PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D10

PROVIDER –
Alameda Hospital - SNF

Provider No.: 05-0211

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
First Coast Service Options, Inc.

DATE OF HEARING -
April 21, 2010

Cost Reporting Period Ended -
December 31, 1995

CASE NO.: 98-0460

INDEX

ISSUE:

Whether the District of Columbia District Court's memorandum decision issued in this case finding the Secretary's methodology was improper under the precedent established in Alaska Professional Hunters Association, Inc. vs. FAA, 177 F.3d 1030 (D.C. Cir. 1999) ("Alaska Hunters"), also applies to the Secretary's low occupancy adjustment.

MEDICARE STATUTORY AND REGULATORY 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. *See* 42 U.S.C. §§ 1395 *et seq*. 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. § 1395h and § 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 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 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 receipt of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

42 U.S.C. §1395x(v)(1)(A), authorizes the Secretary to establish prospective limits on provider costs that are reimbursed under Medicare. Through regulation, the Secretary established limits on routine care costs, referred to as routine cost limits ("RCLs"). The Medicare regulation at 42 C.F.R. §413.30(f)(1) (1995) permits providers to obtain an exception from cost limits for "atypical services" if 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

[1] FIs and MACs are hereinafter referred to as intermediaries.

(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.[2]

In July 1994, CMS (formerly HCFA) released HCFA Transmittal 378[3] which revised the Provider Reimbursement Manual ("PRM") section regarding Requests for Exception to SNF Cost Limits. PRM § 2534.5.A addresses CMS' rule for low occupancy adjustments in determining SNF exception requests and reads in relevant part as follows:

> A. Low Occupancy.-- If a provider's occupancy rate is lower than the average occupancy rate of the providers used to develop the cost limits, an adjustment to the provider's per diem cost may be made . . . . For the purposes of this adjustment, fixed costs are defined as those costs considered fixed by standard accounting practices and those costs that must be incurred by all SNFs in order to meet the conditions of participation in the Medicare program. The provider must identify and quantify all per diem costs, by cost center, that vary with occupancy and, accordingly, must be excluded from the adjustment for low occupancy. In the absence of a specific identification, all per diem costs are deemed fixed and adjusted accordingly .

STATEMENT OF CASE AND PROCEDURAL HISTORY:

Alameda Hospital ("Provider") operated a hospital-based skilled nursing facility (SNF) in Alameda, California. For the fiscal year ended December 31, 1995, the Provider's routine costs exceeded the RCL. The Provider requested an atypical services exception from CMS and then appealed the Intermediary's final determination regarding the request in PRRB Case No. 98-0460. The Provider challenged the Intermediary's calculation of the low occupancy exception as well as the methodology of the 112 percent reimbursement "gap" that arises in atypical services exception requests.

On September 27, 2002 the Board issued a decision in PRRB Case No. 98-0460.[4] The Board found the Intermediary properly applied both the low occupancy adjustment methodology and the 112 percent reimbursement "gap" that affects atypical service exception requests. The Administrator of the Centers for Medicare and Medicaid declined to review the Board's decision and the Provider subsequently filed suit in federal court.

On May 14, 2004, the United States District Court for the District of Columbia issued a memorandum decision and order finding that the Secretary's methodology for calculating "atypical" costs in excess of the RCL was improper. The Court's decision related solely to the 112 percent reimbursement "gap." The Court held that the Secretary had a long established methodology for granting atypical cost exceptions from the RCL limit, and

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[2] 42 C.F.R. §§413.30(f)(1)((i) and (ii).
[3] Provider Final Position Paper, Exhibit 11.
[4] Alameda Hospital – SNF (Alameda, Cal.) v. Blue Cross and Blue Shield Association/United Government Services, LLC-CA., PRRB Dec. No. 2002-D46, September 27, 2002, Medicare and Medicaid Guide (CCH) ¶ 80,905.

failed to follow the Administrative Procedure Act[5] ("APA") notice and comment rulemaking when it abruptly shifted policy by issuing the revised PRM § 2534.5. The Court explained:

> "[T]he Secretary had a long established practice of granting atypical cost exceptions from the RCL limit. The Secretary carried out that practice without fail for, at least, the years between 1984 and July 1994. The length and consistency of that practice is sufficient to establish a definitive agency interpretation of § 413.30(f)'s language concerning the granting of "reasonable" exceptions to the RCL for atypical costs."

With regard to the low occupancy adjustment, the Court remanded the case to the Secretary of the Department of Health and Human Services for further proceedings in accordance with its decision.

On January 12, 2009, the Deputy Administrator for the Centers for Medicare & Medicaid Services issued an Administrator's Order remanding the case to the Board. The Administrator ordered:

> THAT the Provider Reimbursement Review Board's decision in the following case is hereby vacated (PRRB Case No. 98-0460) in accordance with the court's memorandum and order, and
>
> THAT the PRRB will consider the Provider's remaining claim(s) consistent with the procedures at 42 C.F.R. §405.1801, et seq. and the court's opinion and order, and
>
> THAT the PRRB will allow the parties to brief the matter of how the court's memorandum is to be implemented, with respect to the remaining low occupancy issue; and
>
> THAT the PRRB will issue a decision on the remaining claim(s), and
>
> THAT the Board's decision will be subject to 42 C.F.R. §405.1875.

On April 3, 2009, the Board issued a Notice of Reopening and Board Order implementing the Administrator's Order. The sole issue before the Board is whether the United States District Court's memorandum decision, finding the Secretary's methodology was improper under the precedent established in Alaska Hunters, also applies to the Secretary's low occupancy adjustment in this case.

INTERMEDIARY'S CONTENTION

The Intermediary contends that the low occupancy adjustment was properly applied, and that application of the Alaska Hunters case is limited. The Intermediary cites to Devon

[5] 5 U.S.C. § 551 *et seq.*

Energy Corporation v. Kempthorne, 551 F.3d 1030 (D.C. Cir. 1998)("Devon Energy") in which a federal agency's interpretation was alleged as inconsistent with the plain language of the rule and the agency's own prior interpretation of the rule. The Court rejected the application of Alaska Hunters to Devon Energy and distinguished the facts "because the disputed agency advice in that case [Alaska Hunters] had been upheld in a formal adjudication..."[6] The Intermediary asserts that although the low occupancy adjustment may not have been upheld in a "formal adjudication," it did not undercut 30 years of uniform advice as did the policy change in Alaska Hunters.[7]

PROVIDER'S CONTENTIONS

The Provider contends that 42 U.S.C. § 1395x(v)(1)(A) requires the Secretary to take into account direct and indirect costs, and to exclude costs that are unnecessary in the efficient delivery of needed health services. The Provider states that costs are determined by a two step process. First, costs must be found to be reasonable. Second, it must be determined whether costs that fall above the cost limit are attributable to the regulatory basis of an exception.[8]

The Provider asserts that the Secretary's rules concerning excess staffing and the scope of application of the low occupancy adjustment changed in July 1994 with the release of HCFA Transmittal No. 378 which revised PRM §§ 2530 – 2541.1. The Provider states that prior to the release of HCFA Transmittal No. 378, CMS did not apply the low occupancy adjustment to nursing services when considering low occupancy exception requests, and applied the adjustment only to the fixed costs of underutilized space. In support of this contention, the Provider cites to Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, HCFA Adm. Dec. October 20, 1995, Medicare and Medicaid Guide ¶ 43,722 ("Southfield Administrator Decision"). In that case the CMS Administrator applied the low occupancy adjustment only to the fixed costs of underutilized space, which it referred to as "idle capacity." The adjustment was never applied to nursing services. The Provider argues that with the release of HCFA Transmittal No. 378, CMS changed the rule by applying the low occupancy adjustment to nursing services.[9]

The Provider affirms that under the Alaska Hunters case, when an agency has given a regulation a definitive interpretation, it cannot later significantly revise that interpretation without notice and comment. The Provider concludes that the rationale in Alaska Hunters applies to the low occupancy adjustment in this case.

FINDINGS OF FACT CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the relevant law, regulations and guidelines, as well as the evidence presented, the Board concludes the District Court's findings under the Alaska

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[6] Devon Energy Corporation v. Kempthorne, 551 F.3d 1030, 1041 (D.C. Cir. 1998)
[7] Intermediary's Remand Final Statement, p. 4.
[8] Provider's Post Hearing Brief, p. 5.
[9] Transcript at 12-14.

Hunters case also apply to the Secretary's low occupancy adjustment in this case. If an agency had an interpretation of a regulation for an appreciable time period it cannot suddenly change the interpretation of the regulation without notice and comment rulemaking as required under the APA.

Prior to July 1994, the agency calculated the low occupancy adjustment in a certain manner. That changed with the release of HCFA Transmittal No. 378. Previously, the low occupancy rule was applied only to excess space and related fixed costs such as operation of plant, but not to costs such as nursing services, benefits, laundry, food, etc. CMS policy prior to the release of HCFA Transmittal No. 378 addressed specifically what was included in the rule – underutilized space. The evidence supports the Provider's argument that prior to the release of HCFA Transmittal 378, CMS policy did not apply the low occupancy adjustment to direct nursing hours[10]. Clearly there was a change in policy to apply the low occupancy adjustment to the cost of nursing services.

The Board concludes that the Secretary's methodology for calculating the low occupancy adjustment was improper under the precedent established in Alaska Hunters.

DECISION AND ORDER:

The Board finds the District of Columbia District Court's memorandum decision in this case also applies to the Secretary's low occupancy adjustment. The Secretary's new policy regarding the low occupancy adjustment should have been promulgated through notice and comment rulemaking. The case is remanded to the Intermediary to recalculate the SNF exception request utilizing the pre-1994 policy regarding low occupancy adjustments.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith Braganza
John Gary Bowers
Michael W. Harty
Clayton Nix

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: FEB 10 2012

[10] Transcript at 114-118; Provider's Final Position Paper, Exhibit P-40, p. 5; Exhibit P-41, p. 7.