CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Memorial Healthcare Center **Provider** **vs.** **BlueCross BlueShield Association/ National Government Services, LLC - WI** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Year Ending: December 31, 1994 and December 31, 1997** **Review of:** **PRRB Dec. No. 2007-D66** **Dated: August 30, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is a Medicare-certified hospital located in Owosso, Michigan, which included a hospital-based SNF. The Provider requested an exception from the SNF routine cost limits (RCLs) for its cost reporting periods ending December 31, 1994 and December 31, 1997, on the basis that it furnished atypical services. The Intermediary reviewed the Provider's requests and determined that it was entitled to per diem exceptions. However, the Provider contested the methodology that the Intermediary used to calculate the amount of each exception granted. The Provider believed it should be reimbursed all of its costs in excess of the limit.

ISSUE AND BOARD'S DECISIONS

The issue was whether the Intermediary improperly limited the Provider's hospital-based SNF 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.

Citing its decision in Hi-Desert Medical Center,[1] the Board found that 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 regulations. The Board stated that the regulation at 42 CFR § 413.30(f)(1) permits the Provider to request from CMS an exception to the cost limit because it provided atypical services. The Board found that, for fifteen years, the Secretary interpreted the regulation as permitting a provider to recover its reasonable costs that exceeded the cost limits if the provider demonstrated that it met the exception requirements. The Provider's exception request was processed in accordance with § 2534.5 of the PRM[2] issued in July 1994. That section states that the atypical services 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.

Thus, the Board continued, for the purpose of determining the atypical services exception for hospital-based SNFs, CMS replaced the limit with a new "cost limit," i.e., 112 percent of the peer group mean routine services cost. It is also undisputed, the Board stated, that 112 percent of the peer group mean of hospital-based SNFs is significantly higher than the routine cost limit. Thus, under § 2534.5 of the PRM, 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.

The Board stated that, in creating this reimbursement gap, CMS misinterpreted the intent of Congress, and the policy represents a substantive policy change from CMS' prior interpretation of § 413.30(f)(1). The Board observed that the only limit intended by Congress and imposed by the plain language of the statute and regulation is the cost limit. To qualify for an atypical services exception, a provider must demonstrate 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

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[1] 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.

[2] See HCFA [now CMS] Transmittal No. 378.

similarly classified." The Board noted that CMS did not dispute the fact that the Provider was furnishing atypical services.

The Board found that the regulation states that the provider must only show that its cost "exceeds the applicable limit," not that its cost exceeds 112 percent of the peer group mean. The Board stated that the regulatory comparison to a peer group of "providers similarly classified" referred to the "nature and scope of the items and services actually furnished," not of their cost.

Moreover, the Board continued, Congress established the four peer groups to be considered in determining Medicare reimbursement of SNFs: free-standing urban, free-standing rural, hospital-based urban, and hospital-based rural. There was no statutory or regulatory authority granted to CMS to establish a new peer group for hospital-based SNFs, i.e., 112 percent of the peer group mean routine service cost, and to determine atypical service exceptions from a new cost limit rather than from the Congressionally intended limit.

The Board also found that the provisions of § 2534.5 of the PRM referring to the 112 percent requirement are invalid because they were not adopted pursuant to the notice and comment requirements of § 553 of the Administrative Procedure Act (APA). The Board stated that this case is a departure from CMS' earlier method of determining hospital-based SNF exception requests, and therefore requires an explanation for such a change. Section 1888 of the Act only set the formula for determining the cost limit. It did not change the method to be used to determine exceptions, nor did it provide CMS with authorization to adjust its pre-existing policies or regulations.

Further, the Board cited a court decision to support the principle that, because § 2534.5 of the PRM carves out a per se exception methodology contained in the applicable regulation and in the unwritten policy of CMS for fifteen years prior to adoption of § 2534.5, it "effect[ed] a change in existing law or policy'" that is substantive in nature.[3] The Board found that, even if § 2534.5 is considered interpretive, it nevertheless constitutes a significant revision of the Secretary's definitive interpretations of 42 CFR §413.30 and is invalid because it was not issued pursuant to the APA's notice and comment rulemaking.[4]

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

[4] The Board cited to Paralyzed Veterans of America v. D.C. Area, 117 F.3d 579, 586 (D.C. Cir. 1997) and Alaska Professional Hunters Ass'n, Inc v. Federal Aviation Admin., 177 F.3d 1030, 1034 (D.C. Cir. 1999).

In addition, the Board found that there is nothing in the statute or regulation that requires the "gap" methodology interpretation at issue. Pursuant to § 1861(v)(1)(A) of the Act, Congress gave the Secretary broad authority to create regulations establishing the methods to be used and items to be included in determining reimbursement. If the gap methodology had been subjected to the APA rulemaking process, the Board stated that it would have been a legitimate exercise of that authority. However, it was not so promulgated. In addition to the previous arguments herein, the Board stated that it was further persuaded by the District Court's decision in St. Luke's Methodist Hospital v. Thompson[5] that § 2534.5 does not reasonably interpret § 413.30, and was a substantive rewrite of the regulation which imposed another requirement for exceptions. 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 § 1861(v)(1)(A). The Board found that the court ruling in St. Luke's is equally applicable to the present case and supports the Board's conclusion that the partial denial of the Provider's request for an exception to the SNF cost limits should be revised to permit the Provider to recover its costs.

SUMMARY OF COMMENTS

No comments were submitted by either of the parties to the case, or by CMM.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. No comments were submitted for consideration.

During the cost year at issue, Medicare reimbursed for services provided in SNFs largely on the basis of reasonable cost. Prior to 1972, provider's were able to recoup their entire cost of services to Medicare patients, unless such costs were found to be substantially out of line with those of similar institutions. However, Section 1861(v)(1) of the Social Security Act, enacted as section 223 of the Social Security Amendments of 1972 (Public Law 92-603), attempted to limit the amount a provider could be reimbursed by defining reasonable cost. Rather than defining it with precision, § 1861(v)(1)(A) defines reasonable cost broadly as the cost actually incurred, excluding any cost found to be unnecessary in the efficient delivery of needed health services, and authorizes the Secretary to issue appropriate regulations setting forth the methods to be used in computing such

[5] 182 F. Supp. 2d 765 (N.D. Iowa 2001), aff'd 315 F.3d 984 (8th Cir. 2003).

costs. The regulations at 42 CFR § 413.9 establish the determination of reasonable costs specifically for Medicare. If a provider's costs include amounts not related to patient care, or costs that are specifically not reimbursable under the program, those costs will not be paid by the Medicare program. Further, 42 CFR § 413.9(b) provides that the reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used and the items to be included.

Section 223 also amended § 1861(v)(1) to authorize the establishment of limits on allowable costs that will be reimbursed under Medicare. The limits are based on estimates of the costs necessary for the efficient delivery of needed health care services. The limits on inpatient general routine service costs set forth at § 1861(v)(1)(A) apply to SNF inpatient routine costs, excluding capital-related costs. The regulations codified at 42 CFR § 413.30, et seq. implement the cost limit provisions of § 1861(v)(1)(A) of the Act by setting forth the general rules under which CMS may establish limits on SNF costs recognized as reasonable in determining Medicare program payments. It also sets forth rules governing exemptions and exceptions to limits.

Pursuant to § 1861(v)(1)(A) of the Act, CMS has promulgated yearly schedules of limits on SNF inpatient routine service costs since 1979 and notified participating providers of the exceptions process in the Federal Register.[6] Initially, separate reimbursement limits were implemented for hospital-based SNFs and free-standing SNFs. Reimbursement limits for hospital-based SNFs were higher than for free-standing SNFs, due to historically higher costs incurred by hospital-based SNFs. While hospital-based SNFs maintained that they incurred higher costs because of the allocation of overhead costs required by Medicare and higher intensity of care, this was a subject of debate.[7] For cost reporting periods beginning on or after October 1, 1980, the cost limits were changed to 112 percent of the average per diem costs of each comparison group.[8]

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[6] See e.g., 42 Fed. Reg. 36,237 (1976); 44 Fed. Reg. 29,362(1979); 44 Fed. Reg. 51,542 (1979); 45 Fed. Reg. 58,699 (1980); 46 Fed. Reg. 48,026(1981); 47 Fed. Reg. 42,894 (1982).

[7] See HCFA, Report to Congress on the Study of the Skilled Nursing Facility Benefit under Medicare (1985).

[8] See e.g., 45 Fed. Reg. 58,699 (1980); 46 Fed. Reg. 48,026 (1981); 47 Fed. Reg. 42,894 (1982). See also 51 Fed. Reg. 11,234 (1986) (Prior to the schedule of … single limits were calculated at 112 percent of the mean of the routine costs for freestanding and hospital-based SNFs, respectively. Further, the routine costs considered for each comparison group were the routine costs attributable to the particular group…" Id.).

Amid the growing belief that the cost difference between hospital-based and freestanding SNFs was unjustified, Section 102 of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) eliminated the separate limits for hospital-based SNFs and free-standing SNFs, mandating that Medicare pay no more to hospital-based SNFs than would be paid to the presumably more efficient freestanding SNFs. However, the effective dates of these cost limits were retroactively postponed twice by Congress, and were never actually implemented.

In 1984, the Deficit Reduction Act (DEFRA) rescinded the single TEFRA limit for SNFs, and directed the Secretary to set separate limits on per diem inpatient routine service costs for hospital-based SNFs and free-standing SNFs, revising § 1861(v) of the Act and adding a new § 1888 to the Act, specifying the methodology for determining the separate cost limits.[9] Section 1888(a) states that the limit for freestanding SNFs is set at 112 percent of the mean per diem routine service costs for freestanding SNFs, and the limit for hospital-based SNFs is equal to the limit 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. Thus, DEFRA provided a compromise, allowing higher payments for hospital-based SNFs compared to the proposed payment system under TEFRA, but recognizing that not all of the cost differences between hospital-based and freestanding SNFS were justifiable.

The rationale behind the limits promulgated in DEFRA can be found in a report prepared for Congress by HCFA, which studied the cost differences between hospital-based and freestanding SNFs.[10] The results of this report were communicated to Congress before enactment of DEFRA.[11] The report found that while case mix difference accounted for approximately 50 percent of the cost difference, the remaining 50 percent was due to such things as provider inefficiency, facility characteristics, and overhead allocations. This conclusion was supported by three separate studies described in the report. In establishing the hospital-based cost limit at the free-standing limit plus 50 percent of the difference between the free-standing limit and the 112 percent of the mean hospital-based

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[9] Deficit Reduction Act of 1984 (DEFRA), Pub. L. No. 98-369 (Medicare and Medicaid Budget Reconciliation Amendments of 1984), applicable as provided in § 2319(c) and (d) of the amendments. See also § 2530, et. seq. of the PRM.

[10] Health Care Financing Administration Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare, U.S. Government Printing Office, January 1985.

[11] See St. Luke's Methodist Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D11.

routine service costs, Congress accepted the findings of this report, and mandated that the 50 percent difference in costs related to inefficiency, facility characteristics, and overhead allocations[12] were not reasonable costs and should not be reimbursed. This results in the reimbursement gap referred to by the Provider; an amount that a hospital-based facility can never be reimbursed even if it can establish that it exceeded the RCLs because of provision of atypical services.

The finding that the cost difference between hospital-based and freestanding SNFs is largely due to inefficiencies, rather than case mix differences or care provided, has been confirmed in many more recent studies. A study conducted by Abt Associates, Inc., found that hospital-based SNFs have significantly higher per-patient costs than freestanding SNFs after controlling for various factors, but could not explain why.[13] Another study, which compared hospital-based and freestanding SNF costs when controlled for case-mix and staffing patterns, found that less than one-half of the cost differences could be attributed to those factors.[14] A study conducted by the General Accounting Office on the Medicare Exception Process in SNFs found no substantive differences between the characteristics of, and services received by Medicare patients residing in SNFs which had been granted exceptions for atypical services and those in SNFs that did not receive exceptions. As others have noted, "If hospital-based facilities do not serve the more disabled patients or provide higher quality care, then the cost differential is not justified and should not be recognized by Medicare." [15]

In addition to establishing dual limits for hospital-based and freestanding SNFs, DEFRA, in subsection (b) of the new § 1888, mandated that an additional amount be added to the hospital-based SNF limit to account for cost differences between hospital-based and freestanding SNFs that are attributable to excess overhead allocations resulting from Medicare reimbursement principles. However, this

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[12] However, as noted below, an add-on for the overhead allocation was mandated by Congress under DEFRA, but was subsequently disallowed in the Omnibus Budget Reconciliation Act of 1993.

[13] Abt Associates, Inc., Why Are Hospital-Based Nursing Homes So Expensive? The Relative Importance of Acuity and Treatment Setting, Health Services and Evaluation (HSRE) Working Paper No. 3 (Cambridge, Massachusetts: February 2001)

[14] Cost and case-mix difference between hospital-based and freestanding nursing homes, by Margaret B. Sulvetta and John Holahan, Health Care Financing Review, Spring 1986, Volume 7, Number 3, p. 83.

[15] Prospective payment for Medicare skilled nursing facilities: Background and issues, by George Schieber, Joshua Wiener, Korbin Liu, and Pamela Doty, Health Care Financing Review, Fall 1986, Volume 8, Number 1, p. 83.

subsection was subsequently changed, pursuant to § 13503(a) of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66). Instead of requiring the Secretary to "recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities attributable to excess overhead allocations", Congress mandated that the Secretary not recognize those costs as reasonable. Because this add-on had been part of the 50 percent of the cost differences between hospital-based and freestanding SNFs that was considered to be due to excess overhead allocations and inefficiencies of hospital-based SNFs, this change by Congress further shows that the inefficiencies should never be recognized as reasonable, and should not be paid pursuant to the exception methodology. If CMS were to allow exceptions for hospital-based SNFs for costs that fell within the "gap" between the routine cost limit and 112 percent of the peer group mean, it would be paying those very costs which are not recognized as reasonable and which Congress has specifically instructed it not to pay.

The Secretary was also given broad discretion to authorize adjustments to the cost limits under DEFRA provisions. Section 1888(c) provided:

> The 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.

In accordance with this section, the regulation at 42 CFR § 413.30(f) provides for exceptions as follows:

> 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. [Emphasis added.]

Pertinent to this case, § 413.30(f)(1) specifically provides for an exception for atypical services if the provider can show that:

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

This regulation creates a two-prong test, requiring that any exception request examine the reasonableness of the amount that a provider's actual costs exceed the applicable cost limits, and determine the atypicality of the costs by using a peer group comparison, i.e., the 112 percent threshold. A hospital-based SNF's costs are thus compared to the costs of a typical facility (112 percent of the peer group mean) in order to determine if its costs are actually atypical.

Although this peer group comparison exceeds the RCLs established for hospital-based SNFs, it is a practical standard for measuring the atypical nature of a providers' services. It is also the same test used to determine the amount of an exception for a freestanding SNF, and is a standard based entirely upon data from similarly situated hospitals.

Consistent with the statute and regulations, CMS set forth the general provisions concerning payment rates for certain SNFs in Chapter 25 of the PRM. However, Chapter 25 of the PRM did not address the methodology used to determine exception requests. In July 1994, in order to provide the public with current information on the SNF cost limits under § 1888 of the Act, CMS issued Transmittal No. 378.[16] Transmittal No. 378 explained that new manual sections, at § 2530, et seq., were being issued to "provide detailed instructions for skilled nursing facilities (SNFs) to help them prepare and submit requests for exceptions to the inpatient routine service cost limits."

Section 2534.5, as adopted in Transmittal No. 378, "Determination of Reasonable Costs in Excess of Cost Limit or 112 Percent of Mean Cost," explains the process and methodology for determining an exception request based on atypical services. In determining reasonable costs, a provider's costs are first subject to a test for low occupancy and then are compared to per diem costs of a peer group of similarly classified providers. Section 2534.5B of the PRM explains the methodology CMS developed to quantify the peer group comparison that is part of the test for reasonableness:

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[16] Transmittal No. 378 also rendered §§ 2520-2527.4 of the PRM, adopted in July 1975, under Transmittal No. 129, as obsolete.

> Uniform National Peer Group Comparison. – The uniform national peer group data are based on data from SNFs whose costs are used to compute the cost limits. The peer group data are divided into four groups: Urban Hospital-based, Urban Freestanding, Rural Hospital-based, and Rural Freestanding. For each group, an average per diem cost (less capital-related costs) is computed for each routine service cost center (direct and indirect) that the provider reported on its Medicare cost report. For each cost center, a ratio is computed as the average per diem cost to total per diem cost. Those cost centers not utilized on the Medicare cost report must be eliminated and all ratios are revised based on the revised total per diem cost…
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> With cost reporting periods beginning prior to July 1, 1984, for each freestanding group and each hospital-based group, each cost center's ratio is applied to the cost limit applicable to the cost reporting period for which the exception is requested. For each hospital-based group with cost reporting periods beginning on or after July 1, 1984, the ratio is applied at 112 percent of the group's mean per diem cost (not the cost limit), adjusted by the wage index and cost reporting year adjustment factor applicable to the cost reporting period for which the exception is requested. The result is the Provider's per diem cost is disaggregated into the same proportion of its peer group mean per diem cost for each cost center.
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> The SNF's annual per diem cost or, if applicable, the cost as adjusted for low occupancy for each applicable routine cost center (less capital-related costs) is compared to the appropriate component of the disaggregated cost limit or 112 percent of the hospital-based mean per diem cost. If the SNF's per diem cost exceeds the peer group per diem cost for any cost center, the higher cost must be explained. Excess per diem costs which are not attributable to the circumstances upon which the exception is requested and cannot be justified may result in either a reduction to the amount of the exception or a denial of the exception.

Contrary to the Board's findings, the Administrator finds that the exception guidelines in Chapter 25 of the PRM are reasonable and appropriate, as they closely adhere to the requirements of § 1888(a) of the Act and are within the scope of the Secretary's discretionary authority under § 1888(c) of the Act to make adjustments in the SNF RCLs, and under the implementing regulations at § 413.30(f)(1)(i). The Administrator rejects the Board's view that § 1888(a) of the Act and the implementing regulation at 42 CFR § 413.30 entitle all SNFs to be

paid the full amount by which their costs exceed the applicable RCL. The Administrator finds that the policy interpretation in § 2543.5B, requiring the hospital-based SNF costs to be compared to 112 percent of the group's mean per diem costs, is an appropriate method of applying the reasonable cost requirements and is not inequitable.

Furthermore, the Administrator finds use of the methodology set forth in § 2534.5B of the PRM in no way alters or revises Medicare policy as set forth in the regulations at § 413.30(f)(1)(i) but is one method of applying that policy. Indeed, § 2534.5B did not effect a change in CMS policy.[17] Although Congress changed the RCLs for hospital-based SNFs in 1984, the published cost limits since 1980[18] reflect that CMS had previously used a methodology under which the SNFs' per diem costs were compared to a percentage of the peer group mean diem cost.[19]

Notably, § 2534.5B refers to the "cost limit" limit rather than to 112 percent of a SNF's peer group mean per diem cost, only where the terms are interchangeable, i.e., where the cost limit is equal to 112 percent of the SNF's peer group mean cost. For periods prior to the effective date of the hospital-based SNF RCL under DEFRA, July 1, 1984, the term, "112 percent of the peer group mean per diem cost" was synonymous with the term, "cost limit," for both free-standing SNFs and hospital-based SNFs. After June 1984, the free-standing SNF RCL remained at 112 percent of the peer group mean per diem cost. However, as explained above, Congress changed the amount of the hospital-based SNF RCL. Thus, § 2534.5B uses the term of cost limit to refer to 112 percent of the free-standing SNF mean per diem cost, but cannot use the same term for the hospital-based SNFs. Section

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[17] The record in this case does not support the Board's finding that CMS had changed policy.

[18] 45 Fed. Reg. 41,292 (1980) ("We are proposing that the limits be set at 112 percent of each group's mean cost. We believe that the 12 percent allowance above mean cost is a reasonable margin factor in view of the refinements made in the method used to establish the limits."); 45 Fed. Reg. 58,699 (1980) ("[l]imits set at 112 percent of the average per diem labor-related and nonlabor costs of each comparison group." Id.) 46 Fed. Reg. 48,026 (`981); 51 Fed. Reg. 11,234 (1986).

[19] See, e.g., 44 Fed. Reg. 51,542, 51,544 (Aug. 31, 1979) ("We believe the use of a limit based on the average to be superior to a percentile limit. The average is a good measure of the cost incurred in the efficient delivery of services by peer providers…. Since these are the first limits we have established for SNFs, the methodology used does not account for any conceivable variable which could affect SNF costs. As we gain information and experience, the methodology will be refined.")

2534.5B simply recognizes that, after July 1, 1984, the term of cost limit can no longer be used interchangeably with the term of 112 percent of the peer group mean per diem cost for hospital-based SNFs. In short, although the statutory cost limit for hospital-based SNFs was changed under DEFRA, that change did not impact CMS' peer group methodology.

Thus, the Administrator also disagrees with the Board's finding that the methodology for determining an exception for atypical services of a hospital-based SNF using the uniform peer group comparison, as set forth in § 2534.5 of the PRM, constituted a change in policy requiring notice and comment rule-making under 5 USC 552. First, as noted, CMS has consistently compared SNF costs to their comparison group in applying the cost limits. The Administrator finds that the methodology at issue does not involve application of a "substantive" rule requiring publication of notice and comment under the APA. The Secretary has broad authority to promulgate regulations under §§ 1861(v)(1)(A) and 1888 of the Act. Relevant to this case, the Secretary has promulgated a regulation at 42 CFR § 413.30(f)(1) establishing a specific exception from the RCLs based on atypical services. The Secretary does not have an obligation to promulgate regulations that specifically address every conceivable situation in the process of determining reasonable costs.[20] Rather, the Intermediary is required to make a determination of the reasonableness of the exception request, applying the existing reasonable cost statute, controlling regulations, and any further guidance that CMS has issued. The methodology set forth in § 2534.5 of the PRM is a proper interpretation of the statute and the Secretary's rules allowing an exception to the limits on reasonable costs based on atypical services.[21]

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[20] See Shalala v. Guernsey Memorial Hospital, 514 US 87, 96(1995) (The Supreme Court also explained that, "[t]he APA does not require that all the specific applications of a rule evolve by further more, precise rules rather than by adjudication,"); Chrysler Corp. v. Brown, 441 US 281, 302, n. 31 (1979) ("An interpretive rule is issued by the agency to advise the public of the agency's construction of the statutes and the rules which it administers," quoting the Attorney General's Manual on the Administrative Procedure Act," 30 at n.3 (1947).).

[21] Similarly, the Intermediary's application of the methodology set forth at § 2534.5 of the PRM does not constitute a substantive rule, and is consistent with the reasonable cost rules in effect for the cost years at issue. Moreover, the nature of reasonable cost reimbursement requires the determination of allowable costs after the close of the cost reporting period. Application of any reasonable cost comparison determination would constitute a retroactive rulemaking under the Provider's definition of that term.

Furthermore, CMS used this method even before it was set forth in the PRM in July, 1994. On November 16, 1992, HCFA responded to a provider's exception request for its August 31, 1989 cost reporting period by comparing its cost to its peer group mean costs, and granting only a partial exception. This same provider, a hospital-based SNF, had been granted similar partial exceptions for its 1985, 1986, 1987, and 1998 cost reporting periods.[22] On February 23, 1993, HCFA denied another provider's 1985 cost year exception request because the costs did not exceed the peer group per diem cost. HCFA explained[23]:

> The peer group developed by HCFA for evaluating exceptions to the cost limits 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 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. As a result, a hospital-based SNF is only eligible for an exception for atypical services for the amount that its actual costs exceeds 112 percent of the mean costs of hospital-based SNFs and not by the amount that its actual costs exceeds its cost limit.

Thus, contentions by the Provider in this case that there was a change in policy are not supported by the record.

Accordingly, after review of the record and applicable law, the Administrator finds that the methodology set forth in § 2534.5B of the PRM is consistent with the plain meaning of §§ 1861(v) and 1888(a)-(c) of the Act, the legislative intent, and the regulations at 42 CFR 413.30. The Intermediary properly applied the methodology at § 2534B of the PRM in partially denying the Provider's request for an exception to the RCL.

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[22] North Coast Rehabilitation Center, PRRB. Dec. No. 1999-D22 (June 23, 1998), p. 2-3.

[23] New England Rehabilitation Hospital, PRRB Dec. No. 2000-D53 (April 13, 2000), p. 4.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.

Date: **10/29/07** **/s/**

Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services