operating costs went up by 2.2 percent per discharge. Its Medicare costs increased by 17.4 percent per discharge.[6] The increase in Medicare

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[5] See Provider Ex. 6.

[6] See Provider Exhibit 2.

costs caused the Provider to exceed its TEFRA target by a significant amount for the first time in six years. In 1991, the Provider exceeded its TEFRA target amount by $1,741.16 per discharge, or $1.6 million in total.[7]

Between 1985 and 1990, the Provider decreased its Medicare average length of stay by three days, from 33. 7 to 30.7. In 1989, the Medicare average length of stay increased as a result of the Medicare Catastrophic Coverage Act ("MCCA"), which changed coverage policies resulting in the Medicare program covering 365 days of an inpatient stay. During the same period, the Provider decreased hospital-wide length of stay by approximately four days.[8]

The Medicare inpatient hospital benefit under Part A allows patients 90 days of coverage for each spell of illness. For the first 60 days of the spell of illness, Medicare pays for full days, except for a stated deductible. 42 C.F.R. § 409.61(a)(1). From day 61 to day 90, hospital care is subject to a daily coinsurance amount equal to one-fourth of the inpatient deductible. 42 C.F.R. § 409.83(a)(2). After 90 days, the beneficiary has exhausted his or her Medicare coverage. However, every beneficiary has 60 non-renewable lifetime reserve days. The beneficiary can use these lifetime reserve days to avoid a loss of coverage and may draw on them whenever he or she is hospitalized for more than 90 days in a benefit period.[9]

When Medigap insurers required beneficiaries to first exhaust their lifetime reserve days, prior to paying for hospital days, this policy change shifted days from being reimbursed by Medigap insurers to being reimbursed by the Medicare program, thus increasing the Medicare average length of stay, increasing the cost of that length of stay, and decreasing the non-Medicare length of stay.[10]

In October 1992, the Provider, with the assistance of a consulting firm, prepared a letter requesting a TEFRA target rate increase due to the increase in lifetime reserve days. Although Congress amended the law in 1990 to require HCFA to "provide guidance... to assist... hospitals in filing complete applications with the Administrator for exemptions, exceptions, and adjustments under section 1886(b)(4)(A) of the Act," Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, §4005(c)(3), such guidance had not been published at the time the Provider submitted its request. The Provider's request stated:

> During 1991, the LOS increased significantly due to a substantial growth in Medicare days while the number of discharges remained

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[7] Tr. at 41.

[8] See Provider Exhibit 6.

[9] Tr. at 53.

[10] See Provider's Exhibit 5, 6 and 7.

> relatively constant. The change in days was attributable to an increase in the Medicare Lifetime Reserve Days (LTR) incurred throughout the year.
>
> Management has performed a detailed review of the Medicare PS&R reports, Medicare payment vouchers and Blue Cross payment advices to determine the cause of the extraordinary growth in LTR days. Such review revealed that beginning in 1991, Blue Cross required that beneficiaries with Senior Care coverage must initially exhaust their Medicare LTR days before such benefits would be paid. This policy change by Blue Cross no longer allowed Medicare beneficiaries the opportunity or choice to utilize the LTR days at their discretion.

Provider Exhibit B.

The letter estimated lifetime reserve days for 1985 using the ratio of 1990 lifetime reserve days to discharges.

The Intermediary forwarded the Provider's request to HCFA by letter dated November 17, 1992. Mr. Casella stated in his letter to HCFA that he agreed with the provider's rationale for the exception request and its reasonableness.[11]

The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§405.1835-.1841. The Provider is represented by Dennis M. Barry, Esquire, of Vinson & Elkins, LLP. The Intermediary is represented by Eileen Bradley, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that 42 C.F.R. §413.40(g) governs TEFRA adjustments. The Provider's claim for adjustment relief was based on both the lack of comparability between the base year and 1991 and the extraordinary circumstances of a virtual doubling of lifetime reserve days in 1991 compared to prior years. The effect of 1,956 more lifetime reserve days was the resulting increase in cost of approximately $900,000.[12] This amount was "significant," and was caused by events beyond the Provider's control. Accordingly, the Provider is entitled to adjustment relief under the literal wording of the regulation.

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[11] See Intermediary's Exhibit 1-4.

[12] See Provider Exhibit 16.

The Provider contends that it should receive a TEFRA adjustment because its Medicare length of stay increased in real terms and because HCFA's policy explicitly allows for adjustments in cases where the length of stay increases. HCFA's policy allows for an adjustment in cases where "distortions in inpatient operating costs" result in "noncomparability of the cost reporting periods," on the basis of increases in average length of stay of Medicare patients." HCFA Pub. 15-1 §3001.4. Under the current methodology used by HCFA to grant adjustments, the Medicare average length of stay in an appeal year must exceed the Medicare average length of stay in the base year in order to receive an adjustment. Since the Provider's length of stay equaled 33.7 in its base year, and 33.0 in the appeal year, HCFA's formulas, as currently designed would not offer relief.

However, the Provider proffers that the methodology for adjustments based on increased length of stay must be modified to account for a TEFRA update factor consistently lower than market basket. Between 1985 and 1991, the TEFRA target rate increased by 22.7 percent, while the market basket increased by 32.4 percent, a difference of 9.7 percent.[13] The TEFRA update factor in this case is based upon the Provider's own experiences, i.e., how much its TEFRA ceiling increased on an annual basis. The market basket update is based upon figures published by the Congressional Budget Office. Because the TEFRA update factor was not set at a rate equal to the Provider's rate of inflation, the base year cost per discharge could not possibly be representative of current year cost per discharge unless the Provider reduced its length of stay. By 1991, with a TEFRA target rate update 9.7 percent below market basket, the base year costs, the costs which are supposed to serve as a benchmark for current year costs, were in fact worth 9.7 percent less than what they were worth in the base year. Thus, to keep within its target rate, a provider would have to reduce length of stay.

The Provider observes that HCFA recognized that providers would reduce length of stay to live within a lower than market basket TEFRA update. Explaining a TEFRA update factor of 0% for 1986 when the market basket was 4.27%, HCFA stated:

> HCFA used the observed reductions in length of stay during FY 1984 as an indicator of reductions in inpatient hospital ineffective practice patterns.

50 Fed. Reg. 35706.

Similarly, for fiscal year 1987, the update factor was set at 2.3 percentage points below market basket, and HCFA justified the low update factor by stating:

> A primary objective of the prospective payment system is to encourage the efficient provision of hospital care by changing economic incentives under the payment. It is

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[13] See Provider Exhibit 1.

> reasonable to assume that hospitals have (or should have) made substantial productivity gains during the first three years of the prospective payment system.

Id.

At the time, HCFA used the same update factor for Prospective Payment System ("PPS") hospitals as it did for hospitals excluded from PPS. A number of commenters protested that it was inappropriate to apply the same update factor to both PPS and excluded hospitals. HCFA responded that "excluded hospitals have the same opportunities for cost reduction that PPS hospital have already exploited and thereby shown to be feasible ... We expect many excluded hospitals and units will be able to achieve greater efficiency and effectiveness in the delivery of needed services as a response to these limits." 50 Fed. Reg 35715.

The Provider argues that because the TEFRA target rate update factors were based on the assumption that the length of stay would decrease for TEFRA-reimbursed hospitals, HCFA cannot consistently argue that a hospital's costs are not justifiably in excess of the target amount unless its length of stay is greater than it was in the base year. Indeed, holding hospitals to their base year lengths of stay for purposes of TEFRA adjustments, assumes incorrectly that the TEFRA updates have not been consistently lower than market basket, but that the TEFRA target rate has increased at a rate equal to increases in the hospital market basket. If the TEFRA update had consistently equaled the market basket, then the base year length of stay would be a proper point of comparison for purposes of receiving an adjustment. However, because the TEFRA update factor has not increased at the rate of inflation, the base year length of stay is no longer a proper benchmark. Thus, HCFA on the one hand holds hospitals to a lower than market basket TEFRA update but then bases its adjustment formulas on the premise that the TEFRA update has historically equaled market basket.

The Provider observes its own history which shows how closely correlated its length of stay is to the difference between TEFRA and market basket updates. Between 1985 and 1990, the Provider reduced its Medicare length of stay by three days and its hospital overall length of stay by five days. Indeed, the Provider's witness testified that the Provider could not have maintained costs at a level below the target rate without reducing length of stay.[14] Between 1985 and 1990, the real value of the base year operating costs decreased by 8.8 percent (the difference between the cumulative market basket update of 25.9% and the cumulative TEFRA update of 17. 1 %).[15] The Provider's Medicare average length of stay during the same time period decreased by 8.9 percent from 33.7 days to 30.7 days.[16]

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[14] Tr. at 82.

[15] See Provider Exhibit 1.

[16] See Provider Exhibit 6.

The Provider argues that structuring HCFA's formulas to account for reduced lengths of stay would offer substantial relief to the Provider. The formula used by HCFA is as follows:

1. Current year Medicare days

2 Base year Medicare operating costs per discharge (as updated by TEFRA update factor) divided by base year Medicare days = Base year per diem rate

3. Line 1 x Line 2 = Current year imputed costs

4. TEFRA ceiling from worksheet D-1

5. Line 3 - Line 4

6. Disallowance based on a per discharge target amount (supplemental worksheet D-1)

7. ALOS adjustment (lesser of line 5 or line 6)

PRM § 3004.1

Under the current formula, the Provider receives no adjustment because the formula assumes that base year Medicare days are a proper basis for comparison. However, reducing the Medicare days in the base year to account for the low TEFRA update factor would be a more equitable formula. Reducing the base year Medicare days by 9.7 percent (the amount by which the market basket exceeds the TEFRA update in 1991) results in the following average length of stay adjustment for the Provider:

1. Current year Medicare days = 30,129

2. a. Base year Medicare operating costs per discharge, as updated ($13, 477.21) x base year discharges (674)
   b. Base year Medicare days (22,727) as adjusted by 9.7% = 20,522
   Imputed base year cost diem = a/b = $442.63

3. Line 1 x 2 = $13,335, 979.71

4. TEFRA ceiling = $12,304,692.73

5. Line 3 - Line 4 = $1,031,286.98

6. Disallowance based on per discharge target amount = $1,589,679.08

7. Lesser of line 5 or line 6 = $ 1,031,286.98

The Provider notes that HCFA has argued that: (1) the formulas published in Chapter 30 of the Provider Reimbursement Manual are designed to capture any event that causes distortion in operating costs,[17] and (2) the fact that the application of the formulas did not provide meaningful relief to a provider demonstrates that the provider did not suffer a significant distortion in operating costs as a result of the increase in lifetime reserve days. The Provider finds this argument to be a self-serving tautology and takes issue with HCFA's reliance on its formulas as the sole method for granting relief in a TEFRA adjustment case.[18]

The Provider further observes that HCFA's insistence on rigidly adhering to its formulas also does not accord with HCFA's willingness to depart from its formulas in other instances. For example, in the case of the Medicare Catastrophic Coverage Act ("MCCA") of 1988, Pub. L. No. 100-360 (July 1, 1988) [repealed by Medicare Catastrophic Coverage Repeal Act of 1989, Pub. L. No. 101-234 (December 13, 1989], HCFA crafted a formula that would specifically account for the additional days being incurred by providers as a result of the change in the law. 53 Fed. Reg. 38521. HCFA did not employ its HCFA Pub. 15-1 Chapter 30 formulas presumably because such formulas would not have accounted for the changes brought about by the MCCA. Further, the HCFA witness' testimony on the Chapter 30 formulas also raises serious doubt that these formulas capture all distortions in operating costs. The HCFA witness seemed to assert that application of the formulas showed that the Provider's Medicare operating costs did not increase as compared to 1985.[19] Obviously, the Provider's average cost per discharge did increase, or the Provider would not have exceeded its TEFRA limit. Further, during the hearing, it also became apparent that although the Chapter 30 formulas came into use sometime before 1994, there were no instructions nor guidance published to familiarize those in the hospital industry with such formulas.[20] Nor were these formulas, which HCFA states it exclusively uses to determine TEFRA adjustments, published with notice and comment.[21] No evidence was presented demonstrating that the Provider was aware of, or should have been aware of, the formulas when it made its adjustment request.

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[17] Tr. at 190.

[18] Tr. at 199.

[19] Tr. at 185-186

[20] Tr. at 187.

[21] Tr. at 188.

The Provider notes that the Intermediary's principal argument was that the Provider had failed to produce adequate documentation. The Provider believes that all of the evidence presented in the briefs and in testimony support a factual finding that a change in Medigap policies caused the Provider to exceed its TEFRA ceiling. The Provider has introduced testimonial evidence that there was a change in Medigap policies based on the experience of business office personnel.[22] In 1999 hospital staff reviewed 1990 and 1991 patient account files and produced evidence supporting such a finding.[23] The record also has a policy summary in 1991 showing that Blue Cross' Medigap policy required the exhaustion of lifetime reserve days. Moreover, an increase in lifetime reserve days will necessarily increase Medicare operating costs since each additional day results in proportional ancillary and routine costs being assigned to the Medicare program. According to testimony of the Provider's witness, each day of care at the Provider costs an equivalent amount of money, and several studies performed by the Provider support this finding.[24] Thus, for each additional lifetime reserve day incurred by a Medicare beneficiary, there were routine and ancillary Medicare costs that would not have been incurred as such in previous years. Circumstantial evidence also requires a finding that the Medigap policies changed. Lifetime reserve days increased by approximately 2,000 days in 1991.[25] The Medicare length of stay increased at the same time that the non-Medicare length of stay decreased.[26] Length of stay data from 1991 is similar to length of stay data from 1989, the year the MCCA was in effect. The MCCA required Medicare to pay for 365 days of inpatient stay, thereby shifting costs from nonMedicare payors to the Medicare program. The similarities between length of stay data from 1991 and 1989 is significant because in 1989, days that were previously reimbursed by non-Medicare payors were shifted to the Medicare program. Thus, the similarities lead to a conclusion that in 1991, as well, lifetime reserve days previously reimbursed by non-Medicare payors shifted to Medicare payment.

The Provider observes that the reactions of HCFA and the Intermediary also are evidentiary. The Intermediary's representative, who presumably was familiar with Medigap policy changes, reacted to the Provider's application by stating that it was a "reasonable" request, and that he agreed with the Provider's rationale.[27] HCFA partially approved the Provider's request for an adjustment, so it must have believed that there was some uncontrollable event or extraordinary circumstance that caused the Provider to exceed its target rate.

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[22] Tr. at 47.

[23] Tr. at 57.

[24] Tr. at 113-115.

[25] Tr. at 46.

[26] See Provider Exhibit 6-7.

[27] See Intermediary Exhibit 1-4.

The Provider argues that in the alternative, neither the statute, the regulations, nor the manual states that a provider must be able to point to an external event, such as a change in law or policy that caused the increase in lifetime reserve days. Rather, as long as a provider can point to some change in the hospital that caused operating costs to increase significantly, relief should be granted. The statutory section on TEFRA adjustments, for example, states that a change in case mix, regardless of what triggers such a change, requires a TEFRA adjustment. Social Security Act §1886(b)(4)(A)(1). A sudden change in lifetime reserve days is analogous to a sudden change in case mix since both are events beyond the Provider's control that cause a large increase in operating costs. The regulations also do not require a provider to submit evidence that a change in law or policy caused its lifetime reserve day increase. The regulations allow an adjustment whenever there is a:

> Significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits.

42 C.F.R. §413.40(g)(1).

Nothing in the above language requires a provider to identify an event causing the distortion. Similarly, the Provider Reimbursement Manual permits adjustments for changes in length of stay without any requirement that a provider prove what caused the increase. HCFA Pub. 15-1 §3004.1.

The Provider argues that HCFA and the Intermediary have waived any right to challenge the Provider on this issue because it was not until the hearing that they ever raised the documentation argument. When the Provider submitted its application for an adjustment request, it noted that 1985 lifetime reserve days had been estimated based upon 1990 lifetime reserve days.[28] In forwarding the application to HCFA, the Intermediary stated:

> While we agree with the provider's rationale for the exception request and its reasonableness, it is not addressed in the guidelines.

Intermediary Exhibit 4.

If the Intermediary disputed the factual basis for the Provider's request, it should have so stated in 1992 when it reviewed that request. Under HCFA Pub. 15-1 §3004.3, and as corroborated by the HCFA witness,[29] it is incumbent upon the intermediary to verify the facts in a provider's request. The Intermediary is the same legal entity that issued the vast majority of the Medigap policies at issue. It had better access than anyone to the terms of its Medigap policies. The law is clear that when one party has access to information and fails to produce that information, it is proper to draw inferences

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[28] See Provider Exhibit B of the Final Position Paper.

[29] Tr. at 189.

based on the failure to produce that information. Alabama Power v. EPC 511 F.2d 383 (D.C. Cir. 1974). Similarly, HCFA should have requested more information if it thought it was necessary since HCFA Pub. 15-1 §3004.4 requires it to request additional information from an intermediary when the intermediary's recommendation is not supported by sufficient documentation. In this case, the Provider was never notified that documentation was incomplete.[30] HCFA never contacted the Provider to ask for additional information that would demonstrate lifetime reserve days used in 1985. The Intermediary's final position paper never mentioned the issue of documentation. Indeed, HCFA never formally brought up the issue of documentation until the hearing, when counsel for the Intermediary opened with the argument that what we have here is really a documentation case.[31]

The Provider contends that the 1990 statutory amendments also require HCFA to offer a detailed explanation of the grounds on which a request is approved or denied, OBRA 1990, §4005(c)(1)(B), Amending SSA § 1886(b)(4)(A). HCFA acted upon the Provider's request and even granted a small amount of relief, and yet, nowhere in its response did HCFA question that there had in fact been a change in benefits under Medigap policies. Indeed, even the HCFA witness admitted that she could not understand HCFA's response to the Provider's request.[32]

The Provider believes that HCFA's denial cannot be defended on any basis other than the explanation on its face, especially in light of the 1990 statutory amendment requiring HCFA to furnish a "detailed explanation" of its action. Seven years later, after the request was reviewed by the Intermediary and forwarded to HCFA with stated agreement with the Provider's rationale, the Intermediary suddenly describes the Provider's application as "meager,"[33] and argues that the adjustment request was denied because of lack of documentation. Requiring the Provider to meet the documentation standards that the Intermediary and HCFA, in a litigation posture, have now imposed, would violate the longstanding rule against retroactive prescriptions. Moreover, given both HCFA's responsibility to ask for additional documentation when necessary, and the regulatory pronouncement that an application is "complete" when HCFA acts upon it, it would be inequitable and violative of the regulations to require the Provider to submit additional 1985 documentation at this late date. Rather, if documentation on lifetime reserve days is necessary, then the Board should permit the Provider to use 1990 data to demonstrate the distortion in operating costs that occurred during 1991.

The Provider argues that Congress' enactment of the MCCA also demonstrates that Congress expects HCFA to make TEFRA adjustments in cases where a change in law or policy results in costs being shifted from a secondary payor to Medicare. When Congress enacted the MCCA -- a law which

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30 Tr. 137.

31 Tr. at 17.

32 Tr. at 197.

33 Tr. at 24.

eliminated the 90 day spell of illness limitation, thus causing Medicare to cover 365 days of inpatient care per year--it specifically directed the Secretary to make TEFRA adjustments in cases where the MCCA caused hospitals to suffer distortions in costs. In Harmarville Rehabilitation Center Inc., v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 93-D42, May 20, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,558, rev'd. by HCFA Admin. Dec. July 19, 1993 (CCH) ¶41,671 ("Harmarville") the HCFA Administrator argued that Congress' actions proved that Congress interpreted the regulations, prior to passage of the MCCA, as not providing for relief in cases where a change in law or policy shifted costs to the Medicare program. The HCFA Administrator argued that if a change in Medigap policy warranted a TEFRA adjustment, then there would have been no need for Congress to enact of the MCCA, and the promulgation of 42 C.F.R. § 413.40(i).

The Provider counters that the HCFA Administrator's interpretation in Harmarville cannot be correct. First, the HCFA witness admitted in testimony that it is possible HCFA would grant an adjustment due to a change in lifetime reserve days or Medigap policies. Second, as stated in the Provider's supplemental position paper, there are numerous examples of HCFA adjusting TEFRA rates to account for a shifting of costs. For example, when HCFA required certain services to be bundled under Part A, HCFA announced that base period costs would be adjusted by the estimated cost of services that were previously reimbursed under Part B. Thus, all TEFRA providers received adjustments without regard to how their current year costs compared to base year costs using the formulas applied to the Provider in this case. Part A Intermediary Letter No. 83-7. Again, when Congress changed the payment window for excluded hospitals from three days to one day, HCFA stated that this change would warrant a downward TEFRA adjustment. HCFA's rationale was that providers may have previously received adjustments on the basis of the three-day window. HCFA argued that these adjustments would have to be reversed because operating costs previously borne by hospitals under the three-day window would subsequently be shifted to Part B, thereby reducing hospitals' operating costs. 60 Fed. Reg. 29202, 29245 (1995). Although the Harmarville case was not cited or relied upon by the Intermediary during the hearing, and the HCFA witness contradicted arguments in the Intermediary's position paper ostensibly based upon Harmarville, the Provider wishes to distinguish itself from the Harmarville plaintiff. First, in Harmarville, the hospital's Medicare days actually decreased in its appeal year, thus undermining the hospital's claim that the additional lifetime reserve days increased total Medicare days. In the Provider's case, the Medicare days increased by 32.6 percent between 1985 and 1991 (from 22,727 to 30,129), while total days increased only 1.4 percent (46,459 to 47,145).[34] Second, Harmarville's length of stay for non-Medicare patients increased, leading the government to argue that the provider's increased costs may have been due to inefficiencies. Here, the Provider has steadily decreased both its non-Medicare and its Medicare lengths of stay since 1985. Third, in Harmarville, overhead costs increased. The Provider's overhead costs, in contrast, increased at a much lower rate than either the market basket or the TEFRA update

[34] See Provider Exhibit 8.

(7 percent lower than the TEFRA update; 17.5 percent lower than the market basket update).[35] Finally, in Harmarville, the hospital exceeded its TEFRA rate by only $36,000. In this case, the Provider exceeded its target rate by $1.5 million.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that upon receipt of the Provider's October 1, 1992 exception request, it reviewed the Provider's request and noted one aspect of the Provider's request to be related to "non-comparability to the base year" involving an increase in Medicare cost per discharge due to an increase in the use of Medicare lifetime reserve days in 1991 compared to prior years. On November 17, 1992, the Intermediary submitted a letter to HCFA pointing out that the basis for the Provider's exception was not specifically addressed in the guidelines for exception requests.[36] On November 19, 1992[37], the Intermediary sent a letter to the Provider informing it that the exception request had been reviewed but because the issue as it relates to lifetime reserve days was not addressed in the guidelines, the Intermediary was asking for HCFA's evaluation. On March 4, 1994, the Intermediary received HCFA's response which stated, in pertinent part:

> New York's adaptation of Medicare secondary insurance coverage policies is not an issue covered by section 413.40(g) of the Medicare regulations. Health care facilities nationwide, as well as in the state of New York, must assess local and market factors when evaluating staffing, overhead, and cost containment needs.

Intermediary Exhibit I-2.

A review of the applicable regulation at 42 C.F.R. §§413.40(g) and (h) indicates the specific items which may be considered by HCFA and the Intermediary in determining if an exception request is warranted. An increase in the Medicare average length of stay may be one of the bases for an exception. As noted in 42 C.F.R. §413.40 (h) (1) (iii):

> HCFA may adjust the amount of operating costs, under paragraph (c)(1) of this section, to take into account factors such as a change in the inpatient hospital services that a hospital provides, that are customarily provided directly by similar hospitals, or by the manipulation of discharges to increase reimbursement. A change in the inpatient hospital services provided could result from changes that include, but are not limited to, opening or closing a special care unit or changing the arrangements under which such services may be furnished, such as leasing a department... (Emphasis added).

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[35] Tr. at 77-78.

[36] See Intermediary Exhibit 1-4.

[37] See Intermediary Exhibit 1-5.

Id.

While an increase in the average length of stay due to a change in the medical services rendered in the unit may be an allowable adjustment item, the issue in this case does not fall into any of the recognized exception bases as no changes in hospital inpatient services are involved. Further, there is no change in the arrangement of services being rendered at the Provider.

The Intermediary also notes that HCFA Pub. 15-1 § 3004.1B applies. It identifies the review process an intermediary uses to determine the reasonableness of an exception request and involves an increase in the average length of stay of Medicare patients. As noted in that section, common causes for increases in the length of stay which may indicate an exception is applicable are:

1) Increase in medical acuity
2) Change in admission practices and criteria
3) Changes in the type of patients served
4) Changes in practice patterns

Id.

The increase in the average length of stay for Medicare patients due to the use of lifetime reserve days is not an acceptable reason for an exception to the cost limit. As indicated in HCFA's March 4, 1994 determination, this is not a reason for an adjustment to the 1991 rate of increase cost.

The Intermediary notes that in Harmarville Rehabilitation Center v. Shalala, No. 93-1943 (D.D.C 1995), affirmed, 107 F. 3d 922 (D.C. Cir. 1996), the courts upheld HCFA and found that a rehabilitation hospital was not entitled to a TEFRA target amount exception based on the hospital's contention that a mid-base year change in Medigap coverage policy resulted in increased operating cost as a result of an increase in Medicare average length of stay and warranted a TEFRA adjustment. The court concluded that: (1) the hospital did not establish a causal nexus between costs in excess of the target amount and the Medigap policy change; and (2) factors other than the policy change caused the hospital to exceed the rate of increase ceiling. The court upheld the Administrator's decision in which she noted that a change in Blue Cross coverage policy did not entitle a provider to an exception based on extraordinary circumstances, it stated, in part:

> The Administrator finds that the testimony and evidence presented do not support a finding that the change in Blue Cross' Medigap policy constitutes an extraordinary circumstance. The record reveals that changes in medical insurance coverage that result in cost shifting among insurers are not unusual, and indeed, are expected in the health care insurance industry. Thus, like contemporaneous examples of cost shifting among health care insurers reflected in the record, the change in Medigap coverage cannot be deemed highly unusual, unexpected or extraordinary.

The Intermediary further contends that this case is largely a documentation case. It did not have adequate information to determine if an exception could be made in this case. What is at issue is an understandable assertion on the part of the Provider that it had a dramatic increase in lifetime reserve days, and at the same time, it had a dramatic increase in costs. The problem that HCFA faced then and continues to face is what is the nexus and the causal relationship when HCFA does not know how many Medicare patients were enrolled in or were part of the Intermediary's Medigap coverage and were taking advantage of the Medigap policies. Further, the Intermediary did not know how many "per discharges" there were relating to lifetime reserve days. The Intermediary is simply in a gap, and it is this gap that the Provider believes that HCFA had some responsibility for filling. In summary, there are just two points. First, the Intermediary is comparing the 1991 rate year to the base year. That is what the regulations require. Secondly, in the absence of data and analysis, HCFA applied its cost methodologies, took information from the cost report, and reached a result that granted only partial relief compared to what the Provider was seeking.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law-Title XVIII of The Social Security Act:

§1861(v)(1)(A)	-	Reasonable Cost
§1886(b)(4), et seq.	-	Rate of Increase In Target Amounts of Inpatient Hospital Services
Omnibus Reconciliation Act of 1990 Public Law No. 101-508:	-	
§4005(c) et seq.	-	Rate of Increase In Target Amounts of Inpatient Hospital Services
Medicare Catastrophic Coverage Act of 1988 - Public Law No. 100-360	-	Medicare Coverage Catastrophic Coverage
Medicare Catastrophic Coverage Act of 1989 - Public Law No. 101-234	-	Repeal ofMidicare Catastrophic Coverage

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

§§405.1835 - .1841	-	Board Jurisdiction
§409.61(a)(1)	-	Regular Benefit Days
§409.83(a)(2)	-	General Provisions

§413.40(g), et seq.	-	Exceptions
§413.40 (h), et seq.	-	Adjustments
§413.40(i)	-	Assignment of New Base Period

3. Federal Register:

50 Fed. Reg. 35706 (1985)	-	Comments on PPS Update Factors
50 Fed. Reg. 35,715 (1985)	-	Comments on PPS Update Factors
53 Fed. Reg. 38,521 (1988)	-	The Medicare Catastrophic Act of 1988
60 Fed Reg. 29202, 29245	-	Changes to the Hospital Inpatient PPS and Fiscal Year 1996 Rates

4. Program Instructions - Provider Reimbursement Manual (HCFA Pub. 15-1):

§3001.4	-	Long Term Hospitals
§3004, et seq.	-	Adjustments to Rate of Increase Ceiling
Chapter 30	-	Hospitals and Distinct Part Units Excluded From Prospective Oayment System

6. Part A Intermediary Letter

No. 83-7 (6/83)	-	Prospective Payment System--Inpatient Hospital Services

7. Cases:

Harmarville Rehabilitation Center Inc., v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 93-D42, May 20, 1993, Medicare & Medicaid Guide (CCH) ¶41,558, rev'd by HCFA Admin. Dec. July 19, 1993 (CCH) ¶41,671.

Harmarville Rehabilitation Center v. Shalala, No. 93-1943 (D.D.C. 1995) aff'd, 107 F.3d 922 (D.C. Cir. 1996).

Alabama Power v. EPC, 511 F. 2d 383 (D.C. Cir. 1974).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties' contentions, testimony and post-hearing briefs finds and concludes that HCFA properly denied the Provider's TEFRA target rate adjustment due to a change in policy by Medigap insurers. The Board finds the regulations at 42 C.F.R §413.40 (h) allows an adjustment for a distortion between the base year and current year's costs. Thus, the reserve day adjustment could qualify if it is properly documented and shows the nexus between the increased costs and length of stay. The Board finds that based on its review of the entire record the Provider did not provide adequate documentation to support its request. There was nothing in the record to show the number of Medicare lifetime reserve days were included in the base year. Also, there was a lack of detailed information to show the nexus between the Medigap policy change and the Provider's change in Medicare's length of stay. This was required in the Harmarville court case and the Board concurs that for an exception to be allowed, an appropriate nexus is required.

The Board notes that the Provider had not completely accounted for the increase in the Medicare cost per discharge. The total Medicare cost per discharge been 1990 and 1991 was 17%. The Provider's argument regarding the increase in costs due to the average length of stay only amounted to 8%.

Finally, the Board notes that the Provider has argued that the TEFRA rate of increased ceiling was inadequately calculated by HCFA. It argued that a rate more relevant to the hospital "market basket", i.e., 32.4%, should have been used to adjust the base year. The Board observes that HCFA properly followed the regulatory requirements in computing its adjustment factor. Thus, the 23% used by HCFA was correct.

DECISION AND ORDER:

HCFA properly denied the Provider's request for an adjustment to the TEFRA base year costs. The Intermediary's adjustment is sustained.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

Date of Decision: February 23, 2000

FOR THE BOARD

Irvin W. Kues
Chairman