PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2000-D86

PROVIDER -
Fort Bend Community Hospital - SNF
Missouri City, TX

Provider No. 45-0717

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING-
July 28, 2000

Cost Reporting Period Ended -
December 31, 1994

CASE NO. 97-2707

INDEX

ISSUES:

1. Was the Intermediary=s adjustment reclassifying the Provider=s costs from direct to indirect cost centers proper?

2. Did the Intermediary properly apply the low occupancy adjustment in Health Care Financing Administration (AHCFA@) Transmittal No. 378 to HCFA Pub. 15-1 ' 2534.5A?

3. Was HCFA=s refusal to grant an exception for that portion of the Provider=s per diem costs which does not exceed 112% of the total peer group mean cost proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Fort Bend Community Hospital (AProvider@) operates a 7 bed Medicare certified hospital-based skilled nursing facility (AHB-SNF@) in Missouri City, Texas. For the calendar year ended December 31, 1994, the Provider exceeded all of the benchmarks established by HCFA to determine whether it provided atypical services. The Provider had an average length of stay of 7.63 days compared to a national average of 132.34 days, Medicare utilization of 99.17 percent compared to a national average of 52.39 percent, and Medicare SNF ancillary per diem costs of $175.43 compared to a national average of 62.73.[1]

42 C.F.R. '413.30(f)(l) permits a provider to request an exception from the Medicare Routine Cost Limit because it provided atypical services. The Provider requested such an atypical services exception for the cost reporting period ending December 31, 1994.[2] Both the Intermediary and HCFA recognized that the Provider had rendered atypical services, and HCFA granted an exception in the amount of $56.49 per day.[3] With 1,655 Medicare SNF patient days at issue, the total amount of the exception granted was $93,491.

The Provider requested a reconsideration of the approved amount to correct for errors and omissions in the Intermediary=s and HCFA=s methodology in calculating the exception.[4] HCFA responded to the reconsideration request by granting an additional $30.97 per day or $51,255.[5] The total exception granted was $87.46 per day or $144,746.

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[1] See Provider Exhibit P-1, p. 2.

[2] See Provider Exhibit P-2.

[3] See Provider Exhibits P-2 and P-3.

[4] See Provider Exhibit P-4.

[5] See Provider Exhibits P-5 and P-6.

The following items remain in dispute. Issue #1 relates to the Intermediary=s reclassification of costs from the direct cost center to various indirect cost centers. The Intermediary=s letter of January 20, 1998[6] details these reclassifications. The Intermediary reclassified a total of $28,418 of direct costs. $21,000 was reclassified to the employee health and welfare indirect cost center; $3,730 was reclassified to the administrative and general indirect cost center; $436 was reclassified to the maintenance and operation of plant indirect cost center; $2,130 was reclassified to the nursing administration indirect cost center; $1066 was reclassified to the central service indirect cost center; and $56 was reclassified to the social service indirect cost center. The above reclassifications result in a reduction in Medicare reimbursement of approximately $24,000.

Issue #2 relates to the Intermediary=s implementation of Medicare=s low occupancy adjustment to the Provider=s costs during the exception determination. The Provider contends that the Intermediary and HCFA violated '2534.5A of the HCFA Pub. 15-1 by deeming its indirect costs to be fixed, when they were actually variable due to the fact that the Provider is a HB-SNF, and all of its relevant indirect costs are assigned on a variable occupancy and/or usage basis under Medicare cost reporting instructions. The Provider contends that if the Intermediary and HCFA had appropriately applied the low occupancy adjustment, the Provider would be due an additional exception amount of approximately $6,000.

Issue #3 relates to the instruction in HCFA Transmittal No. 378 to the Provider Reimbursement Manual (APRM@) that the atypical services exception of every HB-SNF must be measured from 112 percent of the peer group mean for that HB-SNF. This specific requirement is found in HCFA Pub. 15-1 '2534.5. 112 percent of the peer group mean of every HB-SNF is always significantly higher than its Medicare Routine Cost Limit. Thus, under HCFA Transmittal No. 378, there is a reimbursement gap between the Medicare Routine Cost Limit and 112 percent of the peer group mean which represents costs incurred by a HB-SNF which it can never recover. The Intermediary=s and HCFA=s application of the 112% factor results in a reduction in Medicare reimbursement of approximately $57,000.

The Provider appealed the disputed exception requests to the Provider Reimbursement Review Board (ABoard@). The Provider=s filing meets the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841. The Provider is represented by Frank P. Fedor, Esquire, of Murphy, Austin, Adams, Schoenfeld, LLP. The Intermdiary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

Regarding Issue No. 1 -- the Intermediary=s reclassifying the Provider's costs from direct to indirect cost centers -- the Provider contends that the Intermediary and HCFA failed to follow HCFA=s own

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[6] See Provider Exhibit P-5.

instructions contained in Transmittal No. 378 which requires that both steps of a two step process be taken when an intermediary reclassifies direct costs to one or more indirect cost centers HCFA Pub. 15-1 ' 2534.5B reads in pertinent part:

> Uniform National Peer Group Comparison. **C**. . . If indirect costs are directly assigned (e.g. nursing administration (indirect cost assigned to the direct cost center), the indirect cost elements must be identified and reassigned, for the purpose of constructing the peer group, to the indirect cost center identified with the type of cost incurred. The ratios are then based on the averages for the cost centers reflecting the reassigned costs.[7]

Id.

This instruction is further explained in a September 29, 1997 letter from Mr. James Kenton of HCFA to an intermediary. This letter reads in pertinent part:

> [I]n accordance with a memorandum dated March 13, 1995, from HCFA Central Office to all HCFA Regional Offices, an exception for direct salary costs is computed as the provider's direct salary per diem cost in excess of the peer group direct salary per diem cost. The peer group direct salary per diem cost is determined by dividing the provider-s actual percent of salary costs by total direct costs and applying this percentage to the peer group direct per diem costs. No exception is allowed for the non-salary direct cost per diem. However, if the provider can desegregate the items included as non-salary direct costs into another cost center in the peer group, e.g. central services and supply, it could combine these costs with costs already included in that cost center. The portion of the peer group amount for non-salary direct costs associated with costs that were redistributed to the other cost center of the peer group would also need to be combined with the peer group amount for that cost center. This could result in an additional exception amount for some of the provider's costs previously categorized as non-salary direct costs. Any non-salary direct costs that cannot be redistributed into a different cost center on the peer group will be left in the peer group as non-salary direct costs and no exception is allowed for these costs.[8]

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[7] See Provider Exhibit P-15, pages 9-10; Exhibit P-17 (Carlson) 22:9 - 23:9.

[8] See Provider Exhibit P-26, page 6; Exhibit P-17 (Carlson) 23:2 - 25:9.

Id.

The Provider contends that taking step two of the two step process is necessary to maintain the integrity of the peer group which is used for comparison. The peer group was constructed using settled cost report data from providers for the fiscal years ending 1988 and 1989.[9] The peer group was constructed by taking the direct and disaggregated indirect costs off of the cost reports of providers in the peer group.[10] There was no reason for the intermediaries settling the 1988 and 1989 cost reports to make the type of reclassifications which the Intermediary made in this case as part of the exception determination process.[11] HCFA Transmittal No. 378 states that no reclassifications occurred before the peer groups were constructed.[12] Discovery responses from HCFA describing the process of constructing the peer groups do not mention the reclassification of direct costs.[13] Thus, peer groups, which were used by the Intermediary and HCFA to determine the amount of an exception, actually classified costs between the direct and indirect cost centers as originally classified by the providers filing cost reports and before reclassification occurred.[14]

The Provider argues that most, if not all, hospitals have significant amounts of direct costs of the type reclassified by the Intermediary.[15] The Provider introduced a summary of reclassifications made by numerous intermediaries throughout the country during the exception determination process to demonstrate the prevalence of direct costs of the type reclassified by the Intermediary.[16] The Chart of Account for Hospitals[17] notes that while Amany hospitals do not charge employees benefits directly to responsibility center expense accounts as a part of the regular accounting routine@ . . . A[o]ther hospitals

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9 See Provider Exhibit P-17 (Menning) 70:6-19.

10 See Provider Exhibit P-17 (Carlson) 26:15-24.

11 See Provider Exhibit P-17 (Menning) 70:20 - 71:7.

12 See Provider Exhibit P-17 (Carlson) 40:14 - 41:2; 42:14 - 43:11.

13 See Provider Exhibits P-7 and P-9.

14 See Provider Exhibit P-17 (Carlson) 26:15-24.

15 See Provider Exhibit P-17 (Carlson) 30:17 - 31:1.

16 See Exhibit P-18.

17 Chart of Accounts For Hospitals, by L. Vann Seawell, and published by the Healthcare Financial Management Association.

... choose to charge the costs of such benefits to responsibility center accounts as direct expenses.@[18] This latter practice is directed by HCFA Pub. 15-1, ' 2144.7 which states A[i]f a provider does not charge the cost of fringe benefits directly to the department or cost center where the employee is assigned, then the cost reimbursement forms, which are used to determine Medicare reimbursement, provide the mechanism for the allocation of fringe benefits to the appropriate cost centers.@ Id.

The Provider explains that the failure to complete the two-step process required by HCFA Transmittal No. 378 distorts the peer group comparison to the disadvantage of the Provider. When the Intermediary removes the Provider=s direct costs and fails to make a corresponding reclassification in the peer group, the costs in the Provider=s direct cost center have been disproportionately lowered in respect to the corresponding direct costs of its peer group to which it must compare its direct costs. What was a comparison of Aapples to apples@ before any reclassification occurred has now become a comparison of Aapples to oranges@. The comparison can only be restored to one of like qualities by taking the second step of also reclassifying the peer group.[19]

The Provider notes that pursuant to Transmittal No. 378, the amount of a provider=s exception for direct costs is determined by subtracting the peer group direct salary per diem cost from the Provider=s direct salary per diem cost [Provider=s direct salary per diem cost less peer group direct salary cost = direct salary cost exception]. HCFA Pub. 15-1' 2534.10A.5. The Provider points out that A[t]he peer group direct per diem costs does not separately identify salary cost and non-salary cost.@ Id. Thus, the Provider=s direct salary per diem cost must be derived through an equation. That equation is set forth in HCFA Pub. 15-1 ' 2534.10 A.5. First, the Provider must determine what percentage of its total direct costs are made up of direct salary costs. Second, the Provider must multiply that percentage against the total of the peer group=s direct costs. The complete equation to derive the peer group direct per diem salary costs is as follows: [Factor #1: Percent of Provider=s direct per diem costs which are salary costs] x [Factor #2: total peer group direct costs] [peer group direct salary costs]. The Provider illustrates that when the Intermediary reclassified the Provider=s direct costs, several of which were non-salary costs, to the indirect cost centers, it increased the percentage which becomes Factor #1 in this equation. Indeed, the percentage of the Provider=s direct costs which are made up of direct salary costs becomes very high when most of the direct non-salary costs are reclassified into the indirect cost centers.

The Provider contends that when a corresponding reclassification of direct costs is not made in the peer group, a gross distortion occurs. The equation set forth in HCFA Pub. 15-1 '2534.10A.5 results in direct non-salary costs included in the peer group being considered as direct salary costs of the peer group for the purpose of making the peer group comparison to the Provider=s direct salary costs.

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[18] Chart of Accounts for Hospitals, Chapter 4, Figure 4-3, Two Digit Suffix 15.

[19] See Provider Exhibits P-17 (Carlson) 30:17 - 31:16.

Because the direct costs of the peer group also contain the type of salary and non-salary direct costs which the Intermediary has reclassified out of the Provider=s direct costs, the higher Factor #1 percentage caused by this reclassification sweeps up the direct non-salary costs in the peer group and results in a overstated comparison point for the Provider=s direct salary costs.

The Provider further explains that because the exception process contained in HCFA Transmittal No. 378 drives the determination of the exception amount by the amount of the direct cost comparison to the peer group, the lowering of the Provider=s direct costs caused by the reclassification is not made up by the increase of costs in the Provider=s indirect cost centers.[20]

The Provider notes that HCFA is unable to identify any support for its argument that the peer group does not contain direct costs of the type reclassified by the Intermediary. The Provider also points out that HCFA has not provided a rational explanation for the inconsistency between its resistance to the reclassification of the peer group (step number two of the two-step process) and the instruction in HCFA Transmittal No. 378 and in the September 29, 1997 letter from HCFA=s James Kenton requiring the reclassification of the peer group. The Provider points out that HCFA=s explanation that the September 29 letter was to apply only to small amounts[21] is the classic example of administrative action that is arbitrary and capricious. HCFA has no definition of small amounts, and there is no instruction which would define the threshold between big and small.[22] Moreover, the September 29 letter sets no such limitation. It expressly refers to non-salary direct costs in general, and refers to central services and supplies as an example, and not as a limitation on the type of costs for which the peer group should be reclassified. The financial impact upon the Provider of the Intermediary=s failure to follow the instruction contained in HCFA Transmittal No. 378 results in a short fall of $24,477 in the exception amount due to the Provider.[23]

Regarding Issue #2-- the low occupancy adjustment in HCFA Transmittal No. 378 concerning HCFA Pub. 15-1 ' 2534.5A-- the Provider contends that the Intermediary and HCFA violated this section by deeming certain of the Provider's costs to be fixed costs when these costs were clearly variable costs under standard accounting practices. The Provider points out that the stated purpose of the low occupancy adjustment is to avoid the reimbursement of unreasonable per diem costs which result when fixed costs must be spread over a smaller population than that which typically occupies a peer group SNF. This rationale has also been articulated in HCFA Administrator decisions. Since the inception of

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[20] See Provider Exhibit P-17 (Carlson) 30:17 - 31:16.

[21] See Provider Exhibit P-17 (Menning) 54:22 - 55:5.

[22] See Provider Exhibit P-17 (Menning) 58:16-23.

[23] See Provider Exhibits P-29 and P-30.

the skilled nursing facility cost limit exceptions process, HCFA has interpreted 42 C.F.R. ' 413.30(f)(l) to provide for the evaluation of all applications to ensure that excess costs are not due to excessive staffing or idle capacity (low occupancy), resulting in fixed expenses being spread over fewer inpatient days, creating unnecessarily high costs per patient day. Southfield Rehabilitation Center (Detroit, Mich.) v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, HCFA Administrator Decision 95-D52, October 20, 1995, Medicare & Medicaid Guide (ACCH@) &43,722.

The Provider notes that ' 2534.5A of HCFA Pub. 15-1 creates only a rebuttable presumption that all of the provider=s costs are fixed. A provider is expressly permitted to demonstrate that its costs are in fact variable, and not fixed, and that no low occupancy adjustment is appropriate. The Provider further argues that HCFA improperly applied its low occupancy instruction in HCFA Pub. 15-1 '2534.5A to the Provider=s indirect costs in every indirect cost center except operation of plant. ' 2534.5A specifies that the low occupancy adjustment is made to the provider=s per diem cost. The premise of the adjustment is that when fixed costs must be spread over a lower than typical census, the per diem cost is unreasonably raised. The Provider argues that this premise works well when applied to a freestanding skilled nursing facility. For example, the freestanding facility is required to have the services of a dietician, some portion of those costs are fixed, and the logic of a per diem cost adjustment to instances of low occupancy applies.[24] However, this premise does not apply to HB-SNFs because the costs of the general service cost centers of a hospital-based SNF are statistically allocated by the cost reporting instructions.[25] Thus, they are by their very nature variable. Since they are completely variable on a statistical basis, rises and falls in occupancy do not result in any changes in per diem expenses. Thus, the provider=s per diem cost is self-adjusting under the cost reporting instructions on the basis of occupancy, and no further low occupancy adjustment is logical or appropriate.[26] The costs that are allocated to the hospital-based skilled nursing facility already reflect the SNF's lower occupancy and are therefore a variable cost. They require no further occupancy adjustment.[27]

The Provider contends that recognizing the indirect costs of a HB-SNF as variable is also consistent with standard accounting practices. Because of the statistical allocation of costs to the skilled nursing facility=s indirect cost centers required by the cost reporting instructions, the traditional analysis of attempting to identify fixed and variable costs within these cost centers did not apply. As far as the cost object of the indirect costs of the skilled nursing facility was concerned, they were all variable because of the method by which they were allocated.[28] Indeed, in light of the cost reporting methodology by

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[24] See Provider Exhibit P-21 (Starr) 55:22 - 56:25.

[25] See Provider Exhibit P-21 (Starr) 20:23 - 21:18.

[26] See Provider Exhibit P-21 (Sass) 83:15 - 85:25.

[27] See Provider Exhibit P-21 (Starr) 27:12- 28:6; 50:9 - 18.

[28] See Provider Exhibit P-21 (Sass) 83:15 - 85:16.

which these indirect costs are required to be assigned, it would be a misapplication of standard accounting practices to attempt to identify fixed and variable costs within each indirect cost center which are statistically assigned to routine cost centers.

Regarding Issue #3--HCFA=s refusal to grant an exception for that portion of the provider=s per diem costs which does not exceed 112% of the total peer group mean --the Provider=s contentions fall within three broad categories. First, the gap methodology in HCFA Pub. 15-1 ' 2534.5 is directly inconsistent with the regulation controlling atypical services exceptions and with the statute prohibiting cross-subsidization between Medicare and other payers. Second, the gap methodology in HCFA Pub. 15-1 ' 2534.5 is invalid because it was not adopted pursuant to the notice and comment rule making provisions of the Administrative Procedure Act or as a regulation as required by statute. Third, HCFA=s action in adopting the gap methodology in HCFA Pub. 15-1 ' 2534.5 was arbitrary, capricious, an abuse of discretion and not in accordance with law, and should therefore be overturned under other provisions of the Administrative Procedure Act.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that the methodology utilized by it and HCFA in their determination of the Provider=s exception request as set forth in the HCFA Pub. 15-1, Chapter 25, is consistent with the plain meaning of ''1861 (v)(1)(A) and 1888 (a) through (c) of the Social Security Act, the legislative intent, and the regulations at 42 C.F.R. ' 413.30. Consequently, the Provider is only entitled to partial relief from Medicare=s Routine Cost Limitations on the basis of atypical services. SNF cost limits were first implemented on October 1, 1979. In conformity with ' 1861 (v)(1)(A) of the Social Security 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 hospital-based SNFs and freestanding SNFs on the basis of cost reports submitted by the two types of providers. These separate limits were effectuated because hospital-based 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.

The Intermediary argues that ' 102 of the Tax Equity and Fiscal Responsibility Act (ATEFRA@) eliminated separate limits, mandating single limits based on the lower costs of freestanding SNFs. However, these single limits were never implemented. ' 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 hospital-based SNFs and freestanding SNFs, revising ' 1861 (v) of the Act and adding a new section, ' 1888 to the Social Security Act. ' 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, freestanding SNF cost limits are set at 112 percent of the mean per diem costs of freestanding SNFs, whereas hospital-based limits are computed by adding 50

percent of the cost difference to the appropriate freestanding limit. Furthermore, ' 1888 (c) states that Athe 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....@ Id. Obviously, the Secretary was given broad discretion to authorize adjustments to the cost limits.

The Intermediary argues that the regulations at 42 C.F.R. ' 413.30 clearly state the process by which HCFA established limits on provider=s routine costs and allow for various adjustments. In addition, 42 C.F.R. ' 413.30 (f) provides, in pertinent part, the exception process.

The Intermediary observes that the Provider 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, a provider must demonstrate that it has excess costs, and that these costs were a direct result of operating as an atypical provider. Consistent with the above statuates and regulations, HCFA set forth general provisions concerning the payment rates for certain SNFs in Chapter 25 of the HCFA Pub. 15-1. In July, 1994, to provide the public with current information on the SNF cost limits under ' 1888 of the Social Security Act, HCFA issued Transmittal No. 378. Prior to the issuance of Transmittal No. 378, Chapter 25 of the PRM did not address the methodology used to determine exception requests. Transmittal No. 378 explained that new manual sections, at ' 2530 were being issued to A...provide detailed instructions for SNFs to help them prepare and submit requests for exceptions to the inpatient routine service cost limits....@Id. ' 2534.5 explains the process and methodology for determining an exception request based on atypical services.

The Intermediary notes that the Provider disputes the Intermediary=s reclassification of certain non-patient care costs from direct to indirect cost centers. However, according to HCFA Pub. 15-1 '2534.10 A.5., 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 types of costs incurred. With respect to the low occupancy adjustment, the Intermediary=s computation was performed in accordance with the instructions in the HCFA Pub. 15-1, Chapter 25.

The Intermediary observes that the Provider has failed to link its Aexcess@ costs to atypical patient services. In light of this lack of documentation, the Intermediary/HCFA granted only partial relief from the Medicare Reasonable Cost Limits which is consistent with Congress= intent not to reward a facility=s inefficiencies. Moreover, the Intermediary argues that with respect to the reclassification of various directly assigned indirect expenses for purposes of constructing a provider=s uniform peer group comparison, HCFA Pub. 15-1 '' 2534.5B and 2534.10 present the proper order and methodology for constructing the providers= peer group comparison. HCFA Pub. 15-1 ' 2534.5B requires that a provider=s directly assigned indirect expenses be reassigned to the appropriate indirect expense cost center in the peer group identified with the type of cost incurred. This provision is mandated in the PRM and is not discretionary. The intent of the peer group comparison is to compare each provider=s reasonable costs with HCFA=s estimate of similar costs in the peer group. While directly assigning

various indirect expenses may be permitted for cost reporting purposes, HCFA was not able to estimate either the number of providers in its peer group that did this or the per diem effect of doing it. Accordingly, it was HCFA=s determination, that in the exception=s process, when a provider had indirect expenses that were directly assigned on its cost report, these costs should be reclassified for purposes of determining the provider=s actual per diem amounts that would be compared to the cost limit or peer group mean cost per diem amounts in Colunm C of the appropriate appendix in Chapter 25 of the Manual. ' 2534.5B clearly requires that a provider=s directly assigned indirect expenses must be reassigned for purposes of constructing the peer group. ' 2534.10 then clearly presents the order in which costs are compared to the peer group.

The Intermediary observes that the Provider is arguing that when a SNF has directly assigned indirect expenses, regardless of the nature of these costs, that the direct expense base per diem amounts (Column A of the peer group), the direct expense per diem adjustment ratio (Colunm B of the peer group) and the direct expense portion of the provider=s cost limit, 112 percent of the peer group mean (Column C of the peer group), be broken down or fragmented by the ratio of a provider=s direct salary related cost to total direct expense prior to reclassifications mentioned at PRM 15-1, ' 2534.5B. The Provider further argues that once this has been done, concomitant with the reassignment of any directly assigned indirect costs, a reassignment of a portion of the direct expense peer group amount attributable to the directly assigned indirect expense to the indirect expense cost center to which the provider's costs are reassigned must be made. The Intermediary notes that the Provider is attempting to support this argument by reference to the second paragraph of the James Kenton letter dated September 29, 1997.[29] The Intermediary disagrees for the following reasons. The portion of this letter which ostensibly supports the Provider=s argument was first of all not meant to apply to all directly assigned indirect costs but only to directly assigned routine central service and supply costs and to directly assigned routine pharmacy costs. Furthermore, since HCFA was not able to estimate what if any portion of the peer group direct expense per diem was attributable to directly assigned indirect expenses for the reasons stipulated in the next paragraph, it was HCFA=s decision to deem the entire direct base per diem as salary related with the exception of an individual provider=s direct non-salary related costs which could not be reassigned to an appropriate indirect cost center in the peer group.

The Intermediary notes that the government=s arguments in the case of St. Francis Health Care Center v. Shalala, Case No. 3:97 (N. D. Ohio) (ASt. Francis@) before the United States District Court in the Northern District of Ohio with which the Court agreed, are that an agency=s interpretation of its own regulations is only subject to reversal if it is found to be plainly erroneous or inconsistent with the regulation. In addition, in cases subsequent to St. Francis, the Board has found that Transmittal No. 378 instructions are a proper interpretation of the governing laws and regulations. See Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D67, September 2, 1999, Medicare & Medicaid Guide (ACCH@) &80,311.

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[29] See Exhibit I-12.

The Intermediary further argues that ' 2534.5 of HCFA Pub. 15-1 also requires the Provider=s per diem costs in excess of the cost limit be subjected to a low occupancy test. HCFA wants to ensure that the Program is not paying for costs which would be deemed related to excess capacity. Accordingly, if a provider=s occupancy rate is below 75 percent, all fixed per diem costs (by cost center) are adjusted to reflect its per diem equivalent at the 75 percent occupancy rate. Fixed costs are defined as A...those costs considered fixed by standard accounting practices and those costs that must be incurred by all SNFs in order to meet the conditions of participation in the Medicare program.@ Id. The regulations at 42 C.F.R. ' 483.30 mandate that a facility as defined in 42 C.F.R. ' 483.5 as the entity which participates in the program must have sufficient nursing staff to provide services on a 24-hour basis. HCFA interprets this staffing to be comprised of licensed nurses, utilizing the services of a registered nurse 8 consecutive hours a day, 7 days a week. HCFA considers the entire cost of satisfying the 24 hours per day licensed nursing coverage requirement as fixed costs for purposes of adjusting costs for low occupancy. The Provider is challenging HCFA=s determination of fixed and variable costs within the low occupancy computation.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Social Security Act:

' 1861(v) et seq.	-	Reasonable Cost
' 1888 et seq.	-	Payment To Skilled Nursing Facilities For Routine Services Costs

42 U.S.C.:

' 1395 x (v) (1) (A)	-	Reasonable Cost
' 1395yy (c)	-	Adjustments In Limitations; Publication of Data

Other

TEFRA (' 102)	-	Tax Equity And Fiscal Responsibility Act
DEFRA (' 2319) 1984	-	Deficit Fiscal Responisbility Act

2. Regulations 42 C.F.R:

'' 405.1835-.1841	-	Board Jurisdiction
' 413.30 et seq.	-	Limitations On Reimbursement Costs
' 483.5	-	Definitions
' 483.30	-	Nursing Services

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

' 2144.7	-	Accounting For Fringe Benefits
Chapter 25	-	Limitation On Coverage Of Costs Under Medicare And Notice Of Schedule Of Limits On Provider Costs
Transmittal No. 378	-	Implementing Instructions For '2530ff
' 2530	-	Inpatient Routine Service Cost Limits For Skilled Nursing Facilities
' 2534.5	-	Determination Of Reasonable Costs In Excess Of Cost Limit Or 112 Percent Of Mean Cost
' 2534.5A	-	Low Occupancy
' 2534.5B	-	Uniform National Peer Group Comparison
' 2534.10	-	Atypical Services or Items
' 2534.10 A5	-	Atypical Direct Cost

4. Other Sources:

Chart of Account for Hospitals, by L. Vaun Seawell, Published by the Healthcare Financial Management Association

5. Cases:

Southfield Rehabilitation Center (Detroit, Mich.) v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, HCFA Adminstration Decision 95-D52, October 30, 1995 Medicare & Medicaid Guide ("CCH") &43,722.

St. Francis Health Care Center v. Shalala Case No. 3:97 (N.D. Ohio).

Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D67, September 2, 1999, Medicare & Medicaid Guide (CCH) & 80,311.

North Coast Rehabilitation Center v. Blue Cross and Blus Shield Association, PRRB Dec. No. 99-D-22, February 18, 1999, Medicaare & Medicaid Guide (CCH) & 80,158, modif=d HCFA Administrator, April 15, 1999, Medicare & Medicaid Guide (CCH) & 80,195.

Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Dec. No. No. 99-D61, August 20 1999, Medicare & Medicaid Guide (CCH) & 80,320.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties= contentions and evidence finds and concludes as follows. Regarding issue number 1 - direct versus indirect costs - - the Board finds that HCFA Pub. 15-1 ' 2534.5B applies to the Provider=s factual situation. That section provides HCFA=s methodology for the uniform national peer group comparison. The Board finds this calculation acceptable and in conformity with Medicare law and regulations. The Board further finds that the Provider=s argument for HCFA/Intermediary to apply the second step in the Kenton letter compelling. However, the Board finds no evidence in the record that explains how the peer group study should have been adjusted. Further, there is no attempted calculation of such adjustment to the peer group comparison. Thus, the Board concludes that an adjustment to the peer group=s costs is inappropriate in light of the lack of evidence to support the reclassification of the peer group. In summary, the Board concludes that HCFA=s program instruction for peer group comparison is appropriate and adequate. Further, any adjustment to the peer group calculation must be supported by relevant evidence.

Regarding issue number two--application of the low occupancy adjustment--the Board finds that HCFA Pub. 15-1 ' 2534.5A applies to this situation. That section established an appropriate level of occupancy (75%) and requires an adjustment to Afixed@ cost where a provider=s occupancy falls below

that level. The section further states that costs are deemed to be fixed unless proven otherwise. The Board finds that the Provider did not meet the required proof that its costs were variable and not fixed. Nothing in the record supports which costs are variable and how those costs were calculated. The Board notes that the Provider made an alternative calculation of costs. However, that calculation was not supported by Program Instructions.

Regarding issue number three--the use of the 112% of the peer group mean to measure atypical services costs - - the Board majority finds that pursuant to DEFRA 1984, the Secretary was given broad discretion in authoring adjustments to the RCLs. The Board majority finds that Section (c) of the statute gives HCFA great flexibility in setting limits stating as follows:

> [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.

42 U.S.C. ' 1395yy(c).

Consistent with the foregoing statute and the reasonable cost provisions of 42 U.S.C ' 1395x(v)(1)(A), the regulations at 42 C.F.R. ' 413.30 et seq. provide for an adjustment to the cost limits where a provider furnishes atypical services as compared to the items or services furnished by similarly classified providers. The regulation at 42 C.F.R. ' 413.30(f) provides for exceptions to the RCLs to the extent that costs are reasonable, attributable to the circumstances specified, separately identified and verifiable. The Board majority finds that the regulation affords HCFA a two prong test in which it can compare costs and types of services. Accordingly, the policy set forth in the regulations requires an examination of both the reasonableness of the amount that a provider=s actual cost exceeds the applicable cost limit, and the determination of the atypicality of the costs by using a peer group comparison.

The peer group developed by HCFA for evaluating exceptions to the RCLs for HB-SNFs is set at 112 percent of the mean hospital-based inpatient routine service costs, and not at the HB-SNF=s cost limit. HCFA compares the HB-SNF=s costs to those of the typical facility to determine the amount of its costs that are atypical. Under this methodology, if a HB-SNF can establish that its costs are reasonable and atypical in relation to its peer group, the provider is given an opportunity to demonstrate that its atypical costs are related to the special needs of its patients. Although this peer group criterion for exception eligibility exceeds the RCLs established for HB-SNFs, the Board majority believes the 112 percent peer group level is a practical standard for measuring the atypical nature of a provider=s services. Further, it is the same level used to determine the amount of exceptions for freestanding

SNFs, and is a standard based entirely upon HB-SNF data as opposed to the HB-SNF cost limit which is heavily based upon freestanding SNF data.

The majority of the Board further notes that HCFA=s methodology of using the standard of 112 percent of the HB-SNF peer group mean when reviewing exception requests is clearly set forth in a subsequent publication of HCFA Pub. 15-1 ' 2534.5, as adopted in Transmittal 378 (July 1994). This transmittal explained that new manual sections were being issued to provide detailed instructions for SNFs to help them prepare and submit requests for exceptions to the inpatient routine service cost limits. Based on its analysis of the statute, regulations and program instructions, the Board majority concludes that it was reasonable for HCFA to use the 112 percent peer group level as the standard for reviewing exception requests for HB-SNFs.

Finally, the Board majority acknowledges the Provider=s reliance upon the previous Board=s decision in St. Francis to help support its position and arguments. The majority of this Board notes that its findings are consistent with the Ohio district court=s ruling which upheld the HCFA Administrator=s reversal of the Board=s decision in St. Francis, and subsequent decisions rendered by a majority of the Board in the following cases:

- North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D-22, February 18, 1999, Medicare & Medicaid Guide (CCH) & 80,158, modif=d HCFA Administrator, April 15, 1999, Medicare & Medicaid Guide (CCH) & 80,195.

- Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D61, August 20, 1999, Medicare & Medicaid Guide (CCH) & 80,320.

- Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D67, September 2, 1999, Medicare & Medicaid Guide (CCH) & 80,311.

DECISION AND ORDER:

Issue No.1-- Direct v. Indirect Costs (Uniform National Peer Group Comparison)

HCFA Pub. 15-1 ' 2534.5B properly applies to the Provider=s factual situation. The Intermediary properly reclassified various overhead costs as indirect costs. The Intermediary=s adjustment is affirmed.

Issue No. 2--Application of Low Occupancy Adjustment

HCFA Pub.15-1 ' 2534.5A properly applies to the Provider=s factual situation. The Provider has not proven that it HB-SNF costs were variable. The Intermediary=s adjustment is affirmed.

Issue No. 3 -- Use of 112 of the Peer Group Mean to Measure Atypical Services Costs

The use of the 112% of the peer group mean meets Medicare=s statutory and regulatory requirements. The Intermediary=s adjustments are affirmed.

Board Members Participating

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire (Dissenting - Issue No. 3)
Charles R. Barker
Stanley J. Sokolove

Date of Decision: September 21, 2000

FOR THE BOARD

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover Jr.

I respectfully dissent to Issue #3:

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 CFR ' 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 finds that section c of the statute gives HCFA great flexibility in setting 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 Aatypical costs@ with the concept of Athe 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 AHCFA may establish limits on provider costs recognized as reasonable in determining program payments. . . . Id. The regulation goes on to state that AHCFA 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