CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Mercy Healthcare Bakersfield **Provider** **vs.** **Blue Cross /Blue Shield Association** **United Government Services, LLC-CA** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/94** **Review of:** **PRRB Dec. No. 2005-D5** **Dated: November 19, 2004**

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

BACKGROUND

On October 11, 1993, the Provider was notified that its composite payment rate for outpatient ESRD services would be $134.55.[1] On March 24, 1994, the Provider requested a revised ESRD payment due to the atypical nature of its services in the amount of $272.76. The Intermediary performed a review of the Provider's exception request and recommended that the Provider be granted a rated of $244.78. On April 14, 1994, the Provider's ESRD exception request was transmitted to CMS. On

[1] Provider's Exhibit. A.3. The Provider had until April 29, 1994, to file an exception request.

May 31, 1994, CMS approved a composite exception rate of $175.31. The Provider timely filed an appeal with the Board.

ISSUE AND BOARD'S DECISION

The issue is whether CMS partial denied of the Provider's request for an exception to the ESRD composite rates request based on atypical service intensity and patient mix was correct.

The Board determined that the Provider's ESRD rate should be set at $221.75. The Board agreed with the Provider's position concerning the salary of the lead nurse, and granted the Provider the additional management salary cost of $13.45 per treatment excluded by CMS. The Board also agreed with the Provider's position concerning employee benefits and granted the Provider the full amount of its employee benefits (31.76% of $86.02) instead of the 18.7 percent of salaries determined by CMS. In addition, the Board granted the Provider additional administrative and general costs (A&G) or overhead costs apart from employee benefits. In reaching this determination, the Board rejected CMS' requirement that the Provider show a direct link between increased overhead costs and the atypicality of its ESRD services. The Board determined that such a requirement would be inconsistent with the underlying cost reimbursement principles and would impose an unreasonable burden on providers.

Finally, the Board concurred with CMS' approved increase of $2.10 for Provider's supply cost and denied the Provider's request for additional supply and laboratory costs on grounds that there was no documentation to support those request.

SUMMARY OF COMMENTS

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

Although the Provider agreed with the Board's determination that the Provider was entitled to an exception amount with respect to A&G costs, the Provider disagreed

with the amount of the exception that the Board granted. The Provider argued that it should be reimbursement the full amount of its A&G costs allocable to ESRD services. The Provider contends that there is no justification to determine a provider's allowable A&G costs based on a national average, particularly where there is no showing that the Provider's A&G costs are unreasonable or substantially out of line or were computed incorrectly and where there is no showing as to how the $47 national average was developed.

DISCUSSION

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

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

> [CMS] may approve exceptions to an ESRD facility's prospective payment rate if the facility demonstrates with convincing objective evidence that its total per treatment costs are reasonable and allowable under § 413.174, and that its per treatment costs in excess of its payment rate are directly attributable to ….
>
> (1) *Atypical service intensity (patient mix)*. A substantial proportion of the facility's outpatient maintenance dialysis treatments involve atypically intense dialysis services, special dialysis procedures, or supplies that are medically necessary to meet special medical needs of the facility's patients. The facility is able to demonstrate clearly that these services, procedures or supplies and its pretreatment costs are prudent and reasonable when compared to hose of facilities with a similar patient mix. Examples that may qualify under this criterion are more intense dialysis services that are medically necessary for patients such as:

> (i) Patients who have been referred from other facilities on a temporary basis for more intense care during a period of medical instability, and who return to the original facility after stabilization;
> (ii) Pediatric patients, who require a significantly higher staff-to-patient ratio than typical adult patients; or
> (iii) Patients with medical conditions that are not commonly treated by ESRD facilities, and that complicate the dialysis procedure.

The regulation at 42 C.F.R. § 413.170(f) (5) states that a provider has the burden of proving that it qualifies for an exception to the ESRD composite payment rate.[2] To meet this burden, the provider must also satisfy the documentation requirements of 42 C.F.R. § 413.17(f) (6) which states in part:

> If requesting an exception to its payment rate, a facility must submit to [CMS] its most recently completed cost report…and whatever [other information is] determined by [CMS] to be needed to determine if an exception is approvable…. The materials submitted to [CMS] must:
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> (i) Separately identify elements of cost contributing to costs per treatment in excess of the facility's payment rate;
> (ii) Show that all of the facility's costs, including those costs that are not directly attributable to the exception criteria, are allowable and reasonable under the reasonable cost principles set forth in this part;[3]

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

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

> (iii) Show that the elements or excessive cost are specially attributable to one or more conditions specified by the criteria set forth in paragraph (g) of this section; and
> (iv) Specify the amount of additional reimbursement per treatment the facility believes is required in order to recover its justifiable excess costs.

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

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

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

> [I]s responsible for justifying and demonstrating to [CMS] that the requirement and criteria listed in the instructions are met in full. That is, the burden of proof is on the facility to show that one or more of the criteria are met, and that the facility's costs, in excess of its composite rate, are justified under cost reporting principles.

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

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

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

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program. Moreover, 42 C.F.R. § 413.24 states that providers receiving payment on the basis of reimbursable costs must provide adequate cost data.

elements of excessive cost are specifically attributable to the Provider's atypical patient mix.

Lead Nurse Salary

With respect to the salary cost of the lead nurse, the Administrator disagrees with the Board's determination. The Administrator notes that, in denying the Provider's exception request with respect to the lead nurse's salary, CMS stated that: "we excluded management salary cost of $13.45 per treatment, from projected salaries of $86.02, since this salary represented overhead costs which were not included in the calculation of the $40 national salary media."[4] In reviewing the record, the Administrator finds that CMS excluded the amount identified as management salary, because CMS could not determine from the exception request which job description the management salary was related to, and whether the individual to whom the management salary pertained furnished direct patient care.[5] As noted, supra, in addition to demonstrating that it serves an atypical patient mix, the Provider must also demonstrate, inter alia, that the costs are reasonable and that the elements of excessive cost are specifically attributable to the Provider's atypical patient mix. Therefore, since CMS could not determine from the exception request which job description the management salary was related to, and whether the individual to whom the management salary pertained furnished direct patient care, the Administrator finds that CMS properly determined that the full excess costs of the Provider's lead nurse's salary should not be included in the exception amount.

Employee Benefits

With respect to employee benefits costs, the Administrator disagrees with the Board's conclusion that, absent a finding that the Provider's benefits rate was unreasonable or substantially out-of-line, CMS improperly denied the Provider's full exception for excess employee benefits costs.

In this case, although the Provider meets the "atypical service intensity" criterion of the regulations, the Administrator finds that the Provider is not entitled to the amount of the exception to the Provider's ESRD composite payment rate granted by the Board based on excess employee benefits. Notably, in allowing the higher direct patient care salary costs, under the exception process, a related higher fringe benefits amount is recognized through the application of the 18.7 percent fringe benefit rate to the increased direct patient care salary exception amount. An allowance of higher direct salary costs, under the exception process, results in a direct proportional increase in fringe benefits amounts. Thus, in this

[4] Provider's Exhibit A.3.

[5] Transcript of Oral Hearing at pp. 135-6.

instance, the Provider has received a proportional increase of its fringe benefit allowance corresponding with the allowed increase in direct salary costs.

Although, as noted by the Board, the regulation does not limit an employee's fringe benefit rate to a national average, the PRM provides that CMS will use national data in evaluating the reasonableness of a provider's component costs.[6] Use of a national-salary-benefits fringe average is a reasonable exercise of the agency's discretions with respect to the determination of reasonable costs. It is not an abuse of discretion for CMS to compute the Provider's fringe benefit increase based on a percentage to which nursing benefits are directly reflective of nursing fringe salaries. Rather, tying the fringe benefits increase to the nursing salary increase effectively indicates that the fringe benefits are an integral part of the labor costs for an atypical patient mix.

Significantly, the 18.7 percent fringe benefit rate is not an absolute ceiling to reimbursement of costs over that amount. A provider may warrant an increase above that amount if documentation showing all expenditures incurred for employee benefits is submitted and the costs are linked to the provider's atypical patient mix. Contrary to the Board's finding, CMS, both in allowing the direct patient care salary amount above that included in the composite rate, i.e., the Provider's "actual" salaries, and in denying the employee benefits amount in excess of the 18.7 percent fringe rate, consistently required the Provider to demonstrate that the excess costs were attributable to its atypical patient mix. However, as the Board failed to recognize, unlike the allowed direct patient care salary costs, the Provider failed to demonstrate that its costs in excess of the national average benefits rate were attributable to its patient population. As reflected by the record, the Provider's exception request is absent of documentation which links the excessive employee benefits costs above the 18.7 percent granted by CMS to its atypical patient mix.[7]

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

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

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

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

Overhead Costs

The Administrator disagrees with the Board's decision with respect to its allowance of excess costs for overhead. Under the regulations at 42 C.F.R. § 413.170(g) and § 2720.1 of the PRM, a provider must demonstrate "with convincing evidence" that its per treatment costs are reasonable and "directly attributable" to the basis upon which an exception has been granted.[8] In supporting an atypical patient mix exception request for excess overhead costs, the PRM at § 2725.1.B.4 specifically states:

> Overhead Cost. – There are infrequent instances, (i.e., hepatitis) when an isolated area is required and where higher overhead costs may be justifiable. For these costs to be considered under this exception criteria, documentation must be submitted that identifies the basis of higher overhead costs, the specific cost components to be impacted and the incremental pretreatment costs. General statements regarding a facility's higher overhead costs are not acceptable in meeting the criteria. (Emphasis added).

> in order for HCFA to make a documented, non-arbitrary, non-capricious fringe benefit rate calculation.

University, at n. 3.

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

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

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

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

In sum, the Administrator finds that the Provider did not meet the required "convincing evidence" to justify an approval of an exception under the atypical service intensity criterion for additional direct patient care costs of the lead nurse salary employee benefits and overhead costs. In addition, the Administrator finds that the Provider failed to relate and document its higher costs to its claimed atypical patient mix. General statements that excessive costs are related to the exception criterion do not meet the requirements of the regulation. As set forth in 42 C.F.R. § 413.170(f)(5), "the facility is responsible for demonstrating to [CMS'] satisfaction that the requirements of this section, including the criteria in paragraph (g) of this section are met in full … and that the excessive costs are justified under the reasonable cost principles…." Moreover, the Administrator finds that neither CMS nor the Intermediary, has an obligation to give a provider the opportunity to perfect its ESRD exception request. The regulation at 42 C.F.R. § 413.170(f)(5) and § 2723.3(A) of the PRM as amended by Transmittal 23 make unequivocally clear that the Provider bears the burden of proving to CMS's satisfaction that the requirements and the criteria listed in the ESRD exception request instruction are met in full. Finally, the Administrator agrees with the Board's decision regarding the increase of $2.10 for the Provider's supply costs and the denial of the Provider's request for additional supply costs and laboratory costs.

DECISION

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

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

Date: 1/19/05 /s/

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