PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D67

PROVIDER -
Riverview Medical Center
SNF - Gonzales, LA

Provider No. 19-0207

vs.

INTERMEDIARY - Mutual of Omaha Insurance Company

DATE OF HEARING-
May 21, 1999

Cost Reporting Period Ended -
August 31, 1993

CASE NO. 96-0869

INDEX

ISSUE:

Was HCFA's measurement of an exception to the cost limits for hospital-based SNFs from 112% of the mean hospital-based inpatient routine service costs, instead of from the hospital-based SNF routine cost limit, proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY-.

Riverview Medical Center ("Provider") is a general acute care hospital that operated a Medicare certified hospital-based skilled nursing facility ("HB-SNF") during the fiscal year ended 8-31-93. The Provider was previously granted an exception for Atypical Services for the fiscal year ended 8-31-92. However, the Provider was not reimbursed for the amount of the "gap" and therefore was not able to recover significant portions of its cost of providing atypical services. The Provider appealed the Intermediary's decision to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§405.1835-.1841, and has met the jurisdictional requirements of those regulations. The amount in controversy is approximately $152,543.

The Provider was represented by Frank P. Fedor Esq. Of Diepenbrock, Wulff, Plant & Hannegan, LLP. The Intermediary was represented by Arlen Mieras of Mutual of Omaha Insurance Co.

PROVIDER'S CONTENTIONS:

The Provider contends that HCFA's action was arbitrary, capricious, an abuse of discretion or not in accordance with the law when it adopted a new exception methodology which systematically prevents those HB-SNFs which treat the sickest of patients from receiving a significant portion, and in many cases any portion, of the atypical services exception amount they formerly received.

The Provider points out that this change alone is not sufficient to support a determination that HCFA's New Chapter 25 methodology is arbitrary, capricious, an abuse of discretion and not in accordance with the law. However, the fact that this new methodology is a departure from HCFA's earlier methodology requires HCFA to provide a principled explanation for its change of direction. HCFA's explanation for its change in methodology shows that HCFA's action was arbitrary, capricious, an abuse of discretion and not in accordance with law because HCFA:

1. -Failed to consider the only direct evidence of the intent of Congress;

2. -Offered an explanation for its change in methodology that runs directly counter to the only direct evidence of the intent of Congress on this issue;

3. -Offered an explanation for its change in methodology that runs directly counter to the implicit evidence that Congress intended to compensate HB-SNFs for their cost of treating high acuity patients;

4. -By ignoring the evidence of the intent of Congress on this issue, mistakenly or wrongfully relied on factors which Congress clearly had not intended HCFA to consider;

5. -Offered an explanation for its methodology that is so implausible that it could not be ascribed to a difference in view or the product of agency expertise;

6. -Impermissibly abused its discretion by adopting a discriminatory exception methodology that permits free standing skilled nursing facilities ("FS-SNFs") to obtain up to all of their reasonable costs incurred in furnishing atypical services, but makes it systematically impossible for any HB-SNF to ever do so.

The Provider points out that pursuant to 42 U.S.C. §1395oo(f)(1), HCFA's action in adopting its methodology of quantifying the amount of an atypical services exception for a HB-SNF from 112% of the peer group mean is governed by the provisions of the Administrative Procedure Act (APA), 5 U.S.C. §701 et seq. The APA empowers a reviewing court to overturn agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. §706 (a)(A). "The scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgement for that of the agency." Motor Veh. Mfrs. Assn. v. State Farm Mut. . 463 U.S. 29, 43 (1983).

The Provider contends that HCFA's methodology is a departure from its earlier method of determining HB-SNF exception requests and requires an explanation for its changes of direction. It is "a clear tenet of administrative law that if the agency wishes to depart from its consistent precedent it must provide a principled explanation for its changes of direction." National Bank Media Coalition v. FCC, 775 F.2d 342, 355 (D.C. Cir. 1985). Under the methodology in effect before the implementation of HCFA's Chapter 25 Methodology, the amount of the exception granted was not artificially discounted by a "gap" which makes it impossible for a HB-SNF to recover a significant portion of its cost of providing atypical services. The new Chapter 25 methodology drastically reduces the amount of an exception that a HB-SNF can obtain for providing services in the order of $30 to $60 per patient day.

The Provider points out that there is no dispute of the fact that it furnished atypical services as defined by 42 C.F.R. §413.30(f)(1) or that the Provider qualified for an atypical services exception under 42 C.F.R.§ 413.30(f)(1). The Provider points out that the Intermediary recommended to HCFA that the Provider be awarded an exception for atypical services. HCFA concurred and in fact awarded an exception for atypical services to the Provider. The Provider had strong evidence of the magnitude of the atypical services provided. The Provider points out that:

> Its average length of stay was 18.64 days compared to the national average for urban HB-SNFs of 132.34 days. This significantly lower length of stay is indicative of restorative treatments and intense services to improve the patients' condition for discharge from the facility.

> The ancillary cost per diem was $162.84 compared to the national average for urban HB-SNFs of $62.73. This high ancillary cost demonstrates the intensity and complexity of services provided to improve the patients' conditions for discharge from the facility.
>
> The high Medicare utilization of 93.70% compared to the national average for urban HB-SNFs of 52.39%, demonstrates that the patient population is more elderly and frail requiring a higher level of direct nursing services.

The Provider contends that the only issue is whether a portion of HCFA's methodology in measuring the amount of this exception, which consists of the measuring from the 112% of the peer group mean instead of from the RCL, is arbitrary, capricious an abuse of discretion or not in accordance with law. HCFA has numerous methodologies designed to filter out unreasonable costs which the Provider is not challenging.

The Provider contends that its direct costs are reasonable and attributable to atypical services, and therefore should receive an exception for all direct costs in excess of the cost limit. The standard 9.6 nursing hours per day applies to both FS-SNFs and HB-SNFs. Since the routine cost limit for FS-SNFs is set at 112% of the peer group mean, a FS-SNF is not subject to a "gap" for atypical direct costs. It is unreasonable for a HB-SNF to receive only partial relief for atypical direct costs when it has met all tests for reasonable costs while a FS-SNF may receive all atypical direct costs after meeting the same tests, subject to the same cost thresholds.

The Provider contends that HCFA has no need to apply an inappropriate "gap" methodology that is unsupported by fact or logic for the purpose of filtering out unreasonable costs. In any case, the "gap" does not serve its stated purpose of filtering out unreasonable costs, but instead penalizes HB-SNFs which provide atypical services because they treat the sickest patients.

The Provider points out that HCFA premises its Chapter 25 methodology of measuring the amount of an exception for a HB-SNF from the peer group mean instead of from the Routine Cost Limit (RCL) on the fact that in the Deficit Reduction Act of 1984 (DEFRA '84), Congress chose to create a new dual routine cost limit which set cost limits for FS-SNFs at 112% of the FS-SNF peer review group mean and lowered the former cost limits for HB-SNFs by moving them down from 112% of the HB-SNF peer group mean to 50 per cent of the difference between 112% of the FS-SNF peer group mean and 112% of the HB-SNF peer group mean. The statute implementing this portion of DEFRA '84 is 42 U.S.C. § 1395yy et seq.

The Provider points out that HCFA chose to measure the exception amount of a FS-SNF from 112% of the peer group mean instead of from the RCL because this lowered HB-SNF RCL created by DEFRA '84. The Provider further contends that by removing these costs from the HB-SNFs costs in excess of the limit before advancing in the exception process, HCFA created a permanent "gap" of costs which it would be impossible for a HB-SNF to ever recover. The Provider points out that this

same explanation for HCFA's policy decision to create such a "gap" in the HB-SNF exception methodology is also articulated in the HCFA's Administrator Decision in St. Francis Health Care v. Community Mutual Insurance Company, May 30, 1997 Medicare and Medicaid Guide (CCH) § 45,545. In his opinion the HCFA Administrator states:

> The Administrator agrees with the Board that, presumably, Congress believed there to be no adequate justification for the higher mean per diem costs of HB-SNFs relative to FS-SNFs, other than the possibility that higher HB-SNF costs are due to inefficiencies. Thus, as validated by its report to Congress, HCFA properly determined, in developing the exception process, that 50 percent of the difference between the FS-SNF and the HB-SNF cost limits, i.e., the "gap", was due to HB-SNF's in efficiencies. As such costs are not reasonable, HCFA properly determined that these costs could not be reimbursed pursuant to the exception process.

Id.

The Provider points out that there is no dispute of fact that HCFA made the policy decision to create a non-reimbursable "gap" in the HB-SNF exception methodology 1) because HCFA believed that it was the intent of Congress that HCFA do so, and 2) because HCFA believed that these excluded costs in the "gap" were unreasonable. Both of these conclusions by HCFA are false, have absolutely no basis in fact or logic, and, the policy decision to adopt a methodology based upon these conclusions must be held to be arbitrary, capricious, and not in accordance with law.

The Provider argues that HCFA missed or ignored the only piece of legislative history which speaks directly to the intent of Congress on the precise issue before the Board. In doing so, HCFA's behavior comes squarely within two of the situations which State Farm identified as normally making an agency rule arbitrary and capricious: (1) HCFA entirely failed to consider an important aspect of the problem, and (2) HCFA offered an explanation for its decision that runs counter to the evidence before the agency.

HCFA's Chapter 25 methodology of quantifying the amount of a HB-SNF's atypical services exception from 112% of the peer group mean is in direct contravention to the unambiguous intent of Congress expressed in the legislative history of DEFRA'84 (which created the dual limits) that HB-SNFs could receive up to all of their costs through an exception process for higher costs that result from more severe than average case mix.

The Provider points out that DEFRA '84 unequivocally shows that it was the intent of Congress to treat HB-SNFs which provide atypical services much differently than is the result of HCFA's errant methodology. The last sentence of the statement of congressional intent is most telling. It clearly and unambiguously states that "facilities eligible for exceptions could receive, where justified, up to all of

their reasonable costs," HCFA's Chapter 25 methodology of automatically measuring the amount of the exception of a HB-SNF which has qualified for an atypical services exception from 112% of the peer group mean, instead of from the RCL, makes it impossible for any FS-SNF furnishing atypical services to ever obtain all of its reasonable costs.

The Provider argues that HCFA offered an explanation for its decision that runs counter to the evidence before the agency when it illogically chose to penalize those HB-SNFs which treat the sickest of patients after Congress took great care to compensate HB-SNFs providing only typical services for their cost of providing typical services to sicker patients.

The Provider points out that HCFA ignored the local consequences of its own conclusion as to why Congress set the RCL of HB-SNFs at a higher level than the RCL of FS-SNFs. HCFA understood that it was the intent of Congress that HB-SNFs be reimbursed for the higher cost of providing typical routine services to sicker patients. HCFA stated that "[the studies undertaken from 1983 to 1984 to identify potential contributing ' factors for the cost differences between HB&FS SNFs] concluded that approximately 50 percent of the cost differences were attributable to variations in intensity of care or case mix."[1] The Provider points out that HCFA then draws the following conclusion about the intent of Congress based on the fact: "We believe that, at least in part, as a result of these studies, the Deficit Reduction Act of 1984(DEFRA'84) ... contained a provision to recognize 50 percent of the cost differences between hospital-based and freestanding SNFs in setting the hospital-based limits."[2] HCFA thus understood that for typical routine services Congress intended to reimburse HB-SNFs at a higher level than FS-SNFs because in providing typical services HB-SNFs in general treat sicker patients.

To qualify for an atypical services exception, a HB-SNF must demonstrate that it provides items or services that are atypical in nature and scope compared to the items or services generally furnished by other HB-SNFs. Thus, while HB-SNFs providing only typical services in general treat sicker patients than FS-SNFs, HB-SNFs providing atypical services treat even sicker patients than HB-SNFs providing only typical services.

The Provider argues that logically, the fact that Congress set a higher RCL for FS-SNFs providing only atypical services in order to compensate them for the additional cost of treating sicker patients (which is precisely the conclusion that HCFA has drawn for the DEFRA '84 dual limits) would lead to the similar and parallel conclusion that those HB-SNFs which provide atypical services because they treat even sicker patients than the FS-SNF which provides only typical services should also receive compensation for the cost of treating these sickest of patients.

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[1] Exhibit p-11, p-12

[2] Exhibit p-11, p-12

The Provider contends that instead of following this logic, HCFA illogically created a reimbursement "gap" which penalizes all HB-SNFs which treat the sickest of patients by making it impossible for them to receive compensation for all or some significant portion of the cost of providing atypical services in relation to HB-SNFs which provide only typical services.

The Provider argues that by ignoring the only direct evidence of the intent of Congress on the exception methodology issue, HCFA also runs afoul of a third Motor Veh. Mfrs. Assn.factor by having "relied on factors which Congress has not intended it to consider"463 U.S. 29 (1983). HCFA says that it came up with its methodology "in order to give meaning to Congress' explicit intention that 50 percent of the cost differences between hospital-based and freestanding SNFs not be reimbursed". However Senate Print 98-169[3] shows that this intent of Congress applied only to HB-SNFs providing only typical services, and not to that minority of HB-SNFs which provide atypical services. Congress clearly did not want HCFA to take factors relied upon by Congress for one purpose (to set discriminatory cost limits taking into account presumed additional costs in furnishing typical services for sicker patients), and then use them for a second purpose of setting a discriminatory exception process for those minority HB-SNFs which can prove that they have higher cost because they treat even sicker patients.

The Provider contends that HCFA's Chapter 25 methodology of quantifying the amount of an atypical services exception from 112% of the peer group mean leads to the absurd result of treating the costs of atypical services more severely than the costs of typical services. The RCL discounts the last dollars of the cost to a HB-SNF of providing typical services; HB-SNFs providing only typical services are presumed to have reasonable costs"up to" the RCL. In contrast, the cost of the atypical services provided by a HB-SNF are treated much more severely in that the discount is applied to the first dollar of such cost. For example, a HB-SNF providing typical services at the RCL and atypical services at below 112% of the peer mean receives no compensation for its cost of providing atypical services. In another example, a HB-SNF providing typical services at the RCL and atypical services at an amount above 112% of the peer group mean equal to the amount of the "gap" suffers a 50% discount for its cost of providing atypical services.

The Provider also points out that HCFA's Chapter 25 methodology of quantifying the amount of an atypical services exception from 112% of the peer group mean, leads to the absurd result of assuming that a HB-SNF's costs above the RCL are unreasonable, but then become reasonable again above the higher level of 112% of the peer group mean.

The Provider also argues that HCFA has taken a reasonable conclusion regarding the intent of Congress toward reimbursing the routine costs of HB-SNFs which provide only typical services. and illogically applied that same rationale to HB-SNFs which provide atypical services. It simply does not follow that a consequence intended to apply to a class of HB-SNFs which provide only typical services was also meant to apply to a whole different class of HB-SNFs which provide atypical services.

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[3]Exhibit p-47

The Provider argues that HCFA's policy impermissibly discriminates in favor of FS-SNFs and against HB-SNFs. The effect of HCFA's policy is to greatly favor FS-SNFs over HB-SNFs in the exception process. The Statute giving HCFA the authority to develop and to apply an exception procedure nowhere gives HCFA the authority to practice such discrimination between FS and HB- SNFs. The relevant portion of the controlling statute reads:

> (c) Adjustments in limitations; publication of data:
>
> The Secretary may make adjustments in the limits set forth in subsection (a) of this section with respect to any skilled nursing facility to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this submission on an annual basis.

42 U.S.C. §1395yy(c).

The Provider contends that the Ohio District Court in St. Francis Health Care Center v. Shalala, 10 F. Supp. 2d 887 (N.D.Ohio 1998) chose not to address whether HCFA had provided a principled explanation for its change of exception methodology. It therefore also did not consider the implications of HCFA's failure to consider the only direct evidence of the intent of Congress on the issue and the logical inconsistencies of HCFA's explanation. The court demonstrated confusion about the distinction between typical and atypical routine services. For example, the court addresses the HCFA studies which HCFA claims was the basis for the two-tier cost limits contained in 42U.S.C.§1395yy(a)et seq. The court concludes that"[although the legislative history does not make it express, the studies' conclusion that half the higher costs of HB-SNFs were due to higher acuity patients and the other half to inefficiencies appears to be the reason Congress enacted systematic under reimbursement rates for routine costs incurred by HB-SNFs." (emphasis added). St. Francis, 10 F. Supp. 2d 887.

The Provider contends that the under reimbursement in the Routine Cost Limits only addressed the costs of HB-SNFs which furnished typical services. Even then, HB-SNFs which could not establish that they furnished atypical services still received greater reimbursement than their FS-SNF counterparts because of recognition that even at the atypical service level HB-SNFs generally treated higher acuity patients. However, the stated "under-reimbursement' for HB-SNFs furnishing only typical services contained in subsection (a) of 1395yy et seq.,was not extended to HB-SNFs furnishing atypical services. Subsection §1395yy et seq.,empowered the Secretary to "make adjustments in the limits""based on case mix". The legislative history presented by the Provider in this case (and not considered by the Board or the HCFA Administrator in the St. Francis case, and presented to, but not acknowledged by, the Ohio district Court) plainly shows that far from intending to extend "under-reimbursement" to the exception process, Congress intended that both FS and HB-SNFs should be able to receive "up to all of their reasonable costs" incurred in providing atypical services.

INTERMEDIARY'S CONTENTIONS:

Mutual of Omaha Insurance Company (Intermediary) contends that the methodology utilized by it and HCFA in their determination of the Provider's exception request as set forth in the Provider Reimbursement Manual HCFA Pub. 15-1, Chapter 25, is consistent with the plain meaning of Sections 1861 (v)(1)(A) and 1888 (a) of the Act, the legislative intent, and the regulations at 42 C.F.R. §413.30. Therefore, the Provider is only entitled to partial relief from the routine cost limitations on the basis of atypical services.

The Intermediary points out that the Medicare program pays for the reasonable cost of furnishing covered services to program beneficiaries pursuant to section 1861 (v)(1)(A) of the Act. In response to rising costs, and realizing that the original payment structure gave little incentive for providers to operate efficiently in delivering services, Congress authorized the Secretary to "provide for the establishment of limits on the direct or indirect overall incurred costs ... based on estimates of the costs/necessary in the efficient delivery of needed health services....."Section 223 of the Social Security Amendments of 1972. Hence, the cost limits would reflect the maximum expenses incurred by an efficient provider, costs exceeding the limit would be presumed unreasonable and would not be allowed unless they qualified for a regulatory exception.

The Intermediary points out that section that 223 cost limits for SNFs were first implemented on October 1, 1979. In conformity with section 1861(v)(1)(A) of the Act, HCFA promulgated yearly schedules of limits on SNF inpatient routine service costs and notified participating providers of the exception process in the Federal Register. Beginning with this initial implementation, separate reimbursement limits were derived for HB-SNFs and FS-SNFs on the basis of cost reports submitted by the two types of providers. These separate limits were effectuated because HB-SNFs maintained that they incurred higher costs due to the allocation of overhead costs required by Medicare and higher intensity of care. Effective for cost reporting periods beginning on or after October 1, 1980, these cost limits were based on 112 percent of the average per diem costs of each comparison group.

Section 102 of TEFRA eliminated separate limits, mandating single limits based on the lower costs of freestanding SNFs, however, these single limits were never implemented. Section 2319 of DEFRA of 1984, rescinded the single TEFRA limit for SNFs and directed the Secretary to set separate limits on per diem inpatient routine costs for HB-SNFs and FS-SNFs, revising Section 1861 (v) of the Act and adding a new section, Section 1888 to the Act. Section 1888 (a) specifies the methodology for determining the separate cost limits rather than delegating the Secretary to do so by regulation. Under this specified methodology, FS-SNF cost limits are set at 112 percent of the mean per diem costs of FS-SNFs, whereas hospital-based limits are computed by adding 50 percent of the cost difference to the appropriate freestanding limit. Furthermore, Section 1888(c) et seq., states that "the Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility...." The Intermediary argues that the Secretary was given broad discretion to authorize adjustments to the cost limits.

The Intermediary argues that in accordance with the foregoing provisions of Section 1861 (v)(1)(A), as amended, and Section 1888, the regulations at 42 C.F.R. §413.30 et seq., clearly states the process by which HCFA would establish limits on providers routine costs and allow for various adjustments. In addition, 42 C.F.R. §413.30(f) et seq., provide, in pertinent part, the following exception process:

> Exceptions. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (F)(5) of this section. Adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.
>
> (i) Atypical services. The provider can show that the
>
> Actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally famished by providers similarly classified; and
>
> (ii) Atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

Id.

The Intermediary points out that as indicated in 42 C.F.R. §413.30(f) et seq., providers may obtain an exception for a list of recognizable circumstances including atypical services. However, as a fundamental basis and premise for approval of an atypical service exception, the provider must demonstrate that it has excess costs and that these costs were a direct result of operating as an atypical provider.

The Intermediary points out that consistent with these statutes and regulations, HCFA set forth general provisions concerning the payment rates for certain SNFs in Chapter 25 of HCFA Pub. 15-1. In July, 1994, to provide the public with current information on the SNF cost limits under Section 1888 of the Act, HCFA issued Transmittal No. 378. Prior to the issuance of Transmittal No. 378, Chapter 25 of HCFA Pub. 15-1 did not address the methodology used to determine exception requests. Transmittal No. 378 explained that new manual sections, at section 2530 were being issued to "...provide detailed instructions for skilled nursing facilities (SNFS) to help them prepare and submit requests for exceptions to the inpatient routine service cost limits....." Section 2534.5 et seq., explains the process and methodology for determining an exception request based on atypical services.

The Intermediary argues that in this case, the Provider disputes the Intermediary's reclassification of certain "non-patient care" costs from direct to indirect cost centers. However, according to Section 2534 10A.5 et seq., when a provider has directly assigned indirect costs, the indirect cost elements must be reassigned, for the purpose of constructing the peer group, to the indirect cost centers identified with the type of costs incurred.

The Intermediary argues that the Provider has failed to link its "excess" costs to atypical patient services. In light of this lack of documentation, the Intermediary's /HCFA's grant of only partial relief from the RCL is consistent with Congress' intent not to reward a facility's inefficiencies.

The Intermediary contends that the Provider has failed to fully demonstrate the necessity in the efficient delivery of the atypical items or services. Accordingly, the burden of proof which was upon the Provider has not been met. Therefore, the Intermediary argues that HCFA's determination was not arbitrary or capricious and did in fact properly adhere to Medicare Law, Regulations and Program Instructions and the Provider is not entitled to the entire amount of their exception request under 42 C.F.R. §413.30 et seq.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Laws:

5 U.S.C.:

§701 et seq.	-	Judicial Review
§706(a)(A)	-	Judicial Review

42 U.S.C.:

§ 1395oo(f)(1)	-	PRRB
§ 1395yy et seq.	-	Payment to Skilled Nursing Fscility for Routine Service Costs

Title XVIII of the Social Security Act:

§ 1881(v)(1)(A)	-	Medicare coverage for End Stage Renal Disease Patients
§ 1888(a) et seq.	-	Payment to Skilled Nursing Facilities For Routine Service Costs
§ 1861(v)	-	Reasonable Cost
§ 2319	-	DEFRA of 1984

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

§ 405.1835	-	Right to Board Hearing

§ 405.1841 - Time, Place, Form, and Content of request for Board Hearing

§ 413.30 et seq. - Limitations on Reasonable Costs

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2500 - Limitations on Cost

§ 2530 - Inpatient Routine Service Cost Limits for Skilled Nursing Facilities

§ 2534 et seq. - Request for Exception to SNF Cost Limits

Transmittal No. 378

4. Case Law:

Motor Veh. Mfrs. Assn. V. State Farm Mut. 463 U.S. 29, 43 (1983).

National Bank Media Coalition v. FCC 775 F. 2d 342 (D.C.Cir. 1985).

St Francis Health Care v. Community Mutual Insurance Company HCFA Adm Dec. May 30, 1997, Medicare and Medicaid Guide (CCH) §45,545.

St. Francis Health Care Center v. Shalala, 10 F. Supp. 2d 887 (N.D. Ohio (1998).

North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18, 1999 modif'd HCFA Administration, April 15, 1999.

5. Other:

Senate print 98-169

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority after consideration of the facts, parties' contentions, and evidence presented at the hearing finds and concludes that the Provider was properly reimbursed for its exception to the RCL cost limit.

The Board majority notes that the HCFA letter dated May 7, 1996[4] to the Intermediary states in part: "[t]he hold harmless provisions of the Regional Office Memorandum dated August 11, 1994 appear to apply to RMC-SNF's exception request. Accordingly, the exception request must be submitted utilizing both the rules in Transmittal No. 378 and the rules in effect prior to the implementation of Transmittal No. 378." Id. The Board majority notes that HCFA's letter dated August 14, 1996 to the Intermediary[5] states: "based on the additional documentation that the provider had not previously requested an interim exception, we have processed this request pursuant to Transmittal No. 378..." Therefore, the majority of the Board notes that the Provider was not entitled to the hold harmless provisions of the RO Memo dated August 11, 1994.

The Intermediary used the methodology contained in HCFA Transmittal No. 378 to determine the amount of the exception to the RCL the Provider was entitled. The Provider challenged the validity of this methodology based upon statutory and regulatory provisions controlling Medicare program cost limits applicable to SNFs.

In general, the Provider argues that 42 U.S.C. § 1395 yy(a) et seq. sets the cost limits for SNFs and, if an exception to these limits is granted, a provider is entitled to each and every dollar that its costs exceed the applicable limit. The Provider concludes, therefore, that the methodology contained in Transmittal No. 378 is invalid since it does not reimburse a HB-SNF's costs between the applicable cost limit and 112 percent of the peer group mean cost, in those cases where an exception is granted. Significantly, the Provider maintains that HCFA effectively changed the cost limits set by Congress.

The Board majority, however, finds that the methodology contained in HCFA Transmittal No. 378 is a proper interpretation of the governing laws and regulations. The Board majority agrees that 42 U.S.C. §1395yy(a) et seq., establishes the cost limits applicable to FS and HB-SNFs. However, the Board majority notes that 42 U.S.C. 1395yy(c) et seq., gives the Secretary broad discretion to adjust the limits. In part, the statute states:

> [t]he Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate. . . . The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

42 U.S.C. § 1395yy (c) et seq.

The Board majority finds that, following the intent of 42 U.S.C. 1395yy(c) et seq., HCFA promulgated regulations at 42 C.F.R. 413.30 et seq. which, in part, provide for an adjustment to the cost limits

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[4]Exhibit P-5

[5]Exhibit I-3

where a provider furnishes atypical services, as in the instant case. Provisions at 42 C.F.R § 413.30(f)(1)(i) et seq., provided the basic rules for determining the amount of such an adjustment by explaining that provider's actual costs are compared to the items or services furnished by similarly classified providers. In this regard, the Board majority finds that HCFA Transmittal No. 378 provides the instructions for performing the required comparison.

In addition, the Board majority finds the comparison contained in HCFA Transmittal No. 378 to be a sound approach for determining the amount of HB-SNF exceptions, and rejects the Provider's argument that such an approach is unreasonable. In particular, the Provider points out that the instructions contained in HCFA Transmittal No. 378 presume all HB-SNF costs that are above the limit to be unreasonable until they reach the 112 percent per group mean per diem cost level. The Provider asserts there is no logical basis for this "gap." The Board majority, however, believes the 112 percent peer group level is a practical standard for measuring the atypical nature of a provider's services. It is the same level used to determine the amount of exceptions for FS-SNFs, and is a standard based entirely upon HB-SNF data as opposed to the HB-SNF limit which is heavily based upon FS-SNF data.

Finally, the Board majority acknowledges the Provider's reliance upon the previous Board's decision is St. Francis to help support its position and arguments. This Board majority notes that its findings are consistent with the decision rendered in North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18, 1999, modif'd HCFA Administrator, April 15, 1999.

DECISION AND ORDER:

HCFA's measurement of the exception to the cost limits for hospital-based SNF's from 112% of the mean hospital-based inpatient routine service costs, instead of from the hospital-based SNF routine cost limit was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq. (dissenting opinion)
Charles R. Barker

Date of Decision: September 2, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover Jr.

I respectfully dissent:

The Provider contends that it is entitled to be paid the entire amount of its costs in excess of the cost limit.

In part, 42 U.S.C. § 1395yy(a)(3) states:

> With respect to hospital based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for free standing skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital based skilled nursing facilities located in urban areas exceed the limit for free standing skilled nursing facilities located in urban areas.

42 U.S.C. § 1395yy(a)(3)

The plain language of the statute establishes the cost limits for hospital based skilled nursing facilities located in urban areas.

The implementing regulation 42 C.F.R. § 413.30(a)(2) states in part:

> HCFA may establish estimated cost limits....

This regulation appears to be, in my opinion, contrary and in conflict with the statute since the regulation grants to HCFA that which has heretofore been established.

The Board majority notes that section 42 U.S.C. §1395 yy(c) et seq. gives the Secretary broad discretion to adjust the limits. The Board majority refers to 42 U.S.C. §1395yy which states:

> [t]he Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

It is my opinion that this section is limiting rather than discretionary since only two types of adjustments are permitted, adjustments based upon case mix or circumstance beyond the control of the facility.

It is noted that in the St. Francis Health Care Center v. Community Mutual Insurance Company, PRRB Dec. No. 97-D38, dated March 24, 1997, the Board found for the provider using in part the following:

> [t]he Board finds that the Provider's requests should not have been denied. HCFA's comparison of the Provider's routine service cost per diem to the 112 percent level is inconsistent with both the statute and regulation. In addition, HCFA's comparison confuses the concept of "atypical costs" with the concept of "the cost of atypical services," and produces results that are seemingly unsound.
>
> Contrary to HCFA's exception methodology, which fails to reimburse HB-SNFs for routine service costs that exceed the limit but are less than the 112 percent level (the gap), the Board finds that 42 U.S.C. § 1395yy entitles SNFs, either freestanding or hospital-based, to be paid the full amount by which their costs exceed the applicable cost limit. In part, 42 U.S.C. § 1395yy(a) states:
>
> > [t]he Secretary, in determining the amount of the payments which my be made under this title with respect to routine service costs of extended care services shall not recognize as reasonable. . . per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section . . .
>
> 42 U.S.C. § 1395yy(a).
>
> The Board also finds there is no authoritative basis supporting HCFA's reliance upon the 112 percent peer group per diem to determine the amount of a HB-SNF exception. As discussed above, reliance upon the 112 percent level effectively increases the amount or level a provider's cost must exceed before it may be granted an exception. The Board finds it inappropriate for HCFA to establish and rely upon an amount greater than the limit established by Congress as it would find it inappropriate for HCFA to introduce a methodology that would effectively reduce the limits set by Congress.
>
> The Board notes that 42 C.F.R. § 413.30 provides HCFA with the general authority to establish cost limits. In part, the regulation states "HCFA may establish limits on provider costs recognized as reasonable in determining program payments. . . . Id. The regulation goes on to state that "HCFA may establish estimated cost limits for direct overall costs or for costs of specific items or services. . . . Id. However, the Board finds that the cost limits applicable to SNFs are not presented in the regulations or in HCFA's manual instructions; Congress has superseded HCFA's authority to establish cost limits with respect to SNFs by statutorily mandating them.

St. Francis PRRB Dec. No. 97-D38.

I concur with the findings and conclusion of the Board in the St. Francis case.

It is my opinion that the methodology used by HCFA to determine the amount of the exception from the routine service cost limits for hospital based skilled nursing facilities is not proper and the denial by HCFA of the Provider's request for full exception to the routine service cost limits should be reversed.

Martin W. Hoover, Jr