PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2009-D8

PROVIDER –
Quality 89-92 Hospital Based SNF

Provider Nos.: 05-0008, 05-0058,
05-0132, 05-0152 & 05-0655

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, LLC - CA

DATE OF HEARING -
October 7, 2008

Cost Reporting Periods Ended -
See Attached Listing

CASE NO.: 98-3176G

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ISSUE:

Whether the Centers for Medicare and Medicaid Services' (CMS) methodology for determining the Providers' exception to the hospital-based skilled nursing facility cost limits was proper.

MEDICARE STATUTORY AND REGULATORY GENERAL BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 administering the Medicare program. 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 the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395kk-1. 42 C.F.R. §§413.20 and 413.24.

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(a); 42 C.F.R. §§405.1835-405.1837.

Section 1819(a)(1) of the Social Security Act (Act) defines a skilled nursing facility (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 for exceptions to the limits. Providers may be granted exceptions if they exceeded the limits because of various circumstances. Those circumstances include furnishing atypical services, experiencing extraordinary circumstances beyond their control, being located in areas with fluctuating populations and/or unusual labor costs and operating approved education programs.

The intent of Congress in providing exceptions to the cost limits was to ensure that providers would be reimbursed their reasonable costs for services rendered 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(c); 42 U.S.C. §1395x(v)(1)(A).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

This group appeal involves five providers (Providers) from the state of California which operated hospital-based skilled nursing facilities with FYEs ranging from July 31, 1989 through September 30, 1998. There are 14 cost reporting periods covered by this appeal. (See attached listing). The Providers' SNFs were reimbursed based upon the reasonable costs they incurred to provide health care services to Medicare beneficiaries (42 U.S.C. §1395x(v)) and were subject to the cost limits placed upon SNFs by 42 U.S.C. §1395yy.

The Providers appealed the methodology used by the Intermediary to determine their cost limit exceptions to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations.[1] The Providers were represented by Kenneth R. Marcus, Esq. of Honigman, Miller, Schwartz and Cohn, LLC. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

STIPULATIONS

The Providers and Intermediary have stipulated to the following pertinent facts and parties' positions:

- During the cost reporting years at issue in this case, each of the Providers operated a hospital-based skilled nursing facility (SNF).

- Each of the Providers' SNF was reimbursed based upon the reasonable costs it incurred to provide health care services to Medicare beneficiaries, as provided by 42 U.S.C. §1395x(v), and was subject to the cost limits placed upon SNF costs, as provided by 42 U.S.C. §1395yy.

- In accordance with 42 C.F.R. §413.30(f)(1), each of the Providers requested that its SNF be granted an exception to the cost limits.

- The exception request of each of the Providers was approved.

- The Providers' contend that they should be reimbursed all of their costs in excess of the limit, based on 42. U.S.C. §1395yy(a)(3), which sets the limit for hospital-

[1] The Board denied jurisdiction over eight cost reporting periods in letters dated October 24, 2006. The Provider's requested reconsideration for each decision on November 3, 2006. The Board reversed its original jurisdiction over two of the cost reporting periods, and maintained it did not have jurisdiction over six cost reporting periods. Those providers in which the Board found it lacked jurisdiction are Davies Medical Center, 05-0008 for FYEs 12/31/1994 and 7/29/1998; Glendale Memorial Hospital, 05-0058, FYEs 9/30/1994, 9/30/1995, 9/30/1996; and Saint Francis Memorial Hospital, 05-0152, FYE 6/30/1995.

based SNFs at the limit established for free-standing SNFs plus 50% of the amount by which 112% of the mean per diem routine service cost for hospital-based SNFs exceeds the limit for freestanding SNFs.

- The Intermediary contends that the provisions of Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §2534, entitled Request for Exception to SNF Cost Limits, govern. PRM §2534 directs the Intermediary to calculate cost limit exceptions for hospital-based SNFs at amounts up to 112% of the mean per diem routine service costs for hospital based SNFs. The exception was limited accordingly. Costs exceeding 112% of the mean per diem (i.e. 112% limit) were not found to be otherwise unreasonable.

- The issue presented and the underlying facts in the instant case are identical to the issue presented and underlying facts in Memorial Healthcare (Owosso, Michigan) v. BlueCross BlueShield Association/National Government Services LLC-WI, Dec. No. 2007-D66 (August 30, 2007). The Providers contend that the correct analysis of PRM §2534 was the one articulated by the PRRB in reversing the application of the 112% limit in Memorial Healthcare. The Intermediary contends that the correct analysis of the 112% limit was the one articulated by the Deputy Administrator in reversing the PRRB's Decision in Memorial Healthcare, October 29, 2007.

- The parties request that the Board issue a decision on the merits regarding the Providers and fiscal years identified on Exhibit A in this case on the record without a hearing based on this stipulation and the position papers submitted by the parties.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and guidelines, parties' contentions, and evidence presented, finds as it did in Memorial Healthcare (Owosso, Michigan) v. BlueCross BlueShield Association/National Government Services LLC-WI (Memorial Healthcare, Dec. No. 2007-D66 (August 30, 2007) *rev'd*., CMS Administrator, October 29, 2007 that the methodology applied by CMS in partially denying the Providers' exception requests for per diem costs that exceeded the cost limits was not consistent with the statute and regulation relating to this issue.

The regulation, 42 C.F.R. §413.30(f), permits the Provider to request from CMS an exception from the cost limits for atypical services or other items. It was undisputed in Memorial Healthcare 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. CMS then issued HCFA Transmittal No. 378, in July 1994, which provided that the atypical services or other item exception of every hospital-based SNF must be measured from 112 percent of 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 service cost). It was also undisputed in Memorial Healthcare that 112 percent of the peer group mean of hospital-based SNFs is significantly higher than the 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 or incur only *usual and customary* costs and inappropriately applied that same rationale to hospital-based SNFs that provide *atypical* services or incur *unusual* or *uncustomary* costs. This is contrary to what Congress intended when it implemented the exception process to address the additional costs associated with the provision of atypical services and other items, 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 imposed by the plain language of the applicable statute and regulation is the cost limit. To qualify for an exception a provider must only show that the actual cost of items and services furnished by a provider *exceeds the applicable limit because such items are atypical* or *unusual or uncustomary* in nature and scope, compared to the items or services generally furnished by providers similarly classified.

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 *items* and *services* 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 exceptions from an entirely *new* cost limit rather than from the limit imposed 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 Administrative Procedure Act (APA).

As in Memorial Healthcare, the Board finds 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. 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 service exceptions for hospital-based SNFs after having consistently applied it in a much different manner for 15 years prior to the change.

There is nothing in the statute or regulation that authorizes 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. The Board's decision is supported by the Decision in the *St. Luke's Methodist Hospital v. Thompson*, 182 F. Supp. 2d 765 (N.D. Iowa 2001), aff'd. 315 F.3d 984 (8th Cir. 2003) *(St. Luke's)* which found that HCFA Pub. 15-1 §2534.5 does not reasonably interpret 42 C.F.R. §413.30.

The District Court in *St. Luke's* 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 further 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 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 were equally applicable to the present case and support the Board's conclusion that the partial denial of the Providers' requests for exceptions to the SNF cost limits should be revised to permit the Providers to recover their costs.

DECISION AND ORDER

CMS' methodology for determining the amount of the Providers' exceptions to the hospital-based SNF cost limits was improper. The Providers are entitled to be reimbursed for all of their costs above the cost limits as opposed to being reimbursed only for those costs that exceeded 112 percent of the peer group's mean per diem costs.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes

Michael D. Richards, C.P.A. (recused)
Keith Braganza, C.P.A. (inactive)

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: January 26, 2009