PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2007-D61

PROVIDER -
Montefiore Medical Center
New York City, New York

Provider No.: 33-0059

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services - NY

DATE OF HEARING -
July 24, 2007

Cost Reporting Period Ended -
December 31, 1990

CASE NO.: 96-1582

INDEX

ISSUE:

Whether the Intermediary improperly limited the Provider's hospital-based Skilled Nursing Facility's (SNF's) routine cost limit exception amount to costs in excess of 112 percent of its peer group costs rather than costs in excess of the routine cost limit.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

Section 1819(a)(1) of the Social Security Act (Act) defines a SNF as an institution engaged in providing skilled nursing and related services for residents who require medical and nursing care or rehabilitative services for injured, disabled or sick persons. Section 1861(v)(1)(A) of the Act establishes the method of cost reimbursement for SNFs as well as limitations on reimbursable costs. These limitations are called routine cost limits (RCL) and are addressed in §§1861(v)(7)(B) and 1886(a) of the Act. 42 C.F.R. §413.30 implements the cost reimbursement limits for SNFs and also provides an exception to the limits for providers of "Atypical Services." 42 C.F.R. §413.30(f), states, in part:

> Exceptions. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) of this section. . . . 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.
>
> (1) Atypical services. The provider can show that the---

(i) Actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified; and

(ii) Atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

The intent of Congress in providing an exception to the cost limits to compensate providers for the additional costs associated with the provision of atypical services was to ensure that providers 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 U.S.C. §1395yy(a); 42 U.S.C. §1395x(v)(1)(A).

The issue in dispute in this appeal is whether the Intermediary improperly limited the exception amount to which the Provider was entitled under 42 C.F.R. §413.30(f) of the Medicare regulations.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Montefiore Medical Center (Provider) is an acute care hospital located in New York City, New York. During its cost reporting period ended December 31, 1990, the Provider's facility included a hospital-based SNF. The Provider's SNF was reimbursed based upon the reasonable costs it incurred to provide health care services to Medicare beneficiaries (42 U.S.C. §1395x(v)) and was subject to the cost limits placed upon SNFs at 42 U.S.C. §1395yy.

In accordance with 42 C.F.R. §413.30(f)(1), the Provider requested an exception to the SNF cost limits based upon the provision of furnishing atypical services. Empire Medicare Services (Intermediary) reviewed the Provider's request and forwarded it to CMS, where it was approved.[1] However, the Provider disagrees with the methodology used to calculate the amount of the exception ultimately granted. The Provider believes it should be reimbursed all of its costs in excess of the limit. The Provider's argument is based upon 42 U.S.C. §1395yy(3), which sets the limit for hospital-based SNFs at the limit established for freestanding SNFs plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based SNFs exceeds the limit for freestanding SNFs. The Intermediary, however, calculated the amount of the

[1] National Government Services has replaced Empire Medicare Services as the Provider's intermediary.

Provider's exception based upon program instructions in Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §2534, entitled Request For Exception to SNF Cost Limits. In effect, the manual directs intermediaries to calculate cost limit exceptions for hospital-based SNFs at amounts exceeding 112 percent of the mean per diem routine service costs for hospital-based SNFs "(not the cost limit). . . ."[2]

The Provider appealed the methodology used by the Intermediary to determine its cost limit exception to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $319,000.[3]

The Provider was represented by Dennis M. Barry, Esq., of Vinson & Elkins LLP. The Intermediary was represented by Arthur E. Peabody, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider claims that by refusing to grant an exception for the portion of its per diem costs which do not exceed 112 percent of the total peer group mean cost, CMS has created a reimbursement "gap" that is arbitrary, capricious, not in accordance with Medicare law, and denies reimbursement of costs that qualify as an exception for atypical services.

In addition, the Provider contends that the "gap" methodology in HCFA Pub. 15-1 §2534.5 directly contradicts the regulation controlling atypical service exceptions. The Provider believes that CMS should be given no deference in interpreting this regulation because it has not applied its interpretation consistently over time, and its interpretation is not the result of thorough and reasoned consideration. The "gap" methodology in HCFA Pub. 15-1 §2534.5 is also inconsistent with the statute prohibiting cross-subsidization between Medicare and other payors.

The Provider also believes that 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 (APA) or as a regulation as required by statute.

Additionally, the Provider contends that the language of 42 C.F.R. §413.30(f)(1) could not have originally been intended to support the reimbursement "gap" of HCFA Pub. 15-1 §2534.5 because the original interpretation of the regulation that measured exceptions from the cost limits had been consistently maintained by CMS for fifteen years prior to the issuance of HCFA Pub. 15-1 §2534. CMS' current interpretation of the regulation was not developed contemporaneously with the regulation's original promulgation and is

[2] HCFA Pub. 15-1 §2534 was implemented in July 1994 through the issuance of CMS Program Transmittal No. 378.

[3] Provider's Position Paper (December 13, 2006) at 3. Intermediary's Supplemental Position Paper at 2.

inconsistent with CMS' earlier interpretations; therefore, it is due no deference. The Provider cites St. Luke's Methodist Hospital v. Thompson, 182 F. Supp. 2d 765 (N. D. Iowa 2001), aff'd. Eighth Circuit (St. Luke's), finding HCFA Pub. 15-1 §2534.5 "invalid as an unreasonable interpretation of 42 C.F.R. §413.30 in light of the language of that regulation and the principles underlying the Medicare statute," and Mercy Medical Skilled Nursing Facility v. Thompson, C.A. 99-2765 (D.D.C. May 14, 2004) striking down CMS' approach of limiting exception relief to costs in excess of 112 percent of the peer group.

Finally, the Provider contends that HCFA Pub. 15-1 §2534.5 may not be applied retrospectively to the subject cost reporting period. Bowen v. Georgetown University Hospital, 488 U. S. 204 (1988). The Provider points out that the cost reporting period at issue is the fiscal year ended December 31, 1990, and that the "gap" methodology was not introduced until July 1994.

The Intermediary contends that the Provider's cost limit exception request was properly calculated in accordance with HCFA Pub. 15-1 §2534.5 which prescribes the methodology for making that calculation. The Intermediary relies upon the Administrator's decision in Montefiore Medical Center v. Blue cross Blue Shield Association/Empire Medicare Services, PRRB Dec. No. 2006-D29, June 5, 2006, rev'd., CMS Administrator, July 26, 2006, finding that HCFA Pub. 15-1 §2534.5 is consistent with the plain meaning of the pertinent statute and regulations.[4]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, parties' contentions, and evidence presented, finds as it did in Hi-Desert Medical Center v. United Government Services/Blue Cross Blue Shield Association, PRRB Dec. No. 2007-D17, February 2, 2007, rev'd., CMS Administrator, April 2, 2007. The methodology applied by CMS in partially denying the Provider's exception request for per diem costs that exceeded the cost limit was not consistent with the statute and regulation relating to this issue.[5]

The regulation, 42 C.F.R. §413.30(f)(1), permits the Provider to request from CMS an exception from the cost limits 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 limits 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 percent of

[4] Intermediary's Supplemental Position Paper at 3, 4.

[5] This decision is also consistent with the Board in Glenwood Regional Medical Center v. Mutual of Omaha Insurance Company, PRRB Dec. No. 2004-D23, January 7, 2004, rev'd, CMS Administrator, August 9, 2004, and Montefiore Medical Center v. Blue cross Blue Shield Association/Empire Medicare Services, PRRB Dec. No. 2006-D29, June 5, 2006, rev'd., CMS Administrator, July 26, 2006.

the peer group mean for that hospital-based SNF rather than the SNF's limit. This specific requirement was also established as HCFA Pub. 15-1 §2534.5.

In essence, CMS replaced the limit with an entirely new and separate "cost limit" (112 percent of the peer group mean routine services cost). It is also undisputed that 112 percent of the peer group mean of hospital-based SNFs is significantly higher than the hospital's cost limit. As a result, under HCFA Pub. 15-1 §2534.5, a reimbursement "gap" is created between the limit and 112 percent of the peer group mean that represents costs incurred by a hospital-based SNF which it is not allowed to recover.

CMS reached 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 that 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 substantive change in CMS' prior interpretation and application of 42 C.F.R. §413.30(f), which states:

> Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) of this section. An adjustment is made only to the extent the costs are reasonable, attributable to circumstances specified, separately identified by the provider, and verified by the intermediary.

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

The controlling regulation specifically states that a provider must only show that its cost "exceeds the applicable limit," not that its cost exceeds 112 percent 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 <u>items</u> and <u>services</u> actually furnished" (emphasis added), 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. CMS has no statutory or regulatory authority to establish a *new* "peer group" for hospital-based SNFs (112 percent of the peer group mean routine service cost) and determine atypical service exceptions from an entirely *new* cost limit rather than from the limit intended by Congress.

In addition, the provisions of HCFA Pub. 15-1 §2534.5 that require an exception for hospital-based SNFs to be measured from "112 percent 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 APA.

In this case, CMS' methodology is a departure from its earlier method of determining the amount for 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 CMS 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, 867 F. Supp. 1325 (S.D. Ohio, Nov. 8, 1994).

Because HCFA Pub. 15-1 §2534.5 carves out a *per se* exception methodology contained in the applicable regulation and in the unwritten policy of CMS for 15 years prior to adoption of this manual section, it "effected a change in existing law or policy" that is substantive in nature. Linoz v. Heckler, 800 F.2d 871,877 (9th Cir. 1986).

Even if HCFA Pub. 15-1 §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 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 rulemaking." Paralyzed Veterans of America v. D.C. Arena L.P., 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, 1034 (D.C. Cir. 1999), the Court held: "When an agency has given its regulation a definitive interpretation, and later significantly revises that interpretation, the agency has in effect amended its rule, something it may not accomplish without notice and comment." Without question, that is precisely what CMS did when it changed its methodology of determining atypical services exceptions for hospital-based 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 at 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 U.S.C. §1395 x(v)(1)(A). Had the "gap" methodology been subjected to the rulemaking process under the APA, 5 U.S.C. §553, it would have been a legitimate exercise of that power. However, it was not, and, in addition to the arguments previously presented, the Board is further persuaded by the District Court's decision in the St. Luke's case that HCFA Pub. 15-1§2534.5 does not reasonably interpret 42 C.F.R. §413.30.

The St. Luke's Court found HCFA Pub. 15-1 §2534.5 "invalid as an unreasonable interpretation of 42 C.F.R. §413.30 in light of the language of that regulation and the principles underlying the Medicare statute." The Court reasoned that HCFA Pub. 15-1 §2534.5 created an irrefutable 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 42 C.F.R. §413.30(f) or subsequently enacted statutes."[6] 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 U.S.C. §1395x(v)(1)(A).

The St. Luke's Court stated 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 [HCFA] Pub. 15-1 §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 [reasonable cost limit] 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.

St. Lukes at 787.

The Court also determined that HCFA Pub. 15-1 §2534.5 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

[6] The Secretary argued that his rational 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 cost limits. There were no changes to the statute or regulation concerning the exemption process, however.

> procedural history, the interpretation is the product of "thorough and reasoned consideration."

St. Lukes at 781.

The findings and decision of the St. Luke's Court are equally applicable to the present case and support the Board's conclusion that the partial denial of the Provider's request for an exception to the SNF cost limit should be revised to permit the Provider to recover its costs.

DECISION AND ORDER:

CMS' methodology for determining the amount of the Provider's exception to the hospital-based SNF cost limits was improper. The Provider is entitled to be reimbursed for all of its costs above the cost limit as opposed to being reimbursed only for its costs that exceeded 112 percent of the peer group's mean per diem costs.

Board Members Participating:

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DATE: August 14, 2007

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