PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2015-D18

PROVIDER -
Loma Linda University Medical Center
Loma Linda, California

Provider No.: 05-0327

vs.

MEDICARE CONTRACTOR -
Noridian Healthcare Solutions, LLC

DATE OF HEARING -
August 28, 2012

ESRD Window End Date -
August 30, 2000

CASE NO.: 01-2871R

INDEX

ISSUE:

Whether the denial of the Provider's request for an exception to the end stage renal disease ("ESRD") composite rate by the Centers for Medicare and Medicaid Services ("CMS") was proper.

DECISION

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds that the Medicare Contractor properly denied the Provider's request for an exception to the ESRD composite rate for hospital-based ESRD facilities based on an atypical case mix exception for the exception cycle beginning March 1, 2000.

INTRODUCTION

Loma Linda University Medical Center ("Medical Center" or "Provider") is located in Loma Linda, California and operates a hospital-based dialysis facility to furnish both outpatient and inpatient dialysis services. The Medical Center's assigned Medicare contractor[1] is Noridian Healthcare Solutions, LLC ("Medicare Contractor").

The Medicare program reimburses dialysis facilities for outpatient dialysis treatment under the ESRD prospective payment system ("ESRD PPS") which reimburses dialysis facilities on a per treatment basis using a case-mix adjusted composite payment rate. The Medicare program will adjust a dialysis facility's ESRD composite rate if it qualifies for an exception.[2] This case involves the exception for "Atypical service intensity (patient case mix)" as specified in 42 C.F.R. § 413.184 (hereinafter referred to as an "atypical case mix exception").

In December 1999, CMS announced that a new exception cycle for ESRD composite rates would begin on March 1, 2000.[3] The Medical Center requested that the Medicare program increase its ESRD composite rate for its in-facility outpatient maintenance dialysis program based on the atypical case mix exception. After receiving direction from CMS, the Medicare Contractor denied the Medical Center's request for an atypical case mix exception. The Medical Center appealed the Medicare Contractor's decision to the Provider Reimbursement Review Board ("Board" or "PRRB"). The Board reversed the Medicare Contractor's decision on procedural grounds but the CMS Administrator reinstated the Medicare Contractor's decision.[4]

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[1] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to as Medicare contractors.
[2] *See* 42 C.F.R. Part 413, Subpart H.
[3] *See* Program Memorandum, CMS Pub. 60A, Transmittal No. A-99-59 (Dec. 1, 1999); Program Memorandum, CMS Pub. 60A, Transmittal No. A-00-06 (Feb. 1, 2000).
[4] *See Loma Linda Univ. Med. Ctr. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2006-D39 (Jul. 27, 2006), *rev'd*, CMS Adm'r Dec. (Sept. 12, 2006).

The Medical Center appealed the Administrator's reinstatement to the U.S. District Court for the District of Columbia ("District Court"). However, the District Court remanded the case back to the Administrator for a determination on "the substantive merits," specifically whether the Medical Center met the requirements for an exception to the composite payment rate.[5] The Administrator, in turn, remanded the case back to the Board to make this determination.[6]

The Medical Center was represented by Jack Ahern of Ahern Consulting and Jeffrey A. Lovitky, Esq. The Medicare Contractor was represented by Bernard Talbert, Esq., of the Blue Cross and Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

This case is remanded to the Board for the sole purpose of determining whether the Medical Center substantively met the requirements for an exception to the ESRD composite rate for atypical case mix. Therefore, the Board will limit its findings to this remand.

At the outset, the Board notes that Medicare regulations and manual instructions limit the Board's review of CMS' denial of ESRD exception requests. Specifically, 42 C.F.R. § 413.194(c)(2) (1999) states: "The facility may not submit to the . . . PRRB . . . any additional information or cost data that had not been submitted to HCFA at the time HCFA evaluated the exception request."[7] Thus, the Board has limited its findings to the question of whether the Medical Center met its burden of proof based upon the information and data provided in the exception request itself. The Board references hearing testimony only to clarify or confirm information in the as-submitted exception request.

The regulations governing request for exceptions to the ESRD payment rates set forth submission requirements and criteria for approval. 42 C.F.R. § 413.180(f) (1999) requires a dialysis facility to submit "its most recent cost report . . . and whatever statistics, data and budgetary projections as determined by HCFA to be needed to adjudicate each type of exception." In particular, the statistics and data must "identify elements of cost contributing to costs per treatment in excess of the facility's payment rate" and "[s]how that the elements of excessive cost are *specifically attributable* to one or more of the conditions specified in § 413.182."[8] Section 413.182 (1999) states that HCFA may approve an ESRD facility's exception request "if the facility demonstrates, *by convincing objective evidence*, that its total per treatment costs are reasonable and allowable . . . and that its pretreatment costs in excess of its payment rate are *directly attributable* to . . . (a) Atypical service intensity (patient mix) as specified in § 413.184."[9]

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[5] *See Loma Linda Univ. Kidney Ctr. v. Johnson*, Nos. 06-1926, 06-1927, 2009 WL 735639 (D.D.C. Mar. 17, 2009).
[6] *See* CMS Adm'r Order (Nov. 29, 2011).
[7] *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2726.1 (copy included at Medicare Contractor Exhibit I-3 at 896-897).
[8] 42 C.F.R. § 413.180(f) (emphasis added).
[9] (Emphasis added.)

Finally, § 413.180(g) (1999) specifies that "[t]he burden of proof is on the facility to show that . . . the criteria are met and that the excessive costs are justifiable under the reasonable cost principles . . . ."

To qualify for an atypical case mix exception, § 413.184 (1999) specifies that a facility first "must demonstrate that 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 further has to demonstrate that the "services, procedures or supplies and its per treatment costs are prudent and reasonable when compared to those of facilities with a similar patient mix" and that "its nursing personnel costs have been allocated properly between each mode of care"[10]

The Medical Center provided cost per treatment information on outpatient dialysis services for fiscal years ("FYs") 1997, 1998 and 1999 and projected the cost per treatment for 2000. This information was derived from the cost reports for those periods. However, the Medical Center furnished both inpatient *and* outpatient dialysis services and the cost reports reported all of its costs for these services as only outpatient costs. The Medical Center stated that it used the number of inpatient and outpatient treatments to allocate its costs between inpatient and outpatient services for purposes of preparing information for the exception request.[11]

The CMS reviewer found that: (1) the Medical Center improperly failed to allocate costs between inpatient and outpatient dialysis services on the FY 1997, 1998, and 1999 cost reports and the projected 2000 cost reports; and (2) the Medical Center's attempt to correct this oversight in the exception request was flawed because it failed to use the HCFA-approved statistical basis for allocating costs and failed to get approval to use an alternative allocation methodology.[12] The CMS reviewer observed that using the improper allocation method resulted in identical costs per treatment for both inpatient and outpatient dialysis services even though one would expect the inpatient cost per treatment to be higher and that the Medical Center had not submitted an explanation with supporting information to justify deviating from this expectation.

The Medical Center argues on appeal that the relevant regulations do not prevent the Medical Center from correcting any deficiencies in the cost allocations used in the FY 1997, 1998 and 1999 cost reports and that the exception approval is based on accurate estimates of projected costs rather than historical costs. Further, the Medical Center contends that any cost report allocation errors would have been corrected because the Medicare Contractor had agreed to allow the Medical Center to submit a revised FY 1999 cost report with a corrected allocation. Regardless, the Medical Center maintains that: (1) the allocation methodology used in its exception request resulted in a materially correct allocation (*i.e.*, that nursing time for inpatient and outpatient dialysis services were essentially the same given its outpatients were predominantly pediatric patients which tend to require greater nursing time); and (2) at a minimum, it is clear that the

[10] 42 C.F.R. § 413.184(a)(1) - (2).
[11] *See* Provider Exhibit P-45 at 544; Provider Exhibit P-1, Tab 1.
[12] *See* Provider Exhibit P-2 (CMS letter dated Nov. 15, 2000).

Medical Center's outpatient nursing labor costs exceed the $40 bench mark because the overall direct clinical labor costs for both inpatient and outpatient services of $489 is so far above the composite rate payment (over 3.5 times higher). Finally, the Provider's maintains that the Medical Center technically did use the HCFA approved statistical basis because it used nursing hours to allocate labor costs and not treatments.[13]

As noted above, the ESRD facility has the burden of proof to show that one or more of the exception criteria are met, and that the facility's costs, in excess of its composite rate, are justifiable under reasonable cost principles. 42 C.F.R. § 413.180(f) gives CMS the ability to request "whatever statistics, data and budgetary projections . . . to be needed to adjudicate each type of exception."[14] CMS has delineated numerous items needed to be submitted with an exception request in the PRM 15-1. The Board finds the Medical Center failed to meet the requirements of PRM 15-1 § 2721. Specifically, the Board finds the Medical Center failed to meet its burden of proof because it failed to properly allocate costs between inpatient and outpatient treatments on the as-submitted cost reports for FYs 1997, 1998 and 1999 and the projected 2000 cost report.[15] In this regard, the Board notes that § 2721(C)(11) states the following regarding the allocation of inpatient and outpatient costs of hospital-based facilities:

> C. Documentation For Specific Cost Categories.—The following cost categories have a significant impact on costs and are to be documented by a facility submitting an exception request. *The costs must be* reviewed and *allocated properly between each mode of care*. . . .
>
> 11. Inpatient/Outpatient Costs (Hospital-Based Facilities).—*The facility uses the statistics recommended* in the cost reporting instructions *for cost allocation so that the dialysis costs are properly apportioned between inpatient/outpatient services*.[16]

This allocation error has the potential to inflate the outpatient dialysis costs because inpatient services generally are higher than the same services provided on an outpatient basis. The Board recognizes that, as part of the exception request, the Medical Center attempted to correct this error in by allocating costs between inpatient treatments and outpatient treatments based upon treatments for the FYs 1997, 1998, and 1999,[17] and that similarly the Medical Center used projected number of treatments to allocate costs between inpatient and outpatient services for the projected fiscal year 2000.[18] However,

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[13] *See* Provider's Post-Hearing Brief at 79-94.
[14] 42 C.F.R. § 413.180(f).
[15] The Board notes the Medical Center submitted its cost reports for FY 1997 and 1998 as attachments to its request for an exception. However, it has failed to produce copies of these documents notwithstanding that it should have maintained copies of these documents and that it has the burden of proof. The fact that the Medicare Contractor also was unable to locate copies of these documents has no bearing on the Medical Center's responsibility to maintain copies of its own documents or its burden of proof.
[16] (Underline emphasis in original and italics added.)
[17] Provider Exhibit P-1 at 4, Tab 1.
[18] *Id*. at 4, Tab 2.

the Board finds that the use of treatments to allocate these costs is inconsistent with the statistics required by cost report manual instructions.[19] Further, the Board finds that the record contains no indication that the Medical Center either sought or obtained permission from the Medicare Contractor to use treatments as an alternative basis for allocating costs prior to submitting its exception request.[20]

The Board notes that the Medical Center's allocation methodology is based the assumption that the cost of its inpatient dialysis services was essentially the same as that for its outpatient services. However, the Medical Center did not provide an explanation with supporting information to justify this assumption and its deviation from the standard HCFA-approved allocation methodology. The Medical Center tries to point to the significant number of pediatric outpatients it has to support this assumption; however, the exception request does not contain any cost data to support that assumption.[21] Even if the Medical Center were to have qualitatively exceeded the $40 bench mark for nursing labor costs, the exception request fails to "demonstrate, *by convincing objective evidence*, that its total per treatment costs are reasonable and allowable"[22] because the Medical Center did not properly allocate its costs between inpatient and outpatient services.

Finally, the Board finds that it is not unreasonable for CMS to require accurate information given the statutory requirement that the Medicare program must complete its review of a timely-filed exception request within 60 days of its receipt. CMS does not have a requirement to correct or modify a provider's data when it is submitted incorrectly. In those instances, CMS can request that the Medical Center submit corrected data as long as the provider submits it within the 180-day window. In this case, the Medical Center foreclosed *any* opportunity to submit additional data because it submitted its request for an exception on the 180th day leaving no time for resubmissions or corrections. In particular, there was no time left that would have allowed the Medical Center to submit a revised FY 1999 cost report.

Based on the above, the Board finds that the CMS reviewer properly found that "inpatient costs are inappropriately allocated to its outpatient areas."[23] Further, the Board finds the Medical Center's exception request does not allow CMS to confirm whether the "per treatment costs are prudent and reasonable when compared to those of facilities with a

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[19] *See* PRM 15-2 §§ 3653-3654 (copy included at Provider Exhibit P-2). The Medical Center's suggestion that it technically used the correct allocation methodology is disingenuous because it used treatments to allocate the nursing hours and then used the allocated nursing hours to allocate costs.

[20] *See also* PRM 15-2 § 3617 (provides the process for requesting change in allowable statistical allocation bases).

[21] The Medical Center failed to provide "objective convincing evidence" to explain the increases and establish that the costs were reasonable and prudent when compared to that of facilities with comparable patient mix. Further, while the Medical Center did provide a list of diagnoses and related activities that require additional nursing time, it not provide any time studies to support the number of estimated nursing minutes required for each of these diagnoses and related activities Ratner, the Medical Center had certain patient care staff estimate the number of nursing minutes per activity and the number of times each activity is performed annually and did not provide any information on who the patient care staff were who did the estimation or the methodology the patient care staff used to make the estimations.

[22] 42 C.F.R. § 413.182 (1999) (emphasis added).

[23] Provider Exhibit P-2 at 2-3.

similar patient mix" pursuant to 42 C.F.R. § 413.184(a)(2) (1999)[24] because the Medical Center did not submit any data on comparing its per treatment costs to those of facilities with a similar patient mix as required by the regulation.[25] The Board concludes that CMS' determination to not rule on the Atypical Patient Mix exception criteria is reasonable because the data errors in the submitted exception request were fatal flaws. Similarly, the Board has not addressed the Medical Center's arguments relating to other findings that the CMS review made because these fatal flaws render them moot.

DECISION AND ORDER

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds that Medicare Contractor properly denied the Medical Center's request for an exception to the ESRD composite rate for hospital-based ESRD facilities based on an atypical case mix exception for the exception cycle beginning March 1, 2000.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 1, 2015

[24] (Emphasis added.)
[25] The national data submitted by the Medical Center does not qualify as peer group data.