

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D12

PROVIDER -Seton Medical Center
Daly City, California

DATE OF HEARING-
October 11, 1996

Provider No. 05-0289

Cost Reporting Period Ended -
June 30, 1984

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of California

CASE NO. 86-0429

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ISSUE:

Was the Intermediary's denial of the full TEFRA incentive payment to the Provider proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Seton Medical Center ("Provider") is a general acute care not-for-profit hospital located in Daly City, California. During the fiscal year ended ("FYE") June 30, 1984, the Provider was reimbursed by Medicare based on reasonable costs, subject to the ceiling on the rate of increase provisions of the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), § 1886(b) of the Social Security Act, 42 U.S.C. § 1395ww(b). In addition, the Provider was subject to the limit on inpatient operating costs contained in § 1886(a) of the Social Security Act, 42 U.S.C.

§ 1395ww(a) (the "inpatient operating cost limit").

TEFRA is implemented by Medicare regulations at 42 C.F.R. § 405.463 (1983) (redesignated at 42 C.F.R. § 413.40), which establish a limit ("TEFRA limit") on the rate of increase in hospital inpatient operating costs that will be recognized as reasonable for the purpose of determining Medicare payment. The ceiling is determined for each cost reporting period by multiplying a hospital's TEFRA "target amount" by the number of its Medicare discharges during the period. The target amount is the per discharge limit derived from the hospital's allowable net inpatient operating costs in its TEFRA base year, updated for inflation by the annual "rate-of-increase percentage" published by the Health Care Financing Administration ("HCFA").

The Provider's TEFRA base year was FYE June 30, 1983. Therefore, the TEFRA target amount for the Provider's FYE June 30, 1984 is determined by taking its allowable inpatient operating costs in FYE June 30, 1983, and adjusting that amount by the rate of increase in hospital goods and services plus 1%. 42 U.S.C. § 1395ww(b)(3)(B). Under TEFRA, a hospital is entitled to a TEFRA bonus or incentive payment if its operating costs are less than the target amount. 42 U.S.C. § 1395ww(b)(1)(A).

The inpatient operating cost limit was implemented by Medicare regulations at 42 C.F.R. § 405.460 (1983) (redesignated at 42 C.F.R. § 413.30). For FYE June 30, 1984, the inpatient operating cost limit was based on 120% of the average of operating costs of inpatient hospital services incurred by hospitals in the same grouping for comparable time periods, adjusted by a hospital-specific case mix index. 42 U.S.C. § 1395ww(a)(1)(A).

Providers are entitled to exceptions and adjustments to both the TEFRA limit and the inpatient operating cost limit to take into account factors which result in a distortion in the costs subject to the limits, including significant changes in the services provided by the hospital, as reflected in a change in the hospital's case mix index. 42 C.F.R. § 405.460(g) and (h); 42 C.F.R. § 405.463(g) and (h).

On September 11, 1985, Blue Cross of California (“Intermediary”) issued a Notice of Program Reimbursement (“NPR”) for the Provider's FYE June 30, 1984.¹ This NPR calculated that the Provider's total inpatient operating costs exceeded both the TEFRA limit and the inpatient operating cost limit. The inpatient operating cost was \$5,423.33 per discharge, while the TEFRA limit was \$5,078.97 per discharge and the inpatient operating cost limit was \$5,141.53 per discharge.² The Intermediary applied the limit that resulted in the greater disallowance of costs, which was the inpatient operating cost limit, and disallowed \$1,126,347 of costs.³ In addition, the Intermediary did not allow the Provider to receive a TEFRA incentive payment. On February 28, 1986, the Provider filed an appeal with the Provider Reimbursement Review Board (“Board”).

On March 7, 1986, the Provider filed a request with the Intermediary for exceptions to the TEFRA limit and the inpatient operating cost limit.⁴ The Provider based its exception request on a significant increase in its case mix index and the utilization of a more current wage index. The increase in the case mix index was the result of a substantial change in the nature and type of patients treated due to a dramatic expansion in cardiovascular surgery, cardiac rehabilitation, and diagnostic services that resulted from the addition to the hospital's medical staff of two prominent physicians specializing in cardiac procedures. The Provider requested that its TEFRA target amount be adjusted from \$5,078.97 per discharge to \$5,799.29 per discharge, and that its inpatient operating cost limit be increased from \$5,141.53 per discharge to \$7,848.66 per discharge. Therefore, the Provider requested that the Intermediary increase its Medicare reimbursement by allowing all of the \$1,126,347 of disallowed costs, and also grant the appropriate TEFRA incentive payment.

On July 26, 1988, the Intermediary recommended that HCFA approve the Provider’s request in substantial part.⁵ The Intermediary concluded that the exceptions should be granted based on the substantial increase in the Provider's case mix index.

On January 17, 1989, HCFA issued its decision, which was forwarded to the Provider by the Intermediary on February 6, 1989.⁶ HCFA recognized that the Provider had a significant increase in its case mix index, and that this increase substantially changed the Provider's costs

¹ Provider's Exhibit 3.

² Provider's Exhibit 3; Tr. 20.

³ Tr. at 23.

⁴ Provider Exhibit P-5.

⁵ Provider Exhibit P-6.

⁶ Provider Exhibit P-7.

per discharge. However, HCFA concluded that the Provider could not be granted exceptions to the two cost limits because exceptions may be granted only when a provider has initiated a new service, and the cardiovascular services in question were not newly established at the facility, but instead represented an extensive expansion of an existing service since the prior period.

HCFA determined that the Provider was entitled to an adjustment of its inpatient operating costs based on the significant increase in its case mix index. Although HCFA determined that the increase in case mix accounted for increased costs of \$673.61 per discharge in FYE June 30, 1984, it did not grant adjustments in this amount. Instead, HCFA stated, “. . . [e]xception and adjustment authority to be applied to cost limitations was not intended to create or increase incentive payments.”⁷ Therefore, HCFA limited the adjustments to the TEFRA target amount and the inpatient operating cost limit to only \$344.358 per discharge, which was the amount of the Provider's actual cost increase in FYE June 30, 1984 over the previous year. As a result, HCFA concluded that the Provider should be allowed all of the costs (\$1,126,347) that were disallowed in the Intermediary's original NPR, but denied the Provider's claim to a TEFRA incentive payment.⁸

On April 14, 1989, the Intermediary issued a Revised NPR, in which it allowed all of the Provider's costs that were disallowed in the original NPR.⁹ In addition, the Intermediary granted the Provider a small TEFRA incentive payment in the amount of \$19,928.

The Provider filed a timely appeal with the Provider Reimbursement Review Board (“Board”) pursuant to the provisions of 42 C.F.R. § 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement amount in controversy is \$872,425.

The Provider was represented by Robert A. Klein, Esquire, of Foley, Lardner, Weissburg and Aronson. The Intermediary was represented by James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Provider contends that HCFA and the Intermediary acted improperly in failing to grant the full adjustments to the TEFRA target amount and the inpatient operating cost limit to reflect the increase in the case mix index resulting from the substantial increase in cardiovascular services. The Provider contends that it should have been granted the full

⁷ Id.

⁸ Id.

⁹ Provider Exhibit P-8.

amount of these adjustments to reflect the change in case mix, and that it was entitled under the statute and regulations to a TEFRA incentive payment as a reward for its efficient operations.

The Provider contends that a key feature of the TEFRA reimbursement methodology in place during FYE June 30, 1984 was the TEFRA incentive payment, which was intended to promote efficiency in hospital operations. Hospitals that kept increases in their costs below the TEFRA target amount set for each hospital were entitled to their reasonable costs plus an incentive payment, whereas hospitals whose cost increases exceeded the TEFRA target amount were penalized a portion of their costs in excess of the TEFRA target amount. 42 U.S.C.

§ 1395ww(b)(1); 42 C.F.R. § 405.463(d). The statute directs the Secretary to award a TEFRA incentive payment equal to 50% of the amount by which the target amount exceeds the amount of the operating costs, or 5 percent of the target amount, whichever is less. 42 U.S.C. § 1395ww(b)(1)(A).

The Provider also notes that the statute directs the Secretary to determine TEFRA penalties if a hospital's allowable operating costs exceed the TEFRA target amount. During the cost reporting period at issue, the statute provided that hospitals whose operating costs exceeded their TEFRA target amount would receive reimbursement for only 25% of the amount by which their operating costs exceeded the TEFRA target amount. 42 U.S.C. § 1395ww(b)(1)(B); 42 C.F.R.

§ 405.463(d)(3). Thus, hospitals are motivated to control their operating costs to avoid penalties for exceeding the TEFRA target amount and to obtain an incentive payment under TEFRA if their operating costs are less than the TEFRA target amount.

The Provider notes that HCFA agreed that the Provider was entitled to an adjustment to the TEFRA target amount under the statute and regulations. The statute contains the following provision regarding exemptions, exceptions and adjustments:

The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate

42 U.S.C. § 1395ww(b)(4)(A).

The regulations set forth the following grounds for adjustments to the TEFRA limit:

Adjustments - (1) Comparability of cost reporting periods.

HCFA may adjust the amount of the operating costs considered in establishing cost per case for one or more cost reporting period(s), including both periods subject to the ceiling and the hospital's base period, to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services.

42 C.F.R. § 405.463(h).

The Provider contends that HCFA has itself recognized that the Provider's FYE June 30, 1984 was not comparable to its TEFRA base year due to the substantial increase in the case mix index. In its January 17, 1989 response, HCFA compared the case mix indices for the two years, and acknowledged that the case mix index had increased from 1.2170 to 1.3896.¹⁰ Therefore, HCFA acknowledged that the Provider's costs in FYE June 30, 1984 included \$673.61 per discharge attributable to the change in case mix. HCFA recognized that the Provider was an efficient hospital by stating that when the change in case mix was taken into account, the Provider's costs per discharge between the two fiscal periods were almost identical, in spite of inflation in the amount of 7.6% in FYE June 30, 1984.¹¹

The Provider contends that there is no support in the statute for HCFA's determination that a TEFRA adjustment could not be granted when it would create or increase a TEFRA incentive payment. Instead, the statutory language reflects the Congressional intent that adjustments be granted to fully preserve the TEFRA incentive system, to provide an incentive to hospitals to control increases in their annual operating costs, for example, by reducing lengths of stay. The statute requires HCFA to provide for an "exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where . . . extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period" 42 U.S.C. § 1395ww(b)(4)(A).

The Provider contends that the reference in the statute to the "method under this subsection for determining the amount of payment" clearly refers to the incentive/penalty calculation set forth at the beginning of the subsection in 42 U.S.C. § 1395ww(b)(1), and also shows that distortions in cost should not impact a provider's right to a TEFRA incentive. The statutory language shows that Congress intended adjustments to be granted to neutralize distortions in cost increases, so that the provider receives the same TEFRA incentive to which it would have been entitled absent the cost distortion. The statute does not authorize the Secretary to provide only a partial TEFRA target amount adjustment in order to minimize the TEFRA incentive payment. Had Congress wanted to limit the exception and adjustment process to recognize only actual costs, it could have expressly stated so. Moreover, nothing in the

¹⁰ Provider Exhibit P-7.

¹¹ Provider Exhibit 16; Tr. at 29-31.

legislative history suggests any Congressional intent that a TEFRA adjustment could not be granted when it would create or increase a TEFRA incentive payment.

The Provider further argues that the regulations do not support HCFA's determination to award only partial relief from the effects of a change in the mix of services provided. The regulation states that "HCFA may adjust the amount of the operating costs considered in establishing cost per case . . . to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services." 42 C.F.R. § 405.463(h)(1). The factor which HCFA is to consider is the case mix, not the actual cost increase. This suggests that the full effect of the distorting factor (here a change in the amount of cardiovascular services) must be taken into consideration.

The Provider notes that in its preamble to regulations promulgated in 1983, HCFA clearly expressed its intent to allow providers the full amount of the appropriate adjustment to the TEFRA target amount, even if this entitles the provider to an incentive payment. HCFA made the following comment in the rulemaking notice:

Comment: One comment concerned the statement in the interim regulations that the amount of an exception granted could not raise a hospital's cost limit above its actual cost. The commenter recommended that we permit a hospital's cost limit amount to be increased to reflect the additional justified costs established under the exception so that the limit would not reduce the potential reward that a hospital might earn under the rate of increase ceiling.

Response: Under the rate of increase provision of section 1886(b), a hospital may be paid an incentive payment if its actual costs are less than the hospital's target amount set under that provision. Congress provided such an incentive payment in recognition of a hospital's performance in controlling the growth of its costs.

In part, the amount of a hospital's incentive payment is constrained by its cost limit, in that payment made under the rate-of-increase control provisions [TEFRA target limit] may not exceed a provider's case-mix adjusted cost limit [the inpatient operating cost limit]. Our policy, prior to Pub. L. 97-248, has been to approve an exception (the purpose of which is to recognize a provider's costs in excess of its limit that are not related to inefficiency) only up to the provider's actual incurred cost. The continuation of this policy under the provisions of Pub. L. 97-248 could prevent a hospital from receiving the full amount of a rate-of-increase incentive payment for which it would otherwise qualify.

We agree with the commenters in that we believe it is inappropriate to offer a hospital an incentive payment as a bonus for its efficiency on one hand, while

on the other hand, disallowing payment of the full amount of that incentive by applying a limit also designed to encourage efficiency. Therefore, we are revising our procedure for determining the amount of exceptions to allow the amount of a hospital's total cost limit under an exception to be set at a level recognizing the full amount of justified costs for the purpose of qualifying for the incentive payment under the rate-of-increase target rate provision. However, we must point out that this special determination of a cost limit recognizing costs justified under applicable exception criteria will be used only for the purpose of determining the incentive payment

48 Fed. Reg. 39,412, 39,416 (Aug. 30, 1983).¹² This regulatory comment shows that HCFA clearly intended that providers be granted a change in their TEFRA target amount that recognizes the full amount of justified costs.¹³

As evidence that neither Congress nor HCFA intended to limit adjustments when such adjustments would place a hospital in an incentive situation, the Provider offered the testimony of the former Director of HCFA's Office of Reimbursement Policy. The former HCFA Director, who was responsible for reimbursement policy for the Medicare and Medicaid programs as it related to providers of services, confirmed that there was no Congressional intent or HCFA policy to prevent TEFRA incentive payments in situations such as presented here. The witness testified that he was involved with Congressional staff in connection with developing the TEFRA limits, but that there was never any discussion concerning whether hospitals which obtained an exception or an adjustment to the TEFRA limit were precluded from receiving a TEFRA incentive payment.¹⁴ The witness also testified that he was not aware of any Provider Reimbursement Manual (PRM) provision, bulletin, instruction, or any other type of Medicare program policy which stated that the program would not allow incentive payments in situations when the provider received an adjustment to the cost limits.¹⁵

The Provider contends that the ad hoc nature of HCFA's policy is also shown by the testimony of a HCFA witness in a previous Board case.¹⁶ The witness admitted that there is

¹² Provider Exhibit P-10.

¹³ Tr. at 75-78.

¹⁴ Tr.at 73.

¹⁵ Tr. at 90-91.

¹⁶ Provider's Exhibits 12 and 19. Ms. Sheridan testified in Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 93-D42, Medicare and Medicaid Guide(CCH) ¶

nothing in the statute, legislative history, regulations or PRM instructions that would prohibit a full adjustment to the TEFRA target amount when the provider would earn an incentive payment. The witness stated only that it “was the operating policy of the staff” that made these determinations that made the policy.¹⁷ Thus, HCFA's witness in a previous Board case acknowledged that the policy applied to the Provider was not mandated by the law.

The Provider contends that the fact that the Intermediary granted the Provider a small TEFRA incentive payment in the amount of \$19,928 in the revised NPR demonstrates that there was no consistently followed policy prohibiting incentive payments for providers who established that they were entitled to receive an adjustment to their TEFRA target amount.¹⁸

The Provider contends that HCFA's denial of an incentive payment in the same year as the Provider received a TEFRA target amount adjustment is not supported by an amendment to HCFA's regulations enacted in 1988. The 1988 amendment provided that “HCFA may grant an adjustment only if a hospital's operating costs exceed the rate of increase ceiling imposed under this section.” 53 Fed. Reg. 38,476, 38,534 (Sept. 30, 1988). However, application of the 1988 rule to the Provider's FYE June 30, 1984 cost report would constitute retroactive rulemaking, which is clearly prohibited. Bowen v. Georgetown University Hospital, 488 U.S. 204, 215 (1988).

Furthermore, the Provider contends that the 1988 regulatory change does not resolve the issue presented in this case, as its operating costs for FYE June 30, 1984 exceeded the TEFRA target amount as originally calculated. Thus, even under the 1988 amendment, the Provider would have been entitled to an adjustment to the TEFRA target amount. The 1988 amendment does not address the appropriate amount of an adjustment to the TEFRA target amount, only the circumstances in which an adjustment may be granted.

At most, the rule would appear to prohibit granting an adjustment to a provider who is already below the TEFRA target amount from seeking an adjustment simply to increase the incentive payment to which the provider already was entitled. However, neither the regulation nor its preamble addresses the case of a hospital with operating costs above the TEFRA target amount that, as a result of receiving an adjustment, then becomes entitled under the statute to an incentive payment.

The Provider notes that the Intermediary did not produce any written evidence of HCFA's alleged policy. Instead, it refers to a single paragraph in the September 30, 1982 Federal Register, which contains an obtuse statement regarding limiting payment to costs incurred.

41,558.

¹⁷ Provider Exhibit P-12.

¹⁸ Provider Exhibit P-8.

This sentence states that “a[n] exception allows a hospital to have its ceiling adjusted to take costs into account that would otherwise be disallowed by application of the ceiling.” 47 Fed. Reg. 43,282, 43,288 (Sept. 30, 1982).¹⁹ The Intermediary contends that this sentence somehow evidences a HCFA policy to limit adjustments to the amount of actual costs disallowed. However, this statement refers to exceptions to the TEFRA limit, not an adjustment as is involved here. Furthermore, this statement is inconsistent with the interim final regulation, adopted in the same rulemaking notice, which provides that adjustments should be granted to avoid a distortion of costs between different cost reporting periods. In addition, the HCFA rulemaking comments issued on August 30, 1983, clearly show HCFA's intent that adjustments should be granted in the full amount to eliminate a distortion between different cost periods. Thus, the Intermediary's attempt to base its action on this single sentence in the September 30, 1982 rulemaking notice is unpersuasive.

The Provider contends that the facts of this case vividly illustrate why HCFA's policy of limiting adjustments is antithetical to the Congressional goals in creating the TEFRA limits. Under HCFA's approach to the Provider's FYE June 30, 1984 cost report, providers that experience a significant change in the types and intensities of the services they provide have little incentive to control their costs. In this case, had the Provider's costs increased by \$673.61 per discharge, HCFA would have allowed the full \$673.61 as allowable costs. However, in addition to increasing cardiovascular services, the Provider was able to achieve greater operating efficiencies in some departments and was therefore able to keep its cost increase to only \$344.358 per discharge. Under HCFA's ruling, no incentive payment is awarded even though the Provider accomplished the goal set forth by Congress, *ie.*, restraining its cost increases. Such a policy contradicts Congress' desire to reward efficient hospitals for keeping their costs down.

The Provider notes that the Board addressed the issue of TEFRA adjustments and incentive payments in two previous cases. In Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 93-D42, Medicare and Medicaid Guide (CCH) ¶ 41,558,²⁰ (“Harmarville”) the provider challenged HCFA's denial of an exception or adjustment to the TEFRA target amount to offset the cost impact arising from a change in coverage under Blue Cross Medigap supplemental insurance plan. The provider contended that the effect of this change was to increase the number of Medicare patient days without increasing the number of Medicare discharges. The provider argued that as a result of this change, its base year and rate year costs were not comparable. The intermediary contended that the provider was not entitled to an adjustment to the TEFRA target amount. In addition, the intermediary argued that if the Board found that the provider was entitled to an adjustment, the amount of the adjustment should be limited so that the provider would not receive a TEFRA incentive payment.

¹⁹ Provider Exhibit P-9.

²⁰ Provider Exhibit P-11.

The Board in Harmarville concluded that the provider was entitled to an adjustment to its TEFRA target amount to reflect the increased costs related to the Medigap insurance change. The Board found that:

. . . the Provider is entitled to recover the full amount due whether or not an incentive payment will result. The Board finds no evidence that Congress intended to limit adjustments to the amount by which a provider's rate year costs exceed its target rate. In fact, the Board concludes that the plain language of TEFRA mandates that an adjustment be granted to fully offset the impact of the distortion.

Id. at 36,415. Thus, the Board ordered the intermediary to recalculate the TEFRA target amount “irrespective of whether that rate creates an incentive payment.” Id. at 36,416.

Although the Board's decision in the Harmarville case was reversed by the HCFA Administrator, and the Administrator's reversal was upheld by the district court, those decisions were based on the provider's alleged failure to demonstrate that the change in the Medigap insurance coverage caused the increased costs claimed by the provider. The HCFA Administrator concluded that the hospital had not established the necessary causal link between its costs in excess of the TEFRA target amount and the Medigap insurance coverage change. The Administrator concluded that factors other than the Medigap policy change caused the hospital to exceed its TEFRA target amount. The district court affirmed the Administrator's conclusion that the hospital was not entitled to an adjustment or exception because it did not show a causal nexus between its excess costs and the Medigap change. Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 93-D42, HCFA Admin. Dec., Medicare and Medicaid Guide (CCH) ¶ 41,671 (1993), aff'd, Harmarville Rehabilitation Center, Inc. v. Shalala, C.A. No. 19-1943 (D.D.C. July 21, 1995), Medicare and Medicaid Guide (CCH) ¶ 43,591, aff'd 107 F.3d 922 (D.C. Cir 1996).²¹

The Provider contends that neither the decision of the HCFA Administrator nor that of the district court in Harmarville was based on the issue presented in this case, *i.e.*, whether a provider may receive a TEFRA adjustment and a TEFRA incentive payment in the same year. In contrast to the facts in the Harmarville case, HCFA has already determined that the Provider is entitled to an adjustment to the TEFRA target amount because its costs increased due to a change in case mix.

The Board also addressed the issue of TEFRA adjustments in NME Increase of Target Rate Group Appeal v. Blue Cross and Blue Shield Association/Blue Cross of Florida, PRRB Dec. No. 96-D59, September 5, 1996, Medicare and Medicaid Guide (CCH) ¶ 44, 644.²² In that

²¹ Provider's Exhibits P-13 and P-14.

²² Provider Exhibit P-18.

case, the Board concluded that the 1988 regulatory changes did not bar a provider from receiving an incentive payment at the time an adjustment was granted in a pre-1988 cost report. The Board found that prior to 1988, HCFA did not consistently implement a policy to deny an exception or adjustment to increase a TEFRA incentive payment.

The Provider also contends that it is entitled to an adjustment to the inpatient operating cost limit to reflect the full impact of the change in its case mix index. The inpatient operating cost limit, which was imposed by 42 U.S.C. § 1395ww(a) and 42 C.F.R. § 405.460, applied to routine, ancillary and special care unit operating costs. The inpatient operating cost limit represented an expansion of the previous Section 223 cost limits, which only applied to routine costs. 42 U.S.C. § 1395ww(a)(4); 547 Fed. Reg. 43,282 - 43,283 (Sept. 30, 1982).²³ Amounts payable under the TEFRA target calculation, including incentive payments, may not exceed this operating cost per discharge limit. 42 U.S.C. § 1395ww(b)(1).

The inpatient operating cost limit is based on the costs incurred for inpatient hospital services by hospitals in the same grouping, adjusted by a hospital-specific case mix index. 42 U.S.C. § 1395ww(a)(1)(A)(I). The hospital groupings reflect the type of services furnished, geographical area, hospital size, nature and mix of services furnished, and type and mix of patients treated. 42 C.F.R. § 405.460(b)(1). For FYE June 30, 1984, the inpatient operating cost limit was based on 120% of the average of operating costs of inpatient hospital services incurred by hospitals in the same grouping for comparable time periods. 42 U.S.C. § 1395ww(a)(1)(A). In addition, the Secretary established a case mix index for each hospital, based on the general mix of types of the hospital's medical cases. 42 U.S.C. § 1395ww(a)(1)(B)(I).

Providers were entitled to receive adjustments to the inpatient operating cost limit “to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services.” 42 C.F.R. § 405.460(h). The Provider contends that the Intermediary used an improper methodology to adjust its inpatient operating cost limit. In the revised NPR, the Intermediary simply used the amount of the Provider's actual operating costs as the inpatient operating cost limit.²⁴ Under the statute and regulations, the inpatient operating cost limit is to be calculated based not on the Provider's costs, but on the following two factors: (a) 120% of the average costs of hospitals in the same grouping; and (b) the hospital's case mix index. 42 U.S.C. § 1395ww(a); 42 C.F.R. § 405.460(b).

The Provider contends that in making an adjustment to the inpatient operating cost limit, HCFA failed to follow the regulatory requirement that the adjustment “take into account factors which could result in a significant distortion in the operating costs of inpatient

²³ Provider Exhibit P-9.

²⁴ Provider Exhibit P-8.

hospitals.” 42 C.F.R.

§ 405.460(h). HCFA should have adjusted the inpatient operating cost limit to recognize the change in case mix from 1.2170 in FYE June 30, 1983 to 1.3896 in FYE June 30, 1984.²⁵

This substantial change in the type of the Provider's patient services generally provided created a significant distortion in the Provider's operating costs, and the appropriate amount of the inpatient operating cost limit cannot be calculated unless the Provider's actual case mix index is used.²⁶

In the preamble to regulations promulgated in 1983, HCFA stated that it was changing its previous policy regarding the amount of an exception granted under the Section 223 limits. The previous policy was to limit the amount of an exception so that a hospital's cost limit could not exceed its actual costs. 49 Fed. Reg. 39,412, 39,416 (Aug. 30, 1983).²⁷ In the 1983 preamble, HCFA expressly revised this policy, stating that it would thereafter determine the amount of exceptions so as to recognize “the full amount of justified costs,” even when doing so resulted in a limit amount greater than actual operating costs. *Id.* As the language of the preamble reveals, it did so with the conscious understanding that recognizing the full amount of justified costs could lead to the payment of a TEFRA incentive amount.

The Provider contends that the inpatient operating cost limit should be adjusted to fully reflect the revised case mix index, and that this results in an inpatient operating cost limit of \$6,581.93 per discharge, an increase of \$1,440.40 over the original calculation.²⁸ This inpatient operating cost limit is far in excess of the TEFRA target limit, and therefore does not limit the incentive payment to which the Provider is entitled.

The Provider contends that to the extent that HCFA has a policy limiting adjustments to the TEFRA target amount and the inpatient operating cost limit to the actual increase in costs, such policy is void because it was not promulgated in accordance with the Administrative Procedure Act, 5 U.S.C. § 553 (“APA”), which dictates that substantive rules may be put into effect only after they are promulgated pursuant to the notice and comment rulemaking provisions of that statute. Not all administrative rules are subject to notice and comment rulemaking procedures. However, rules that change existing law or policy, or create new law, are substantive rules subject to the notice and comment rulemaking requirements. Sentara-Hampton General Hospital v. Sullivan, 980 F.2d 749, 759 (D.C. Cir. 1992).

²⁵ Provider Exhibit P-7.

²⁶ See Provider Exhibit P-17.

²⁷ Provider Exhibit P-10.

²⁸ Provider Exhibit P-17.

If HCFA had a policy regarding partial adjustments, such policy is clearly a “substantive rule.” Such policy would impose upon the adjustment and incentive provisions of the statute a qualification nowhere directly authorized in the statute or regulations, and which, in fact, would be inconsistent with congressional intent and the preamble to the regulations promulgated in 1983. As can be seen from this case, such a policy can have a very real effect upon providers: it operates to deny them TEFRA incentive payments. Because the policy was never published in the Federal Register, nor were public comments on it ever solicited or received, the APA prohibits its application.

The Provider contends that the plain language of TEFRA, the regulations in effect during FYE June 30, 1984, and the purpose before the TEFRA legislation all mandate that the Provider be granted the full amount of the TEFRA adjustment. Similarly, the plain language of the statute and regulations entitle the Provider to a substantial increase in its inpatient operating cost limit. The Provider was entitled to receive these adjustments regardless of whether an incentive payment would result, and it is entitled to the resulting incentive payment.

The Provider contends that HCFA and the Intermediary acted improperly when they implemented the adjustments to the TEFRA limit and the inpatient operating cost limit by adjusting the limits, rather than adjusting the amount of operating costs. Under the applicable regulatory provisions, the Intermediary should have adjusted the Provider's operating costs to take into account the change in case mix index. 42 C.F.R. §§ 405.460(h) and 405.463(h).²⁹ When the costs for either FYE June 30, 1983 or FYE June 30, 1984 are adjusted to take into account the change in case mix, the Provider is entitled to a TEFRA incentive payment in the amount of \$872,425.³⁰

INTERMEDIARY'S CONTENTIONS:

The Intermediary argued that the only issue presented in this case was whether HCFA could limit the relief under 42 C.F.R. § 413.40 to the Provider's actual costs and thereby prohibit the incentive payment the Provider was seeking. The Intermediary believes the issue is strictly a legal argument. The Intermediary acknowledges there is no real dispute between the Intermediary and the Provider as to the facts of this case.³¹ 42 C.F.R. § 413.40 limits exceptions to the rate of increase ceiling to the actual costs of the provider. § 413.40(g) states: “HCFA may grant an adjustment requested by the hospital only if [the] hospital's operating costs exceed the rate of increase ceiling imposed under this section.” The Intermediary maintains this regulation clearly precludes the granting of the relief (i.e. incentive payment)

²⁹ Tr. at 39-43.

³⁰ Provider Exhibits P21A and 21B; Tr. at 39-43.

³¹ Tr. at 11.

sought by the Provider.

The Intermediary points out that while the regulatory language was first announced in March of 1988 and made final the following August, it was intended as a clarification of an existing regulation. The preamble to the 1988 proposed rule (found at 53 Fed. Reg. 38476, Sept. 30, 1988) states:

“We are also proposing to revise sec. 413.40 (g) and (h) to clearly state that we would not grant an exception or adjustment to a hospital’s rate-of-increase ceiling if the hospital’s costs do not exceed its target amount. We believe an actual disallowance of costs as a result of the application of the rate-of-increase ceiling is a necessary precondition to HCFA’s granting an exception or adjustment. . .”

Id.

The Intermediary points out that HCFA specifically relied on language in the earlier interim final rules, issued in 1982,³² which states that an exception allows a hospital to have its ceiling adjusted to take costs into account that would otherwise be disallowed by application of the ceiling. The Intermediary acknowledges that while the regulation did not contain the specific language not found until 1988, it was always HCFA’s position that the adjustments would be granted only to the extent that actual operating costs were disallowed due to TEFRA limits.³³ Therefore, the Intermediary argues that it is bound by that regulation and under the regulation, there is no entitlement to an adjustment except to the extent of the Provider’s actual cost and not to the extent of creating or expanding an incentive payment.³⁴

The Intermediary contends that the Board correctly decided the issue in the present case in the case of Mercy Hospital v. Blue Cross and Blue Shield of Florida, PRRB Dec. 91-D37, April 3, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,147, (“Mercy Hospital”). In that decision, the Board found that no TEFRA relief was available as there was no disallowance of the Provider’s actual cost. The Board’s decision cited 42 C.F. R. § 413.40 (g) and (h) stating that the regulation was revised as a clarification of existing policy and that HCFA may grant an exception or adjustment only if the hospital’s operating costs exceed the rate-of-increase ceiling, and that the Board also said it did not have the authority to reverse the regulation.³⁵ The Intermediary points out that the HCFA Administrator agreed with the Board’s

³² Provider Exhibit P-9.

³³ Tr. at 12.

³⁴ Id. at 12-13.

³⁵ Tr. at 13-14.

determination stating that Congress did not intend that the adjustment process be used to increase incentive payments to hospitals. Mercy Hospital v. Blue Cross and Blue Shield of Florida, PRRB 91-D37, May 30, 1991, HCFA Admin. Dec., Medicare and Medicaid Guide (CCH) ¶ 39,245 (1991).

The provider sought judicial review in that case and the U.S. district court for the District of Columbia affirmed the HCFA Administrator's decision. The court stated that the Secretary denied the plaintiff's request because plaintiff's cost increase, which resulted in a lower bonus payment but no losses for the plaintiff, was not the sort of distortion for which adjustments are granted under the Secretary's policy. The court held that, ". . .granting adjustments only where a hospital stands to lose money is a reasonable accommodation of a hospital's needs".³⁶

The Intermediary also notes that the Board subsequently reversed its position 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 and Medicaid Guide (CCH) ¶ 41,558. The Intermediary, however, argued the Board was incorrect in its determination in that case.³⁷ Further the Intermediary pointed out that the HCFA Administrator reversed the Board's decision in Harmarville, relying instead on the rationale in Mercy Hospital. The Intermediary also points out that the Board also followed its Harmarville rationale in its decision in NME Increase of Target Rate v. Blue Cross and Blue Shield of Florida, PRRB Dec. No. 96-D59, September 5, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,644, ("NME Target Rate").

In summary, the Intermediary believes the parties are at issue in this case because HCFA has stated that no relief is warranted under the adjustment process when no costs are disallowed. The Intermediary asserts it is bound to follow that regulation and believes the Board is bound by it as well.³⁸ The Intermediary bases its position on the regulation as well as instructions from HCFA, decisions of the HCFA Administrator, and the decision of the district court in Mercy Hospital.

CITATION OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 5 U.S.C.:

§ 553

- Administrative Procedures Act

³⁶ Tr. at 14.

³⁷ Tr. at 14-16.

³⁸ Id. at 17.

2. 42 - U.S.C.

- § 1395x(v)(1)(A) - Reasonable Cost
- § 1395ww(a) - Determination of Costs for Inpatient Hospital Services; Limitations; Exemptions; Operating Costs of Inpatient Hospital Services
- § 1395ww(b) - Computation of Payment; Definitions; Exemptions; Adjustments

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

- § 405.1835-1841 - Board Jurisdiction
- § 405.460
(Redesignated at § 413.30) - Limitations on Reimbursable Costs
- § 405.463
(Redesignated at 42 C.F.R. § 413.40) - Ceiling on Rate of Hospital Cost Increases

3. Cases:

Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988).

Harmarville Rehabilitation Center, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 93-D42 (1993), Medicare & Medicaid Guide (CCH) ¶ 41,558, rev'd, HCFA Admin. Dec., Medicare & Medicaid Guide (CCH) ¶ 41,671 (1993), aff'd, Harmarville Rehabilitation Center, Inc. v. Shalala, C.A. No. 19-1943 (D.D.C. July 21, 1995), Medicare & Medicaid Guide (CCH) ¶ 43,591, aff'd 107 F.3d 922 (D.C. Cir 1996).

NME Increase of Target Rate Group Appeal v. Blue Cross and Blue Shield Association/ Blue Cross of Florida, PRRB Dec. No. 96-D59, September 5, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,644.

Mercy Hospital v. Blue Cross and Blue Shield of Florida, PRRB 91-D37, Medicare & Medicaid Guide (CCH) ¶ 39,147, April 3, 1991, rev'd HCFA Admin Dec., Medicare & Medicaid Guide (CCH) ¶ 39,245, May 30, 1991.

Sentara-Hampton General Hospital v. Sullivan, 980 F.2d 749 (D.C. Cir. 1992).

4. Other:

47 Fed. Reg. 43,282 (Sept. 30, 1982).

48 Fed. Reg. 39,412 (Aug. 30, 1983).

53 Fed. Reg. 38,476 (Sept. 30, 1988).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, the parties' contentions, evidence presented, testimony elicited at the hearing, and post-hearing briefs, finds and concludes that it was improper for HCFA and the Intermediary to refuse to adjust the Provider's TEFRA target amount and the inpatient operating cost limit to fully reflect the change in case mix, thereby, denying the Provider a TEFRA incentive payment.

The Board agrees with HCFA that the Provider was entitled to an adjustment, rather than an exception, to its inpatient operating costs to take into account a significant distortion due to the substantial increase in its case mix index.³⁹ The Board notes two sections in the regulations, in effect during the year in question, which discuss adjustments to a provider's inpatient operating costs to take into account factors which could result in a significant distortion. The Board notes the regulations discuss the reasoning for granting adjustments to a provider's inpatient operating cost limitation. In 42 C.F.R. § 405.460(h), Adjustments, . . . HCFA may adjust the amount of a hospital's inpatient operating costs to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services.

Id. (emphasis added.)

Likewise, the regulations set forth the following requirements for adjustments to the TEFRA rate of increase limitation:

Adjustments - (1) Comparability of cost reporting periods.

HCFA may adjust the amount of the operating costs considered in establishing cost per case for one or more cost reporting period(s), including both periods subject to the ceiling and the hospital's base period, to take into account factors which could result in a significant distortion in the operating costs of inpatient hospital services.

42 C.F.R. § 405.463(h)(1). (emphasis added.)

³⁹ Provider Exhibit P-7.

The Board has looked for guidance in the regulations and the PRM and concludes that the above sections provide the only pertinent reference regarding the issue in this case, i.e. adjustments due to significant distortions in operating costs. The Board interprets the above referenced sections to mean that when a significant distortion in costs (beyond a provider's control) is recognized, (i.e. case mix index as noted in HCFA letter dated January 17, 1989, Provider Exhibit P-7), the operating costs are adjusted, not the TEFRA target limit. As a result of HCFA's recommendation, the Provider's costs were reimbursed in full.⁴⁰

The Provider contends that had it not had the "significant distortion" that increased the case mix index, its costs would have been lower than its TEFRA target amount and section 223 limitation thereby qualifying it for an incentive payment. The Board notes that 42 C.F.R. § 405.463(d)(2) discusses incentives where the situation occurs when a provider's inpatient operating costs are less than or equal to the TEFRA target amount.

. . . [I]f a hospital's allowable inpatient operating costs per case do not exceed the hospital's target amount for the applicable cost reporting period, reimbursement to the hospital will be determined on the basis of the lowest of :

(i) the inpatient operating cost per case plus 50 percent of the difference between the operating cost per case and the target amount.

Id.

The Board has searched for guidance on incentives and except for the above, finds no clear directions on incentives as related to TEFRA adjustments of cost. The Board notes that HCFA limited the amount of the Provider's adjustment to the amount by which the Provider's costs exceeded the target amount and accordingly did not recognize an incentive payment. Based on HCFA's determination, the Provider was reimbursed its costs in full. The Board, however, finds no evidence in the law or regulations that Congress had intended to limit the Provider's adjustment to the amount by which costs exceed the target amount thereby denying the Provider an incentive payment.

While the Board is relying on the 1984 regulations (42 C.F.R. §§ 405.460 and 405.463) in effect at the time of this case, it notes that revisions were made to the regulations in 1988. The revisions included specific language to prohibit TEFRA target limit exceptions or

⁴⁰ The Board notes the evidence shows that after the Intermediary received HCFA's letter (Provider Exhibit P-7), it issued a revised NPR to implement HCFA's determination. The Intermediary adjusted the TEFRA and section 223 limits to arrive at the same number, the Provider's 1984 cost per discharge, thereby enabling the Provider to recover its costs in full. (Provider Exhibit P-8, Pg. 4, Tr. at 34-46.) However, since the limits and costs were now equal, the Provider did not qualify for an incentive payment.

adjustments in instances where a provider had not exceeded its TEFRA limit. 42 C.F.R. §§ 413.40 (g) and (h). In the case at hand, the Provider's costs did in fact exceed its TEFRA limit, and accordingly, HCFA recognized the significant distortion which caused the Provider's costs to increase and recommended it be reimbursed its costs in full. The Board notes, however, that the 1988 regulations do not address the relationship between TEFRA adjustments and incentive payments. The Board finds that the regulations in effect during the Provider's rate year place no limitations on adjustments to preclude incentive payments. To the contrary, HCFA's action denying a full adjustment is inconsistent with the agency's policy as stated in the preamble to the regulations promulgated in August, 1983. HCFA stated that it would be "inappropriate to offer a hospital an incentive payment as a bonus on one hand, while on the other hand disallowing payment of the full amount of that incentive by applying a limit also designed to encourage efficiency." 48 Fed. Reg. 39,412, 39,416 (Aug. 30, 1983).

After having searched the regulations and the PRM as to how TEFRA adjustments relate to incentive payments, the Board turned to evidence presented in the case. The Board finds the evidence presented in the form of testimony, as to the practices of HCFA and Congressional intent related to TEFRA adjustments and incentive payments, persuasive.

The Board notes that testimony from the former Director of HCFA's Office of Reimbursement Policy confirmed that there was no Congressional intent or HCFA policy to prevent TEFRA incentive payments in a situation as the case in hand.⁴¹ The witness, who was involved with Congressional staff in connection with developing the TEFRA limits, testified that there was never any discussion concerning whether hospitals which obtained an exception or an adjustment to the TEFRA limit were precluded from receiving a TEFRA incentive payment. The witness also testified that he was not aware of any PRM provision, bulletin, instruction, or any other type of Medicare program policy which stated that the program would not allow incentive payments in situations when the provider received an adjustment to the cost limits.

Based on the Board's analysis of the regulations related to this case and on the testimony presented, the Board concludes that :

An adjustment, to take into account an event that could cause a significant distortion in the operating costs, can change the Provider's cost per discharge and entitle a provider to be reimbursed its costs.

An adjustment, to take into account an event that could cause a significant distortion in the operating costs, cannot change the TEFRA target limit per discharge.

To determine whether a provider is eligible for an incentive payment, the actual cost per discharge should be adjusted to eliminate the distortion, and if by doing so, the

⁴¹ Tr. at 90-92.

adjusted cost per discharge is less than the TEFRA target limit per discharge, then an incentive payment is due.

The Board notes that in HCFA's letter dated January 17, 1989 (Provider Exhibit P-7), the methodology used to arrive at the adjustment recognized that due to a significant change in the case mix in FY 1984 (as compared to base year 1983), the FY 1984 costs contained \$673.61 per discharge specifically related to the case mix distortion. The Provider's cost per discharge between both years, however, only increased \$344.36. Based on the HCFA methodology, it would indicate that the Provider effectively absorbed a portion of the increase in costs due to an increase in the case mix index. By achieving efficiencies elsewhere in its operation, HCFA acknowledged that had the Provider not had a large expansion of cardiovascular services (resulting in the case mix increase), the costs per discharge would have been almost identical between both years.

The Board also finds the Provider's argument persuasive that the section 223 routine cost limit should have been revised to take into consideration the significant increase in the case mix index.⁴² The Board finds that HCFA should have recalculated the operating cost limit to recognize the change in case mix from 1.2170 in FYE June 30, 1983 to 1.3896 in FYE June 30, 1984.⁴³ Adjusting the limit to fully reflect the revised case mix index results in an inpatient cost limit of \$6581.93 per discharge, an increase of \$1440.40 over the original calculation.⁴⁴ The Board notes that since the revised operating cost limit is in excess of the TEFRA target limit, it does not have any effect on an incentive payment to which the Provider may be entitled.

In summary, the Board finds that the Provider's adjusted allowable operating cost per discharge (after removing the case mix distortion of \$673.61 per discharge) does not exceed the TEFRA target limit per discharge. Therefore, the Provider is due an incentive payment of 50 percent of the difference between the adjusted cost and the TEFRA target limit. 42 U.S.C. § 1395ww(b)(1)(A). See Provider Exhibit P-21B.

In addition, to indicate the lack of consistency and clarity in this case, the Board notes that the Intermediary adjusted the TEFRA target limit to an amount equal to the Provider's cost per discharge (Provider Exhibit P-8) on the revised June 30, 1984 NPR. In direct contradiction to the statement in HCFA's January 19, 1989 letter that, ". . . adjustment authority to be applied to cost limitations was not intended to create or increase incentive payments. . ."⁴⁵, the

⁴² Tr. at 43-46.

⁴³ Provider Exhibit P-7.

⁴⁴ Provider Exhibit P-17.

⁴⁵ Provider Exhibit P-7.

Intermediary did in fact make a \$19,928 incentive payment to the Provider based on the difference between adjusted costs⁴⁶ and the TEFRA limit. The TEFRA limit in this instance was based solely on the Provider's current year cost per discharge. (Provider Exhibit P-8, Pg.4, Ln. 60) According to statutory provisions, the TEFRA target amount for the Provider's FYE June 30, 1984 is determined by taking its allowable inpatient operating costs in FYE June 30, 1983, and adjusting that amount by the rate of increase in hospital goods and services plus 1%. 42 U.S.C. § 1395ww(b)(3)(B).

The Board concludes that the amount of the TEFRA incentive to which the Provider is entitled must be based on the revised NPRs for FYE June 30, 1983 and FYE June 30, 1984. The revised TEFRA target limit for FYE June 30, 1984 prior to the adjustment is \$5,186.25 per discharge, based on the revised NPR for FYE June 30, 1983.⁴⁷ Also, as discussed above, the Provider's inpatient operating cost limit should be adjusted to \$6,581.93 per discharge to reflect the change in case mix.⁴⁸

The Board concludes that the appropriate method of implementing the adjustments is by adjusting the Provider's costs in FYE June 30, 1984. Therefore, for purposes of computing an incentive payment, the Provider's cost per discharge in FYE June 30, 1984 should be adjusted downward by the \$673.61 per discharge related to the change in case mix. When these adjustments to the Provider's costs and limits are calculated correctly, the Provider is entitled to a TEFRA incentive payment in the amount of \$872,425.⁴⁹

DECISION AND ORDER:

HCFA and the Intermediary improperly refused to grant the Provider the full adjustment to the TEFRA target amount to which it was entitled. The Provider's costs in FYE June 30, 1984 should have been adjusted by the full \$673.61 per discharge attributable to the change in case mix. In addition, HCFA and the Intermediary should have adjusted the Provider's inpatient operating cost limit by \$1,440.40 per discharge to reflect the change in case mix index. The Intermediary is instructed to make a TEFRA incentive payment to the Provider for FYE June 30, 1984 in the amount of \$872,425.

⁴⁶ The adjusted costs that resulted in the incentive payment were unrelated to the adjustments for HCFA's case mix changes. Tr. at 36-37.

⁴⁷ Provider Exhibit P-16.

⁴⁸ Provider Exhibit P-17; Tr. at 43-45.

⁴⁹ Provider Exhibit P-21B, Tr. at 39-45.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Teresa B. Devine
Henry C. Wessman, Esquire

Date of Decision: December 10, 1997

FOR THE BOARD:

Irvin W. Kues
Chairman