PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2002-D50

PROVIDER –
Providence Hospital-Centralia SNF
Centralia, Washington

Provider No. 50-5025

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
Premera Blue Cross

DATE OF HEARING -
September 5, 2002

Cost Reporting Period Ended
December 31, 1991

CASE NO. 96-1033

INDEX

ISSUE:

Was the decision of the Health Care Financing Administration ("HCFA"), pursuant to its Provider Reimbursement Manual ("PRM") § 2534.5, to refuse to grant an exception for that portion of the Provider's per diem costs which exceed the Routine Cost Limit, but which do not exceed 112% of the total peer group mean cost, arbitrary, capricious, an abuse of discretion or not in accordance with law?

REIMBURSEMENT AT ISSUE: $46,044 (total costs of $12.44/day in excess of the revised routine cost limit for 3,701 days)

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Providence Hospital (Provider) is a voluntary non-profit, church-related, general-short term hospital located in Centralia, Washington. The 41-bed hospital-based SNF was certified on Jan. 1, 1967. Average occupancy for the fiscal year in question was 88.9%, with 27.8% Medicare utilization.

Provider filed its cost report for the year ended Dec. 31, 1991 in a timely manner. The Intermediary ("Blue Cross") issued a Notice of Program Reimbursement ("NPR") on Aug. 31, 1994, and a revised NPR was issued on Nov. 13, 1996. Provider filed a Skilled Nursing Facility ("SNF") exception request with the Intermediary on Feb. 24, 1995[1] and requested an exception for full relief from the effective SNF Routine Cost Limit in the amount of $9.38/day for 3,701 Medicare SNF patient days (total of $34,716 requested). This amount was subsequently changed to incorporate revised RCLs, and total costs in excess of the revised limit were changed to $46,044 or $12.44/day.

The Intermediary declares that there is no adjustment in dispute and that it is unable to determine the reimbursement effect of the Provider's appeal of this issue. The Intermediary and HCFA contend that no exception relief should be granted the Provider because the hospital-based SNF's per diem costs of $133.32 did not exceed the peer group per diem mean cost of $152.79[2]. HCFA denied Provider's request on Aug. 9, 1995[3], and Provider appealed the denial and requested a hearing before the Provider Reimbursement Review Board ("Board") on Jan. 31, 1996.

PROVIDER'S CONTENTIONS:

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, is arbitrary, capricious and not in accordance with law.

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[1] Provider Exhibit P-1
[2] Intermediary Exhibit I-2
[3] Provider Exhibit P-3

Both the peer group mean and 112% of the peer group mean exceed the Routine Cost Limit. Denial of an exception request on the basis of applying the principle that the exception be measured from 112% of the peer group mean cost rather than from the Routine Cost Limit is wholly in conflict with the applicable law.

In Blue Cross' exception calculations following HCFA's instructions, Providence's per diem cost was determined to be $133.32 per day. Blue Cross did not recommend approval of the exception request because Providence's costs did not exceed 112% of the peer group mean of $152.79. By its refusal to allow an exception request for the amount between the RCL of $120.88 per day and the per diem cost of $133.32 solely because that part of the actual cost did not exceed 112% of the peer group mean of $152.79, HCFA created a reimbursement "gap" of efficiently incurred and reasonable costs that qualify for allowance as an exception request but for which HCFA will not pay.

Providence claims this reimbursement "gap" is not in accordance with either the statutes or the regulations concerning reimbursement of exception requests, and that it is entitled to full compensation if it makes an adequate showing under one or more of the provisions established by the Secretary setting forth the criteria of an exception request to an RCL.

Reasonable cost is defined as only those costs "actually incurred, excluding therefrom any part of incurred cost[s] found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. §1395x(v)(1)(A). The reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services." Id. (emphasis added). The Secretary is authorized to establish appropriate cost limits as part of her method of determining reasonable costs. Id. See Good Samaritan Hospital v. Shalala, 508 U.S. 402, 124 L.Ed. 368 (1993).

In a statement that "reasonable cost" means the full cost that is actually incurred, the statute prohibits Medicare and other payers from "cross-subsidizing" each other, stating that "[s]uch regulations shall (i) take into account both direct and indirect costs of providers of services…in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs." 42 U.S.C. §1395x(v)(1)(A)(i) (emphasis added) and 42 C.F.R. §413.50.

Section 1395yy(a), Title 42, United States Code, establishes the definition of the Routine Cost Limit applicable to Providence in this appeal. "Dual limits" are established for freestanding SNFs and for hospital-based SNFs. The RCL for freestanding SNFs is set at "112 per cent of the mean per diem routine service cost for freestanding skilled nursing facilities," while the RCL for hospital-based SNFs is set at "the limit for freestanding skilled nursing facilities…plus 50 percent of the amount by which 112 percent of the mean per diem routine service cost for hospital-based skilled nursing facilities…exceeds

the limit for freestanding skilled nursing facilities." 42 U.S.C. §1395yy. This section does not qualify the prohibition against cross-subsidization contained in §1395x(v)(1)(A)(i), nor does it prohibit hospital-based SNFs from obtaining full reimbursement of reasonable costs.

The Routine Cost Limit sets only a presumptive, and not a conclusive, limitation on the reimbursement that a provider may receive for its reasonable costs. The regulations permit various exceptions, exemptions, and adjustments to the limit. 42 C.F.R. §413.30(f). Section 413.30, Title 42, Code of Federal Regulations "sets forth rules governing exemptions, exceptions, and adjustments to limits established under this section that HCFA may make as appropriate in consideration of special needs or situations of particular providers." Indeed, the Supreme Court has in part relied on the existence of these exceptions, exemptions, and adjustments in limiting a provider's right to contest the Secretary's method of cost reimbursement:

> The agency's development – and continued augmentation – of a list of situations in which the cost limits would be waived is difficult to harmonize with an interpretation of clause (ii) that would give a provider the right to contest the application of any particular and statutorily authorized method to its own circumstances. Rather, it is consistent with a view that the cost limits by definition entailed generalizations that would benefit some providers while harming others, and with a desire to refine these approximations through the Secretary's creation of exceptions and exemptions.

Good Samaritan, 124 L.Ed. at 382. The Supreme Court further recited a comment in the Committee Reports "explaining that the cost limits were merely ´presumptive` and that ´[p]roviders would, of course, have the right to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.`" Id. at 379, n.10. The Court noted that the Secretary argued in Good Samaritan that "it is entirely possible that by providing for exceptions, exemptions, and reclassifications, the agency satisfied this demand." Id.

HCFA has acknowledged the presumptive nature of the Routine "Cost Limits" for SNFs as recently as July, 1994 in the PRM, §2530, where it states: "The limits are a presumptive estimate of reasonable costs…" (emphasis added).

> Not only are the Routine Cost Limits merely a presumptive limitation on reimbursement, they also contemplate the right of a provider to receive full compensation for its reasonable costs incurred if the provider qualifies within one of the exceptions established by the Secretary. For example, in the Senate Finance Committee print pertaining to the Senate Bill that became §1395yy, Title 42, U.S.C., it is stated that providers, where justified, should be able to receive "up to all of their reasonable costs" through the exception process:

"Under this provision, both hospital-based and freestanding facilities could continue to apply for and receive exceptions from the cost limits in circumstances where high costs result from more severe than average case mix or circumstances beyond the control of the facility….Facilities eligible for exceptions could receive, where justified, up to all of their reasonable costs."

Finance Committee of the 98th Congress of the United States Senate, Senate Print 98-169, Vol. 1 at 947.

That "Facilities eligible for exceptions could receive, where justified, up to all of their reasonable costs," is important because the statute it references (§1395yy(a), Title 42, U.S.C.) set the Routine Cost Limits for hospital-based SNFs somewhat below the mean, while the RCLs applicable to freestanding SNFs were set significantly above the mean for the peer group of such facilities. Prior to the enactment of this statute, the Routine Cost Limits applicable to hospital-based SNFs were set at 112% of the mean for the peer group consisting only of hospital-based SNFs.

Congress' reduction, in §1395yy(a), of the RCL applicable to hospital-based SNFs reflected an uncertainty concerning the justification for the significantly higher average costs experienced by hospital-based SNFs. Nevertheless, the exception request process, with the possibility to recover all costs, was retained, and highlighted, as a necessary "safety valve" to protect hospital-based SNFs whose costs were higher due to reasons, such as atypical services, that are justified. The 1986 amendment to §1395yy instructed the Secretary to publish on an annual basis "the data and criteria to be used for purposes" of making adjustments to the RCLs as applied to individual SNFs. 42 U.S.C. §1395yy(c). However, the Secretary has never published such "data and criteria."

The mere fact that Congress saw fit to set the Routine Cost Limits for hospital-based SNFs below 112% of the mean per diem routine service costs for hospital-based SNFs does not give HCFA the authority to arbitrarily raise, to a level above this legislatively set cost limit, the point from which an exception will be measured, thereby making it impossible for a provider to obtain full relief. Congress actually changed the calculation of the Routine Cost Limit from 112% of the mean routine service costs for the peer group consisting only of hospital-based SNFs to a Routine Cost Limit that for hospital-based SNFs was somewhat below the mean of the peer group. However, even if this is the case, an exception request would be from the RCL, not from 112% of the peer group mean.

This distinction between Congress' authority to set an arbitrary cost limit and HCFA's responsibility to follow the requirements of the Administrative Procedure Act in implementing the direction of Congress that exception requests to such limits be granted was recognized in University of Cincinnati, d/b/a University Hospital v. Shalala, U.S. District Court for the Southern District of Ohio, Western Division, C-1-93-841, Nov. 8, 1994, ¶42,976, CCH Medicare and Medicaid Guide. In that case, HCFA argued it could use an arbitrary number as the benefits-to-salary fringe benefits average for the purpose of determining the amount of an exception request for a hospital seeking an atypical services exception to the composite rate for end-stage renal disease services. HCFA

defended the use of such an arbitrary number by arguing that the 18.7 ratio was part of the composite rate that Congress had ordered frozen. The court responded:

> While Congress might have frozen the bottom-line composite rate number, it did not disturb HCFA's obligation to make composite rate exceptions, as described by 42 U.S.C. § 1395rr(b)(7), in accordance with 5 U.S.C. § 706 [The Administrative Procedure Act]. That is, Congress may have ordered HCFA to uniformly apply a certain composite rate, even though the components of such composite rate might now be out-of-line with reality, but that does not give HCFA the right to justify using out-of-line-with-reality component numbers to make exception determinations.

HCFA's conclusion that the maximum amount available for an exception is the amount by which actual costs exceed 112% of the peer group mean, rather than the amount by which actual costs exceed the Routine Cost Limit, is an unlawful attempt to repeal this statutory safety valve. For if costs, otherwise proven to be reasonable, are still not reimbursed because of HCFA's "gap," then the cross-subsidization expressly prohibited by 42 U.S.C. §1395x(v)(1)(A)(i) will occur and the opportunity for full compensation contemplated by 42 U.S.C. §1395yy will be frustrated.

The reimbursement "gap" created by HCFA is wholly inconsistent with HCFA's regulations. Section 413.30, Title 42, CFR sets forth rules governing exceptions and adjustments to limits that HCFA may make as appropriate in consideration of special needs or situations of particular providers. Section 413.30(f) shows that an exception is an adjustment to a Routine Cost Limit, not from some higher undisclosed and unpublished adjustment to some higher threshold concocted by HCFA:

> **(f)** *Exceptions.* **Limits** established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8)….An 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. (emphasis added).

Section 413.30(f)(1)(i), Title 42, C.F.R., addressing an exception for atypical services, specifically identifies one of these "circumstances" as the provider showing that the "[a]ctual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope…." (emphasis added). This regulation specifically states that the provider must show that its cost only "exceeds the applicable limit," not that it exceeds 112% of the peer group mean.

The regulations thus recite that "exceptions" are made to "limits," and that "limits…may be adjusted." The plain meaning of this language demonstrates that the Routine Cost Limits are only presumptive, and not conclusive, limitations on reimbursement and that a hospital-based SNF may prove entitlement to full compensation under an exception request.

HCFA's action in adopting the "GAP" methodology was arbitrary, capricious, an abuse of discretion and not in accordance with law.

Pursuant to 42 U.S.C. §1395oo(f)(1), HCFA's adopting its methodology of quantifying the amount of an atypical services exception for a hospital-based SNF from 112% of the peer group mean is governed by the provisions of the Administrative Procedure Act, 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 judgment for that of the agency." Motor Veh. Mfrs. Assn. V. State Farm Mut. ["State Farm"], 463 U.S. 29, 43, 77L. Ed. 2d 443, 457-458 (1983).

> Nevertheless, the agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.' Burlington Truck Lines, Inc., v. United States, 371 U.S. 156, 168, 9 L. Ed. 2d 207, 83 S. Ct. 239 (1962). In reviewing that explanation, we must 'consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.' Bowman Transportation, Inc. v. Arkansas-Best Freight System, Inc. [419 U.S. 281] at 285, 42 L. Ed. 2d 447, 95 S. Ct. 438; Citizens to Preserve Overton Park v. Volpe, [401 U.S. 402] at 416, 28 L. Ed. 2d 136, 91 S. Ct. 814. Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id., 463 U.S. at 43, 77 L. Ed. 2d at 458.

In this case, HCFA's methodology is a departure from its earlier method of determining hospital-based SNF exception requests and requires an explanation for its change 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 change of direction." National Black Media Coalition v. FCC, 775 F.2d 342, 355 (D.C. Cir. 1985). Under the methodology in effect before the implementation of HCFA's PRM Chapter 25 methodology, the amount of the exception granted was not artificially discounted by a "gap" which makes it impossible for a hospital-based SNF to recover a significant portion of its cost of providing atypical services. The new PRM Chapter 25 methodology drastically reduces the amount of an exception that a hospital-based SNF can obtain for providing atypical services from $30 to $ 60 per patient day.

HCFA premises its methodology of measuring the amount of an exception for a hospital-based SNF from the peer group mean instead of from the Routine Cost Limit on the fact that in the Deficit Reduction Act of 1984 ["DEFRA '84"] Congress chose to create new

dual routine cost limits which set cost limits for freestanding SNFs at 112% of the freestanding SNF peer group mean and lowered the former cost limits for hospital-based SNFs by moving them down from 112% of the hospital-based SNF peer group mean to 50% of the difference between 112% of the freestanding SNF peer group mean and 112% of the hospital-based SNF peer group mean. 42 U.S.C. §1395yy.

Two letters from HCFA[4] explain that HCFA chose to measure the exception amount of a hospital-based SNF from 112% of the peer group mean instead of from the Routine Cost Limit because of this lowered hospital-based SNF Routine Cost Limit created by DEFRA '84. The HCFA responses each state:

> For hospital-based SNFs, section 1888 of the Act and related legislative documentation, and the studies which identified legitimate cost differences in setting hospital-based cost limits, described above, guided the policy not to deem the remaining cost differences, that is, those costs between the hospital-based cost limit and 112% of the hospital-based peer group mean costs, as reasonable costs. **In order to give meaning to Congress' explicit intention that 50% of the cost differences between hospital-based and freestanding SNFs not be reimbursed, we remove these costs from the SNF's costs in excess of the limit before advancing in the exception process.**

By "removing these costs from the hospital-based SNFs' costs in excess of the limit before advancing in the exception process" HCFA created a permanent "gap" of costs that would be impossible for a hospital-based SNF to ever recover.

HCFA made the policy decision to create a nonreimbursable "gap" in the hospital-based 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 are false, have no basis in fact or logic, and, as explained in the following, the policy decision to adopt a methodology based upon these conclusions must be held to be arbitrary, capricious, an abuse of discretion and not in accordance with law.

This same explanation for HCFA's policy decision to create such a "gap" in the hospital-based SNF exception methodology is also articulated in HCFA's Administrator Decision in St. Francis Health Care Center v. Community Mutual Insurance Company ["St. Francis"], May 30, 1997, ¶45,545, CCH Medicare and Medicaid Guide[5]. 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,[6] HCFA properly determined, in developing

[4]Provider Exhibits P-6 and P-7
[5] Provider Exhibit P-10
[6] Provider Exhibit P-27

the exception process, that 50% of the difference between the FS-SNF and the HB-SNFs cost limits, i.e., the "gap," was due to HB-SNFs' inefficiencies. As such costs are not reasonable, HCFA properly determined that these costs could not be reimbursed pursuant to the exception process.

HCFA failed to consider, and offered an explanation that is directly counter to, the only direct evidence of the intent of Congress on the issue.

HCFA's policy decision was based on its reading of the enabling statute (42 U.S.C. §1395yy), related legislative documentation, studies which identified legitimate cost differences in setting hospital-based cost limits[7] and its "Report to Congress." But HCFA missed or ignored the legislative history that speaks directly to the intent of Congress on the precise issue before the Board, failed to consider an important aspect of the problem, and offered an explanation for its decision that runs counter to the evidence before the agency. In doing so, HCFA exemplified 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 PRM Chapter 25 methodology of quantifying the amount of a hospital-based 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 hospital-based 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.

In the Deficit Reduction Act of 1984, Explanation Of Provisions Approved By The Committee on March 21, 1984, Committee On Finance United States Senate, Senate Print 98-169, volume I, pages 947-948[8], it is unequivocally shown that it was the intent of Congress to treat hospital-based SNFs that provide atypical services much differently than is the result of HCFA's errant methodology. This Senate print states in relevant part:

> Under this provision, both hospital-based and freestanding facilities could continue to apply for and receive exceptions from the cost limits in circumstances where high costs result from more severe than average case mix or circumstances beyond the control of the facility. Indicators of more severe case mix include a comparatively high proportion of Medicare days to total patient days, comparatively high ancillary costs, or relatively low average length of stay of all patients (an indicator of the rehabilitative orientation of the facility). **Facilities eligible for exceptions could receive, where justified, up to all of their reasonable costs.** (emphasis added).

[7] Provider Exhibits P-6 and P-7
[8] Provider Exhibit P-9

HCFA's PRM Chapter 25 methodology of automatically measuring the amount of the exception of a hospital-based SNF which has qualified for an atypical services exception from 112% of the peer group mean, instead of from the Routine Cost Limit, makes it impossible for any hospital-based SNF furnishing atypical services to ever obtain all of its reasonable costs.

HCFA understood that for typical routine services, Congress intended to reimburse hospital-based SNFs at a higher level than freestanding SNFs, because in providing typical services, hospital-based SNFs generally treat sicker patients.

While hospital-based SNFs providing only typical services in general treat sicker patients than freestanding SNFs, hospital-based SNFs providing atypical services treat even sicker patients than hospital-based SNFs providing only typical services.

The fact that Congress set a higher Routine Cost Limit for hospital-based SNFs providing only typical services in order to compensate them for the additional cost of treating sicker patients (which is the conclusion HCFA has drawn for the DEFRA '84 dual limits) would lead to the similar and parallel conclusion that those hospital-based SNFs which provide atypical services because they treat even sicker patients than the hospital-based SNFs which provide only typical services should also receive compensation for the cost of treating these sickest of patients.

However, instead of following this logic, HCFA created a reimbursement "gap" which penalizes all hospital-based SNFs which treat the sickest patients by making it impossible for them to receive full compensation for the cost of providing atypical services in relation to hospital-based SNFs which provide only typical services.

HCFA claims that its methodology gives meaning to Congress' explicit intention that 50% of the cost differences between hospital-based and freestanding SNFs not be reimbursed.[9] However, Senate Print 98-169[10] shows that this intent of Congress applied only to hospital-based SNFs providing only typical services, and not to that minority of hospital-based SNFs which provide atypical services.

HCFA's PRM Chapter 25 methodology of quantifying the amount of an atypical services exception from 112% of the peer group mean results in treating the costs of atypical services more severely than the costs of typical services. Hospital-based SNFs providing only typical services are presumed to have reasonable costs "up to" the RCL and are fully reimbursed up to that limit. In contrast, a hospital-based SNF providing typical services at the RCL and atypical services at below 112% of the peer group mean receives no compensation for its costs of providing atypical services. A hospital-based 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 costs of providing atypical services. HCFA's methodology of quantifying the amount of an atypical services exception from 112% of the peer group mean leads to the assumption

[9] Provider Exhibits P-6 and P-7
[10] Provider Exhibit P-9, pages 020-021

that a hospital-based SNF's costs above the RCL are unreasonable, but then become reasonable again above the higher level of 112% of the peer group mean.

HCFA has taken a conclusion regarding the intent of Congress toward reimbursing the routine costs of hospital-based SNFs which provide only typical services and illogically applied that same rationale to hospital-based SNFs which provide atypical services.

HCFA's methodology impermissibly discriminates between freestanding and hospital-based SNFs in the exception process and goes beyond the discretionary authority that Congress delegated to the Secretary of Health and Human Services. Freestanding SNFs measure their exceptions from their Routine Cost Limit, while hospital-based SNFs must measure their exceptions from 112% of the peer group mean, creating the "gap" between their RCL and their 112% peer group mean. As a result of this differential treatment, freestanding SNFs can recover "up to all of their reasonable costs," while hospital-based SNFs cannot.

The statute giving HCFA the authority to develop and apply an exception procedure nowhere gives HCFA the authority to practice such discrimination between freestanding and hospital-based SNFs, nor does it articulate any express intent of Congress to discriminate between freestanding SNFs and hospital-based SNFs in the exception process. 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 subsection on an annual basis.

42 U.S.C. § 1395yy(c)

Although the statute grants the Secretary broad discretion as to whether or not to make an adjustment in the limits, and as to the appropriate extent of the adjustments made, it nowhere permits the secretary to discriminate against hospital-based SNFs by adopting a methodology allowing freestanding SNFs furnishing atypical services to obtain up to all of their reasonable costs, but denying the same opportunity to hospital-based SNFs which also provide atypical services. HCFA's drawing such a conclusion from this statute is clearly arbitrary, capricious, an abuse of discretion and not in accordance with law.

HCFA's decision to also illogically penalize those hospital-based SNFs which treat the sickest patients after Congress took care to compensate hospital-based SNFs for their higher cost of providing atypical services to sicker patients also runs counter to the evidence before the agency.

By ignoring evidence of the intent of Congress, HCFA mistakenly or knowingly relied on factors which Congress clearly had not intended HCFA to consider. In addition, HCFA's adoption of the "gap" methodology "is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." (another State Farm factor).

The Ohio District Court in St. Francis Health Care Center v. Shalala [also "St. Francis"], case No. 3:97 CV7559, Northern District of Ohio, Western Division, CCH Medicare and Medicaid Guide, ¶300,026, 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 Ohio District Court also demonstrated confusion about the distinction between typical and atypical services. For example, the court addressed the HCFA studies which HCFA claimed were the basis for the two-tier cost limits contained in 42 U.S.C. § 1395yy(a) and concluded that "[a]lthough the legislative history does not make it express, [the studies'conclusion that half the higher costs of hospital-based SNFs were due to higher acuity patients and the other half to inefficiencies] it appears to be the reason Congress enacted systematic under-reimbursement rates for routine costs incurred by [hospital-based] SNFs." (emphasis added).

This statement misses the point, for the "under-reimbursement" in the Routine Cost Limits only addressed the costs of hospital-based SNFs that furnished typical (and not atypical) services. Even then, hospital-based SNFs that could not establish that they furnished atypical services still received greater reimbursement than their freestanding SNF counterparts, because of recognition that even at the typical service level hospital-based SNFs generally treated higher acuity patients. However, the legislated "under-reimbursement" for hospital-based SNFs furnishing only typical services contained in subsection (a) of 42 U.S.C. § 1395yy was not extended to hospital-based SNFs furnishing atypical services. Subsection (c) of §1395yy empowered the Secretary to make "adjustments in the limits" "based upon case mix." However, far from intending to extend "under-reimbursement" to the exception process, the intent of Congress was that both freestanding and hospital-based SNFs should be able to receive "up to all of their reasonable costs" incurred in providing atypical services.[11]

The provisions of PRM §2534.5 that require an exception for a hospital-based SNF to be measured from 112% of the peer group mean rather than from the routine cost limit are invalid because they have not been adopted pursuant to notice and comment rulemaking as required by the Administrative Procedure Act (APA) and/or have not been adopted as a regulation.

The APA, Sections 500-576, Title 5, United States Code, require that when a policy acts as a substantive rule and alters an existing regulatory scheme, the Secretary must adopt that policy according to procedures set forth in the APA ("notice and comment

[11] Provider Exhibit P-9, pages 020-021

rulemaking" procedures). Mt. Diablo Hosp. Dist. v. Bowen, 860 F.2d 951, 956 (9th Cir., 1988).

It is undisputed that PRM §2534.5 is not a regulation and was not adopted pursuant to notice and comment rulemaking procedures. The issue in this case is whether PRM §2534.5 is an "interpretive" rule, and thus exempt from notice and comment rulemaking procedures, or whether it is a "substantive" rule, and subject to the requirements of §553. An interpretive rule clarifies or explains existing law, while a substantive rule effects a change in existing law or policy.

PRM §2534.5 is clearly a substantive rule because it effects a change in existing law and policy articulated in applicable regulations and statutes, and it carves out an exception to HCFA's pre-existing practice and methodology for measuring the amount of an exception request for a hospital-based SNF.

PRM §2534 is inconsistent with the plain language of the regulation governing exception requests for atypical services. CFR 42 §413.30(f) states that for exceptions generally, "[limits] established under this section may be adjusted upward for a provider" (emphasis added) if certain enumerated circumstances are met; no mention is made of making an adjustment from some higher number concocted by HCFA. To receive an exception for atypical services a provider must show that the actual cost of items or services furnished by the provider exceeds the applicable limit because such items or services are atypical in nature and scope. The controlling regulation specifically states that the provider must show that its cost only "exceeds the applicable limit," and not that it exceeds 112% of the peer group mean.

PRM §2534.5 is also inconsistent with numerous statutes governing the Medicare program. It is inconsistent with the legislative intent behind 42 U.S.C. §1395yy, which established "dual" routine cost limits for freestanding and hospital-based SNFs. In doing so, it contemplated the opportunity for both freestanding and hospital-based SNFs to apply for and receive "up to all of their reasonable costs." Section 1395yy only set the formula for determining the cost limit; it did not change the method to be used to determine exceptions to the cost limit nor provide HCFA with any legal authorization to adjust its pre-existing policies or regulations. Congressional imposition of a rate that is out of line with economic reality (in that case concerning the composite rate for end-stage renal disease services) "does not give HCFA the right to justify using out-of-line-with-reality component numbers to make exception determinations." University of Cincinnati, d/b/a University Hospital v. Shalala, U.S. District Court for the Southern District of Ohio, Western Division, C-1-93-841, Nov. 8, 1994, ¶42,976, at footnote 6, CCH Medicare and Medicaid Guide.

PRM § 2534.5 is also inconsistent with the anti cross-subsidization principle contained in §1395x(v)(1)(A)(i), Title 42, United States Code, which states that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance

programs." Both reimbursement of reasonable costs and avoidance of cross-subsidization are self-evident purposes of an atypical services exception. An atypical services exception allows a provider to be reimbursed its full costs for providing Medicare services, whereas failure of the provider to be reimbursed its full costs for providing Medicare services would result in subsidization of Medicare by private-pay patients and those covered by other payors.

PRM §2534.5 continues HCFA's long-standing policy in this regard as it affects freestanding SNFs by measuring an exception from the "applicable limit." This disparate treatment given freestanding and hospital-based SNFs by §2534.5 was not found in the policy of HCFA until the adoption of this section.

Because PRM §2534.5 carves out a per se exception to the exception methodology contained in the applicable regulation and in the unwritten policy of HCFA before its adoption, it "effect[ed] a change in existing law or policy" and is substantive in nature. Linoz v. Heckler, 800 F.2d 871, 877 (9th Cir. 1986).

PRM §2534.5 must also be held to be invalid because it violates 42. U.S.C. §1395hh(a)(2), which states:

> No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1). (emphasis added).

Section 2534.5 of the PRM is invalid, as is the policy stated therein, because it establishes and changes a substantive legal standard governing the payment for services. The Board has already correctly decided that an exception should be measured from the routine cost limit instead of from 112% of the peer group mean, and the board should repeat this analysis in this case.

In March, 1997, the Board issued a decision that required the measurement of hospital-based SNF exceptions from the amount by which a facility's costs exceed the routine cost limit rather than from 112% of the peer group mean. St. Francis Health Care Centre (sic) v. Community Mutual Insurance Company [also "St. Francis"], PRRB Hearing Dec. No. 97-D38, Case Nos. 95-0586 and 95-0587 (Mar. 24, 1997), CCH Medicare and Medicaid Guide ¶45,159.[12]

> In the case where a H[ospital] B[ased]-SNF qualifies for an exception, it is reimbursed only for the amount that its costs exceed the 112 percent level. The provider is not reimbursed for the amount that its costs exceed the cost limit up to the 112 percent level because this portion of costs, the

[12] Provider Exhibit P-10

> gap, is considered unreasonable. The Board disagrees with the concept that costs are considered unreasonable once they exceed the cost limit but become reasonable again once they exceed the even greater 112 percent level.

Id., at 53,323. The Board also determined that "[i]f an exception is granted, the provider is to be paid each and every dollar that its costs exceed the limit." Id., at p. 53,321.

On May 30, 1997 the HCFA Administrator reversed the decision of the Board and concluded that the Intermediary had properly denied the provider's requests for an exception to the reasonable cost limits. St. Francis Health Care Center v. Community Mutual Insurance Company, HCFA Administrator Decision, May 30, 1997.[13]

The Administrator argues that PRM §2534.5 reflects no change in HCFA policy and is therefore not void for HCFA's failure to comply with notice and comment rulemaking under the APA. However, HCFA's application of PRM § 2534.5 is inconsistent with existing law in the following ways:

1. PRM § 2534.5 is inconsistent with the plain language of the governing regulation 42 C.F.R. § 413.30(f), which states that "limits….may be adjusted upward." Section 413.30(f)(1)(i) states that an atypical services exception is proven when a provider shows that atypical items and services cause costs to "exceed [] the applicable limit;"

2. PRM § 2534.5B is inconsistent with the routine cost limit and exception mechanism established by the governing statute 42 U.S.C. § 1395yy under which providers are given the opportunity to obtain full relief by proving an exception; and

3. PRM § 2534.5 is inconsistent with the anti cross-subsidization principle contained in 42 U.S.C. § 1395x(v)(1)(A)(i).

Legally, there are numerous problems with the HCFA Administrator's decision, and the Administrator's conclusion runs counter to:

1. The clearly stated legislative intent that through the exception process hospital-based SNFs could receive up to all of their reasonable costs;

2. HCFA's own acknowledgment in § 2530 of the PRM, and other authority supporting this same conclusion, that the Routine Cost Limit is a presumptive estimate of reasonable costs.

3. At least one existing case directly on point by analogy that Congress' act in setting an arbitrary cost limit does not give HCFA authority to arbitrarily measure the amount of an exception request. University of Cincinnati, d/b/a

[13] Provider Exhibit P-11

> University Hospital v. Shalala, U.S. District Court for the Southern District of Ohio, Western Division, C-1-93-841, Nov. 8, 1994, ¶42,976, CCH Medicare and Medicaid Guide.

HCFA Administrator decisions are not binding precedent:

> Decisions by the Administrator are not precedents for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy) having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.

PRM § 2927(C)(6)(e). The provider is unaware of the publication of any new regulation, HCFA ruling, or manual instruction as a result of the HCFA Administrator decision in St. Francis. The Board should **not** follow the HCFA Administrator's decision in the St. Francis case unless the Board is persuaded by the reasoning of that decision.

In reviewing the St. Francis v. Shalala decision, the Sixth Circuit split two to one in favor of HCFA's position (205 F.3d937 6th Cir. 2000). However, a material error made by the Sixth Circuit majority in deciding how much deference to give HCFA's interpretation of its regulation, and whether it's manual provision was exempt from the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"), was the majority's assumption that the controlling regulation at 42 C.F.R. § 413.30(f)(1) was promulgated pursuant to the discretion given to HCFA in the 1984 codification of 42 U.S.C. § 1395yy(c), (the "DEFRA" statute that lowered the Routine Cost Limit of hospital-based skilled nursing facilities to the mid-point between 112% of the peer group mean of free-standing skilled nursing facilities and that of hospital-based skilled nursing facilities). The fact is that 42 C.F.R. § 413.30(f)(1) predated 42 U.S.C. § 1395yy(c) by five years, that it could therefore never have been the original intent of HCFA to incorporate the reimbursement "gap" of PRM § 2534.5 into the language of the regulation, and the regulation had in fact been interpreted to **exclude** such a reimbursement "gap" for **ten years** after the codification of 42 U.S.C. § 1395yy(c).

The Board should give no deference to HCFA's claimed interpretation of 42 C.F.R. § 413.30(f)(1) because its current interpretation was not developed contemporaneously with the regulation and has not been consistently applied over time. "Deference is due when an agency has developed its interpretation contemporaneously with the regulation, when the agency has consistently applied the regulation over time, and when the agency's interpretation is the result of thorough and reasoned consideration." Sioux Valley Hospital v. Bowen, 792 f.2d 715, 719 (8th Cir. 1986).

42 U.S.C. § 413.30(f)(1) provides for the granting of exceptions from the Routine Cost Limit for SNFs which provide atypical services as therein defined. The substance of 42 C.F.R. § 413.30(f)(1) was first issued as a regulation effective July 1, 1974.[14] The precise language of 42 C.F.R. § 413.30(f)(1) was issued as an amended regulation effective July 1, 1979.[15] With no changes to its text, as "part of our overall plan for reorganization of the regulations in 42 C.F.R. Part 405 in order to make them easier to locate and use,"[16] the regulation was redesigned in 1986 as 42 C.F.R. § 413.30(f)(1), the designation by which it was identified at the time relevant to this dispute.[17]

Although 42 U.S.C. § 1395yy lowered the relative Routine Cost Limit of HB-SNFs, it did not prohibit HB-SNFs which qualified for an atypical services exception from obtaining full reimbursement of reasonable costs.

Consistent with this legislative history and with its interpretation of 42 C.F.R. § 413.30(f)(1) prior to the codification of 42 C.F.R § 1395yy, HCFA continued to measure the exceptions it awarded to HB-SNFs from the Routine Cost Limit, and not from some point above the Routine Cost Limit.

It was only in July, 1994, ten years after the codification of 42 U.S.C. § 1395yy, that HCFA issued Transmittal No. 378, which included PRM § 2534.5, which now required that the exception amount of a HB-SNF be measured from 112 percent of its peer group mean. PRM § 2534.5 is a radical departure from the previous original interpretation of 42 C.F.R. § 413.30(f)(1) which had been consistently maintained by HCFA for fifteen years. As such, HCFA's new "interpretation" of 42 C.F.R. § 413.30(f)(1) in the form of PRM § 2534.5 is owed no deference by the Board or a court.

Even if PRM § 2534.5 should be considered an "interpretive" rule, it nevertheless constitutes a significant revision of the Secretary's definitive interpretation of 42 C.F.R. § 413.30(f)(1) and is therefore invalid because it was not issued pursuant to notice and comment rulemaking.

"Once an agency gives its regulation an interpretation, it can only change that interpretation as it would formally modify the regulation itself: through the process of notice and comment rulemaking." Paralyzed Veterans of America v. D.C. area, 117 F.3d 579, 586 (D.C. Cir. 1997).

The analysis of whether PRM § 2534.5 is invalid because it was never adopted pursuant to the notice and comment rulemaking provisions of the APA is impacted by a new case from the District of Columbia Circuit (Alaska Professional Hunters Ass'n., Inc. v. Federal Aviation Admin., 177 F.3d 1030 (D.C. Cir. 1999) which holds that even though a

[14] It was originally numbered 20 C.F.R. § 405.460(f)(2). 39 Federal Register 20164 (June 6, 1974). Exhibit P-18)

[15] The regulation was now numbered 42 C.F.R. § 405.460(f)(1). 44 Federal Register 31802, at 31804 (June 1, 1979). Exhibit P-19.

[16] 51 Federal Register 34790 (September 30, 1986). Exhibit P-20.

[17] The regulation was renumbered 413.30(e)(1) effective September 7, 1999. 64 Federal Register 42610 (August 5, 1999).

rule is "interpretive," and not "substantive," it must nevertheless be adopted through notice and comment rulemaking if it significantly revises the definitive interpretation by an agency of its regulation. This new law is highly relevant to this case because for 15 years HCFA definitely interpreted 42 C.F.R. § 413.30(f)(1) to require HB-SNFs to measure the amount of an exception from their Routine Cost Limit, and not from the higher point of 112 percent of their peer group mean.

Blue Cross and HCFA do not deny that Providence provided atypical services. Although they did not address the issue of whether Providence provided atypical services in their denial, Providence believes it provided sufficient proof to support the position that it treated a patient population with an atypically high acuity.

Using HCFA's standard methodology but measuring from the revised Routine Cost Limit rather than 112% of the original peer group mean, Providence is requesting an exception for atypical direct nursing salary costs of $11.34 per day and $7.10 per day for atypical indirect costs.[18] (see Exhibit P-4).

The total per day amount of the exception request for atypical direct and indirect costs is $12.44, and the total exception amount requested is $46,044, computed as follows:

Direct atypical expenses: $11.34
Indirect atypical expenses: $7.10
Total direct and indirect atypical expenses: $18.44
Provider's per diem cost: $133.32
Provider's Routine Cost Limit: $120.88
Total atypical costs in excess of RCL: $12.44
Total allowable exception: $12.44
Total Medicare days: 3,701
Total allowable exception amount: $46,044

Provider's conclusions:

HCFA's refusal to grant an exception in the full amount requested is arbitrary, capricious, and not in accordance with law.

HCFA has created a reimbursement "gap" for hospital-based SNFs in which hospital-based SNF providers cannot receive full reimbursement of their costs regardless of the validity and strength of the provider's showing that it is entitled to full reimbursement under an exception request. This reimbursement "gap" violates the clear direction of the governing statutes and regulations that allow all SNF providers the opportunity to obtain full reasonable cost reimbursement for costs that exceed the presumptive Routine Cost Limits, is in violation of HCFA's own regulations regarding exception requests, is unreasonable and leads to an irrational result, is a violation of due process, and is invalid.

[18] Provider Exhibit P-4

PRM Chapter 25's requirement that hospital-based SNFs' exceptions to the Routine Cost Limit be measured from 112% of the peer group mean rather than from the cost limit is an attempt to change and establish a substantive rule or regulation and is invalid under the APA.

INTERMEDIARY'S CONTENTIONS:

Providence Hospital's hospital-based SNF's routine costs exceeded the applicable RCL during FYE Dec. 31, 1991.

The issue before the Board is whether HCFA's interpretation of Provider's exception request as set forth in PRM-1 Section 2534.5 is a proper interpretation of 42 CFR 413.30(f)(1). More specifically, the issue is whether it is proper for HCFA to allow the exception for atypical costs for a hospital-based SNF only to the extent that total routine costs exceed 112% of the peer group mean costs rather than to the extent that routine costs exceed the hospital-based SNF's RCL.

The Intermediary and HCFA properly made their determinations not to allow the Provider's hospital-based SNF's exception to RCL, pursuant to 42 CFR 413.30 and PRM-1, Sections 253Off, 2531ff and 2534ff.

Provider's per diem cost of $133.32 did not exceed 112% of the peer group per diem mean cost of $152.79, so an exception to the inpatient routine service cost limits is not available under these circumstances.[19] The Provider did not demonstrate with compelling or convincing evidence that the Intermediary or HCFA failed to make its determination in accordance with the referenced Program regulation and instructions.

This appeal is identical to the appeal covered by the Board's decision in St. Francis Health Care Centre (sic) v. Community Mutual Insurance Company, decision No. 97-D38,[20] and the Provider used that decision to support its argument. It should be noted, however, that the HCFA Administrator reversed the Board's decision[21] and determined that the use of the methodology set forth in PRM-1, Section 2534.5 in no way alters or revises the Medicare policy set forth in 42 CFR 413.30(f)(1). It rejected the Board's view that Section 1888 of the Social Security Act (42 U.S.C. Section 1395yy) and 42 CFR 413.30(f) entitle all SNFs to be paid the full amount by which their costs exceed the applicable RCL because of the fact that the statute allows for exceptions. The Administrator also determined that requiring hospital-based SNFs' costs to be compared to 112% of the group's mean per diem costs is an appropriate method of applying the reasonable cost requirement and is not inequitable.[22]

The U.S. District Court, Northern District of Ohio, Western Division, No. 3:97 CV 7559, June 13, 1998, St. Francis Health Care v. Shalala affirmed the Administrator's decision.

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[19] Intermediary Exhibit I-2 and I-3
[20] Intermediary Exhibit I-6
[21] Intermediary Exhibit I-7
[22] Intermediary Exhibit I-7

The Court found that PRM-1, Section 2534.5, is a proper interpretation of 42 U.S.C. Section 1395yy and 42 CFR 413.30(f). The Court also determined that, although the Program instruction creates an irrebuttable presumption that costs below the hospital-based SNFs'112% level are unreasonable, the presumption is neither arbitrary nor capricious.

Intermediary's conclusion:

The Board should uphold the referenced Program regulations and instructions and HCFA Administrator's and Courts' decisions that supported the Intermediary's and HCFA's determinations, pursuant to 42 U.S.C. Section 1395oo, 42 CFR 405.1867 and PRM-1, Section 2924.6.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law – 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable costs
§ 1395x(v)(1)(A)(i)	-	Cross-subsidization
§ 1395yy(a)	-	DEFRA '84 "Dual Limits"
§ 1395yy	-	Routine Service Costs
§ 1395hh(a)(2)	-	Exceptions to limits
§ 1395yy(c)	-	Adjustments to the RCL
§ 1395oo	-	Provider Reimbursement Review Board
§ 1395oo(f)(1)	-	Atypical services exception

Law – 5 U.S.C.:

§ 701 et seq.	-	Administrative Procedures Act
§ 701(a)(A)	-	"Arbitrary" and "capricious" standard
sections 500-576	-	APA "notice and comment rulemaking"

2. Regulations – 42 C.F.R.:

§ 405.1867	-	Sources of Board's Authority
§ 413.30(f)	-	Adjustments to Cost Limits
§ 413.30(f)(1)	-	Atypical exceptions
§ 413.30(f)(1)(i)	-	Applicable Limit
§ 413.30 et seq.	-	Exceptions, exemptions, and adjustments to cost limits
§ 413.50	-	subsidization

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

§ 2924.6	-	Scope of Board's Authority
§ 2534.5	-	Determination of Reasonable Costs in Excess of Cost Limit or 112% of Mean Cost
§ 2530	-	Presumptive Nature of Routine Cost Limits
§ 2927(C)(6)(e)	-	Administrator Decisions Are Not Binding Precedent
§ 2530.1	-	General principles
§ 2530.2	-	Routine Service Cost limits
§ 2530.3	-	Classification for cost limit application

4. Case Law:

Good Samaritan Hospital v. Shalala, 508 U.S. 402, 124 L.Ed. 368 (1993)

University of Cincinnati, d/b/a/ University Hospital v. Shalala, U.S. District Court for the Southern District of Ohio, Western Division, C-1-93-841, Nov. 8, 1994, ¶ 42,976, CCH Medicare and Medicaid Guide

Motor Veh. Mfrs. Assn. v. State Farm Mut. ["State Farm"], 463 U.S. 29, 43, 77L. Ed. 2d 443, 457-458 (1983)

National Black Media Coalition v. FCC, 775 F.2d 342, 355 (D.C. Cir. 1985)

St. Francis Health Care Center v. Shalala, case No. 3:97 CV7559, Northern District of Ohio, Western Division, CCH Medicare and Medicaid Guide, ¶300,026

Mt. Diablo Hosp. Dist. v. Bowen, 860 F.2d 951, 956 (9th Cir.,1988)

Linoz v. Heckler, 800 F.2d 871, 877 (9th Cir.,1986)

St. Francis Health Care Center v. Shalala, U.S. Court of Appeals for the Sixth Circuit, case No. 98-3965, (Feb. 25, 2000), ¶300,420 CCH Medicare and Medicaid Guide

Sioux Valley Hospital v. Bowen, 792 f.2d 715, 719 (8th Cir.1986)

Paralyzed Veterans of America v. D.C. area, 117 F.3d 579, 586 (D.C. Cir.,1997)

Alaska Professional Hunters Ass'n., Inc. v. Federal Aviation Admin., 177 F.3d 1030 (D.C. Cir., 1999)

St. Luke's Methodist Hospital v.Thompson, U.S. District Court for the Northern District of Iowa, Cedar Rapids Division, No. C 00-13, Sept. 26, 2001, 182 F.Supp. 2d 765, ¶300,832 CCH Medicare and Medicaid Guide

St. Francis Health Care Center v. Community Mutual Insurance Company, May 30, 1997, ¶45,545, CCH Medicare and Medicaid Guide (Administrator's Decision)

St. Francis Health Care Centre (sic) v. Community Mutual Insurance Company, PRRB Hearing Dec. No. 97-D38, Case Nos. 95-0586 and 95-0587 (Mar. 24, 1997), CCH Medicare and Medicaid Guide ¶45,159

5. Other:

Report to Congress on the Study of the Skilled Nursing Facility Benefit under Medicare

Finance Committee of the 98th Congress of the United States Senate, Senate Print 98-169, Vol. 1 at 947

HCFA Transmittal No. 378

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

The Board majority finds that the methodology applied by HCFA in denying the Provider's exception request for per diem costs which exceeded the Routine Cost Limit (RCL) was an appropriate application of policy in accordance with the statutory and regulatory provisions set forth under 42 U.S.C. § 1395yy et seq. and 42 C.F.R. § 413.30 et seq..

HCFA's action was based on perceived inefficiencies and cost allocation methodologies associated with hospital-based SNF's. As part of the Deficit Reduction Act ("DEFRA") of 1984, Congress lowered the RCL for HB-SNFs relative to the RCL for FS-SNFs. This change was codified at 42 U.S.C. § 1395yy(a). The RCL for FS-SNFs remained at "112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities . . ." The RCL for HB-SNFs, however, was lowered to "the sum of the limit for freestanding skilled facilities. . ., plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities . . exceeds the limit for freestanding skilled nursing facilities. . ." The Secretary's authority to make adjustments to these newly-established RCLs "to the extent the Secretary deems appropriate" was reaffirmed in § 1395yy(c).

As the Court in St. Francis (at 4) noted, the two-tiered reimbursement system enacted by Congress implicitly recognizes that certain systemic inefficiencies, "associated with unreasonable costs", are associated with HB-SNFs. "The Secretary's interpretive guideline does nothing more or less than to incorporate that recognition . . . .the individual judgments arising out of those determinations would produce an increased potential for inconsistency, and could also undermine the two-tier reimbursement scheme established by Congress. It is not arbitrary and capricious for the Secretary to adopt a rule that may turn out to be overbroad in the interest of promoting efficiency and uniformity in the administration of a complex and highly technical regulatory program". Id. At 5.

Pursuant to the Deficit Reduction Act of 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 by 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 hospital-based SNFs is set at 112 percent of the mean hospital-based inpatient routine service costs, and not at the hospital-based SNF's cost limit. HCFA compares the hospital-based SNF's costs to those of the typical facility to determine the amount of its costs that are atypical. Under this methodology, if a hospital-based 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 hospital-based SNFs, the Board's 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 hospital-based SNF data, as opposed to the hospital-based SNF cost limit, which is heavily based upon freestanding SNF data.

The Board majority notes that HCFA's methodology of using the standard of 112 percent of the hospital-based 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 clarifying 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 not unreasonable for HCFA to use the 112 percent peer group level as the standard for reviewing exception requests for hospital-based SNFs.

The Board majority further notes that in the 6th Circuit St. Francis case, the Appellate Court stated that several studies concluded that 50% of the cost difference between HB-SNFs and FS-SNFs was attributable to variations in intensity of care, or case-mix, and that inefficiency was deemed the likely cause of the other 50%. Congress has always left intact the Secretary's authority to make adjustments to cost limits" to the extent the Secretary deems appropriate". 42 U.S.C. § 1395yy (c). After eliminating the provision authorizing additional reimbursement to HB-SNFs for costs associated with the Medicare cost allocation process, Congress completed the process of rejecting differing reimbursement for HB-and FS-SNFs in the 1993 Omnibus Budget Reconciliation Act and the Balanced Budget Act of 1997, culminating in a prospective payment system based on a federal per diem rate. The Board majority opines that it was recognition of the "50% inefficiency factor" in HB-SNFs, more than any other factor, that triggered the PPS mechanism for SNFs.

The Board majority acknowledges the Provider's reliance upon the previous Board's decision in St. Francis, supra, to help support its position and arguments. The Board majority notes that its findings are consistent with the circuit court ruling which upheld the HCFA Administrator's reversal of the Board's decision in St. Francis and 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.
- New England Rehabilitation Hospital v. C&S Administrative Services for Medicare, PRRB Case No. 2000-D53, May 24, 2000, Medicare & Medicaid Guide (CCH) ¶ 80,443.
- Mercy Medical Center SNF-Daphne v. Mutual of Omaha Insurance Company, PRRB Dec. No. 01-D38, July 27, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,727.

Finally, the Board majority takes note of the court's reasoning in the St. Luke's Methodist Hospital decision. The Court states, "However, in light of the potential breadth of the discretionary language in the regulation, the Court declines to conclude that PRM § 2534.5 is necessarily inconsistent with the regulatory language and will instead focus on whether, taking into consideration the appropriate level of deference due, the Secretary has construed the regulation is a reasonable, non-arbitrary manner."

After its analysis the Court then concludes that "Upon applying the appropriate level of deference under Christensen, the Court finds that PRM § 2534.5 is an unreasonable interpretation of the exception eligibility process of 42 C.F.R. § 413.30. The Court does not agree that 42 U.S.C. § 1395yy, read in conjunction with 42 C.F.R. § 413.30, reasonably results in the interpretation promulgated by the Secretary in PRM § 2534.5. There is no inherent conflict between the Secretary's original longstanding interpretation of 42 C.F.R. § 413.30 and Congress' subsequent imposition of a two-tiered RCL measure through 42 U.S.C. § 41395yy.

The Board majority does not find the St. Luke's Court reasoning to be persuasive.

DECISION AND ORDER:

HCFA's methodology for measuring the entitlement of hospital-based SNFs to exception relief under 42 C.F.R. § 413.30(f) and HCFA's denial of the Provider's exception request was proper. HCFA's determination in this area is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary B. Blodgett (dissenting)
Suzanne Cochran, Esquire (dissenting)

DATE OF DECISION: September 30, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Gary Blodgett and Suzanne Cochran

We respectfully dissent with the majority opinion in the Providence Hospital-Centralia SNF case wherein HCFA[23] refused to grant an atypical services exception for that portion of the provider's per diem costs which did not exceed 112% of the peer group mean routine services cost.

HCFA's refusal to approve additional costs for providing atypical services that were in excess of Provider's Routine Cost Limit (RCL) but not by more than 112% of the peer group mean cost limit was not consistent with the statutes and regulations relating to this issue.

The intent of Congress in providing an exception to the routine cost limit to compensate providers for the additional costs associated with the provision of atypical services was to ensure providers that they would be reimbursed their full costs for providing those additional services and that patients not covered by Medicare would not be unfairly burdened with subsidizing the cost of the care of Medicare patients. 42 USC §1395yy(a); 42 USC § 1395x(v)(1)(A).

The regulation, 42 CFR Section 413.30(f)(1), permits the Provider to request from HCFA an exception from its Routine Cost Limit because it provided atypical services. It is undisputed that for 15 years the Secretary interpreted the regulation as permitting a provider to recover its reasonable costs that exceeded the RCL if it demonstrated that it met the exception requirements. The Provider's exception request was processed in accordance with HCFA Transmittal No. 378, which was issued in July, 1994 and decreed that the atypical services exception of every hospital-based SNF must be measured from 112 % of the peer group mean for that hospital-based SNF rather than the SNF's Routine Cost Limit. This specific requirement was also published as Section 2534.5 of the Provider Reimbursement Manual (PRM).

In essence, for the purpose of determining atypical services exceptions for HB-SNFs, HCFA replaced the Routine Cost Limit with an entirely new and separate "cost limit" (112% of the peer group mean routine services cost). It is undisputed that 112% of the peer group mean of every hospital-based SNF is always significantly higher than the hospital's RCL. As a result, under section 2534.5 of the Provider Reimbursement Manual, a reimbursement "gap" is created between the RCL and 112% of the peer group mean which represents costs incurred by a hospital-based SNF which it is not allowed to recover.

HCFA has taken a 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. This is contrary to what Congress intended when it implemented the exception process to address the additional costs associated solely with the provision of atypical services, and it clearly represents a

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substantive change in HCFA's prior interpretation and application of 42 CFR § 413.30(f)(1) and PRM § 2534.5.

> 42 CFR Section 413.30(f)(1) states that
>
> "*limits* established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section…..an 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." (emphasis added)

The *only* limit intended by Congress and imposed by the applicable statute and regulation is the Routine Cost Limit. To qualify for an atypical services exception a provider must show that the "actual cost of items or services furnished by the provider *exceeds the applicable limit* (Routine Cost Limit) *because such items or services are atypical* in nature and scope, compared to the items or services generally furnished by providers similarly classified." (emphasis added) That Providence Hospital was providing atypical services and, but for the methodology described, would have been entitled to an exception, was not contested by HCFA.

The controlling regulation specifically states that the provider must only show that its cost "exceeds the applicable limit;" *not* that its cost exceeds 112% of the peer group mean. The comparison to a peer group of "providers similarly classified," required by the regulation, is of the "nature and scope of the items and services actually furnished," not of their cost. Also, it must be noted that Congress itself established the four "peer groups" that are to be considered in determining Medicare reimbursement of skilled nursing facilities: free-standing urban, free-standing rural, hospital-based urban and hospital-based rural. HCFA had no statutory or regulatory authority to establish a *new* "peer group" for hospital-based SNFs (112% of the peer group mean routine service cost) and determine atypical services exceptions from an entirely *new* cost limit rather than from the Routine Cost Limit as intended by Congress.

In addition, the provisions of PRM § 2534.5 that require an exception for a HB-SNF to be measured from "112% of the peer group mean" rather than from the routine cost limit are invalid because they have not been adopted pursuant to notice and comment rulemaking as required by the Administrative Procedure Act.

In this case, HCFA's methodology is a departure from its earlier method of determining hospital-based SNF exception requests and requires an explanation for its change 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 change of direction." National Black Media Coalition v. FCC, 775 F.2d 342, 355 (D.C. Cir. 1985).

42 U.S.C. §1395yy only set the formula for determining the cost limit; it did not change the method to be used to determine exceptions to the cost limit nor provide HCFA with

any legal authorization to adjust its pre-existing policies or regulations. Congressional imposition of a rate that is out of line with economic reality (in a case concerning the composite rate for end-stage renal disease services) "does not give HCFA the right to justify using out-of-line-with-reality component numbers to make exception determinations." University of Cincinnati, d/b/a University Hospital v. Shalala, No. C-1-93-841, (S.D. Ohio, Nov. 8, 1994), ¶42,976, at footnote 6, CCH Medicare and Medicaid Guide.

Because PRM § 2534.5 carves out a *per se* exception to the exception methodology contained in the applicable regulation and in the unwritten policy of HCFA for 15 years prior to adoption of this manual section, it "effect[ed] a change in existing law or policy" and is substantive in nature. Linoz v. Heckler, 800 F.2d 871,877 (9th Cir. 1986).

Even if PRM § 2534.5 should be considered an "interpretive" rule, it nevertheless constitutes a significant revision of the Secretary's definitive interpretation of 42 C.F.R. §413.30 and is, therefore, invalid because it was not issued pursuant to notice and comment rulemaking. "Once an agency gives its regulation an interpretation, it can only change that interpretation as it would formally modify the regulation itself: through the process of notice and comment rulemaking." Paralyzed Veterans of America v. D.C. Area,117 F.3d 579, 586 (D.C. Cir. 1997).

In a District of Columbia Circuit Court decision, Alaska Professional Hunters Ass'n., Inc. v. Federal Aviation Admin., 177 F.3d.1030 (D.C. Cir. 1999), the Court held that even though a rule is "interpretive" and not "substantive," it must nevertheless be adopted through notice and comment rulemaking if it significantly revises the definitive interpretation by an agency of its regulation. Without question, that is precisely what HCFA did when it changed its methodology of determining atypical services exceptions for HB-SNFs after having consistently applied it in a much different manner for 15 years prior to making the change.

There is nothing in the statute or regulation that requires the gap methodology interpretation in issue here. Congress gave the Secretary broad authority to establish "by regulation" the methods to be used and items to be included in determining reimbursement. 42 USC §1395x(v)(1)(A). Had the gap methodology been subjected to the rulemaking process under the APA, 5 USC § 553, we do not contest that it would have been a legitimate exercise of that power. However, it was not, and, in addition to the arguments we have previously presented, we are further persuaded by the District Court's decision in *St. Luke's Methodist Hospital v. Thompson,* 182 F. Supp. 2d 765 (N.D. Iowa, 2001), that PRM §2534.5 does not reasonably interpret 42 CFR § 413.30. *Id* at 784.

The *St. Luke's* Court recognized that its holding was contrary to that of the Sixth Circuit in *St. Francis Health Care Centre v. Shalala*, 205 F.3d 937 (6th Cir. 2000). It explained that, shortly after the *St. Francis* Court issued its opinion applying the deference standard established by the Supreme Court in *Chevron v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), the Supreme Court issued its decision in *Christensen v. Harris*

County, 529 U.S. 576 (2000). The *Christensen* Court held that a lower level of deference is to be accorded to an agency interpretation where the interpretation is not contained in the statute or regulation itself but rather is articulated through less formal means such as "policy statements, agency manuals, and enforcement guidelines." *Christensen* at 777[24]. The *St. Luke's* Court concluded that the *Christensen* standard was applicable to the issue. It cited the gap methodology as an "abrupt and significant alteration of a longstanding, consistently followed policy…developed years after the regulation it interprets and the statute it purports to incorporate" as a "weighty" factor in the deference analysis under *Christensen. Id.* at 780.

The sole issue on summary judgment in the *St. Luke's* case was "whether HCFA's methodology of determining the amount of an atypical service exception under HCFA Transmittal Number 378, as found in PRM section 2534.5, is arbitrary and capricious or not in accordance with law." The court noted that when the issue is whether the agency has erred in interpreting its own regulations, the plain meaning of a statute or regulation, if there is one, controls, regardless of an agency's interpretation. *Id.* at 775. The *St. Luke's* Court found "PRM §2534.5 invalid as an unreasonable interpretation of 42 CFR 413.30 in light of the language of that regulation and the principles underlying the Medicare statute." The Court reasoned that PRM §2534.5 created an irrebuttable exclusion of gap costs that, if permitted to stand, would allow the Secretary to "substantively rewrite the regulation to impose an additional hurdle for exceptions eligibility not clearly contemplated by the language of the regulation or subsequently enacted statutes."[25] *Id.* The Court also found that application of the gap methodology would result in non-Medicare payors subsidizing the care of Medicare patients in violation of 42 USC §1395x(v)(1)(A). *Id.* at 787. Clearly, that cannot be disputed.

The *St. Luke's* Court further concluded that "[t]here is no explicit language in either 42 C.F.R. § 413.30 or 42 U.S.C. § 1395yy which mandates the Secretary's interpretation. The regulation refers only to discretionary adjustments to the 'applicable limit,' and the statute is silent as to its effect on the pre-existing exceptions process." *Id.* at 781.

The *St. Luke's* Court goes on to state that "[t]he Court does not agree that 42 U.S.C. § 1395yy, read in conjunction with 42 C.F.R. § 413.30 reasonably results in the interpretation promulgated by the Secretary in PRM § 2534.5. There is no inherent conflict between the Secretary's original, longstanding interpretation of 42 C.F.R. §413.30 and Congress' subsequent imposition of a two-tiered RCL measure through 42 U.S.C. § 1395yy. Absent persuasive evidence to the contrary, there is no reason to believe that Congress, in enacting 42 U.S.C. § 1395yy, meant to override the distinction between typical and atypical service reimbursement eligibility explicitly recognized in 42 C.F.R. § 413.30." *Id*. at 787.

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[24] *St. Luke's Methodist Hospital v. Thompson, supra* at 787, fn 19.

[25] The Secretary argued that his rationale for the "gap methodology" was based on legislative changes to the statute in 1984 in which 112% of the mean was used to calculate new Routine Cost Limits. There were no changes to the statute or regulations concerning the exemption process, however.

The Court also determined that, "PRM § 2534 represents an abrupt and significant alteration of a longstanding, consistently followed policy and was developed years after the regulation it interprets and the statute it purports to incorporate. The Secretary has failed to persuade this Court that despite its incongruous and inconsistent procedural history, the interpretation is the product of 'thorough and reasoned consideration.' " *Id*. at 781.

The findings and decision of the St. Luke's Court are equally applicable to the present case and support the dissenters' contention that the denial of Providence Hospital's request for an atypical services exception should be reversed.

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