CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of: **Toyon 85-98 112% Hospital-Based Peer Group Mean; Catholic Healthcare West 96-98 112% Hospital-Based Peer Group Mean; Sutter Health 91-99 112% Hospital-Based Peer Group Mean; St. Joseph Health System 92-98 112% Hospital-Based Peer Group Mean; Toyon 1999 112% Hospital-Based Peer Group Mean; Toyon 2000 112% Hospital-Based Peer Group Mean; and Toyon 2001 112% Hospital-Based Peer Group Mean** **Providers** **vs.** **BlueCross BlueShield Association/ First Coast Service Options, Inc.** **Intermediary**	**Claim for:** **Provider Cost Reimbursement Determination for Cost Year Ending: Various** **Review of:** **PRRB Dec. No. 2010-D35** **Dated: June 10, 2010**

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. The Provider submitted comments requesting that the Board's decision be affirmed. The Center for Medicare submitted comments requesting that the Board's decision be revised. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Providers are hospital-based skilled nursing facilities (SNFs) appealing FYEs ranging from 1985 through 2001. This appeal covered 74 cost reports. During the cost reporting years at issue in this case, the Providers were reimbursed based upon the reasonable costs incurred to provide health care services to Medicare beneficiaries, as provided by §1861(v)

of the Social Security Act and were subject to the routine cost limits (RCLs) placed upon SNFs as provided in §1888 of the Act. In accordance with 42 C.F.R. §413.30(f)(1), the Providers requested individual exceptions to the cost limits. The exception request of each of the Providers was approved. However, the Providers appealed the methodology used by the Intermediary to determine their cost limit exceptions. The Providers' contend that they should be reimbursed all of their costs in excess of the routine cost limit, instead of 112 percent of the peer group mean.

ISSUE AND BOARD'S DECISION

The issue was whether CMS' methodology for determining the Providers' exception to the hospital-based skilled nursing facility cost limits was proper.

The Board found that the methodology applied by CMS, in partially denying the Providers' exception requests for per diem costs that exceeded the cost limit, was not consistent with the statute and regulations. The Board noted that its decision in this case is consistent with its decision in several other cases.[1]

The Board stated that the regulation at 42 C.F.R. §413.30(f)(1) permits a provider to request from CMS an exception to the cost limit because it provided atypical services. The Board claimed that it was undisputed 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. CMS then issued HCFA Transmittal No. 378 in July 1994, which provided that the atypical services exception for a hospital-based SNF must be measured from 112 percent of the peer group mean for the hospital-based SNF, rather than from the hospital-based SNF's cost limit. The Board noted that this specific requirement was also established in Provider Reimbursement Manual (PRM) (HCFA Pub. 15-1) §2534.5.

Thus, the Board continued, CMS replaced the limit with a new "cost limit," i.e., 112 percent of the peer group mean routine services cost. The Board stated that 112 percent of the peer group mean of hospital-based SNFs is significantly higher than the applicable routine cost limit. Thus, under §2534.5 of the PRM, a reimbursement "gap" is created between the cost limit and 112 percent of the peer group mean that represents costs incurred by a hospital-based SNF, which are not allowed.

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[1] See Glenwood Regional Medical Center, PRRB Dec. No. 2004-D23; Montefiore Medical Center, PRRB Dec. No. 2006-D29; Hi-Desert Medical Center, PRRB Dec. No. 2007-D17; Montefiore Medical Center, PRRB Dec. No. 2007-D61; Memorial Health Care, PRRB Dec. No. 2007-D66; Quality 89-92 Hospital Based SNF, PRRB Dec. No. 2009-D8; Canonsburg General Hospital SNF, PRRB Dec. No. 2009-D37. All of these decisions were reversed by the Administrator on review.

The Board stated that CMS reached a conclusion regarding the intent of Congress toward reimbursing the routine costs of hospital-based SNFs, and inappropriately applied that same rationale to hospital-based SNFs that provide atypical services or incur unusual or uncustomary costs. This, the Board found, was 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 clearly represents a substantive change in CMS' prior interpretation and application of 42 C.F.R. §413.30(f). 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 similarly classified.

The Board found that 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 Board stated that 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. The Board also stated that Congress itself established the four "peer groups" that are to be considered in determining Medicare reimbursement of SNFs: freestanding urban, freestanding rural, hospital-based urban, and hospital-based rural. The Board claimed that CMS had no statutory or regulatory authority 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 exceptions from a new cost limit rather than from the limit imposed by Congress.

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 it found CMS' methodology to be a departure from its earlier method of determining the amount for hospital-based SNF exception requests and which requires an explanation for such a change. The Board claimed that §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. The Board noted 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 prior to adoption of this manual section, it "effected a change in existing law or policy" that is substantive in nature.

The Board found that, even if §2534.5 is considered an interpretive rule, it nevertheless constitutes a significant revision of the Secretary's definitive interpretations of 42 C.F.R.

§413.30 and is invalid because it was not issued pursuant to the APA's notice and comment rulemaking.[2]

In addition, the Board found that there is nothing in the statute or regulation that authorizes 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.

The Board stated that its decision was supported by the holding in St. Luke's Methodist Hospital v. Thompson[3] that § 2534.5 does not reasonably interpret 42 C.F.R. §413.30. The Board found that 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.

SUMMARY OF COMMENTS

The Providers commented, stating that the Board's decision was correct in this case. The Providers claimed that the Administrator's decisions on the reimbursement gap have made the consistent mistake of stating that the SNF exception regulation at 42 C.F.R. §413.30(f) was promulgated after and in accordance with §1888(c) of the Act, added by the Deficit Reduction Act of 1984 (DEFRA). The Providers argued that the SNF exception regulation was promulgated five years before DEFRA. From the initial establishment of the routine cost limits, the Secretary provided by regulation for an exception process by which providers were paid additional amounts if they could prove that their costs exceeded the routine cost limits due to the provision of needed, atypical services.

The Providers also noted that the Administrator, in previously stating that "Chapter 25 of the PRM did not address the methodology used to determine exception requests", while technically correct, avoids the well established fact that the Secretary had otherwise definitively interpreted the SNF exception regulation at 42 C.F.R. §413.30(f) well before publication of PRM §2534.5. From at least 1983 through early 1994, a draft set of

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[2] 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).

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

guidelines[4] were uniformly used by CMS (formerly the Health Care Financing Administration (HCFA)) to review and approve each SNF atypical services exception request. The process charges the fiscal intermediary with reviewing the request and determining the reasonableness of all the costs, by comparing them to similar costs of a "peer group" of providers. The Providers cited to a deposition and subpoena duces tecum request for CMS staff, one of four reimbursement specialists within HCFA who both processed exception requests and eventually helped develop PRM §2534.5. The Providers argued that based on CMS staff's testimony and accompanying documents provided by him, from at least 1983 until 1994, there was no "gap" applied to exception requests, instead, the amount of an approved exception was counted from the cost limit itself, not from 112 percent of the mean. The Providers also noted that a healthcare financial consultant who supervised the preparation of over 600 atypical services exception requests noted that the amount of the exception before 1994 was measured from the routine cost limit.[5] Thus, the Providers stated that based on all the evidence, 42 C.F.R. §413.30(f) was consistently interpreted not to include a "gap", but instead to measure the exception from the cost limit.

The Providers also argued that the Report to Congress, on which the Administrator relies for the conclusion that 50 percent of the difference in costs between hospital-based SNFs and freestanding SNFs was due to inefficiency, was not issued until six months after the enactment of DEFRA. The Providers cited the court in St. Luke's Methodist Hospital v. Thompson as support. The Providers also pointed out that the court in this case found that the Report could not be "reasonably read to affirmatively conclude that the 'unexplained' variance between freestanding and hospital-based SNF costs is due to hospital-based SNF inefficiency."[6]

The Providers next noted that there is no reasonable reading of Section 1888(a) and (c) of the Act in the context of the pre-DEFRA SNF exception regulation and methodology to support the reimbursement gap. The Providers claimed the only reasonable conclusion that can be drawn from the enactment of §1888(a) and (c) is that Congress used the 50 percent figure to set a lower cost limit for hospital-based SNFs providing only typical services, subject to the existing exception process that would continue to reimburse both hospital-based SNFs and freestanding SNFs without any "gap" in the exception process. The Providers cited the Legislative History, Senate Finance Committee, which accompanies DEFRA which states that:[7]

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[4] Providers' Revised Final Position Paper, Exhibit P-15 at pp.68-180. The Administrator notes that each of the Hospital Groups in this group appeal has its own Revised Final Position Paper, however, all exhibits for each Hospital Group are the same.
[5] Providers' Revised Final Position Paper, Exhibit P-22 at p. 7.
[6] Id.
[7] Providers' Revised Final Position Paper, Exhibit P-6 at p. 4.

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

The Providers stated that it was on this basis that the Eighth Circuit Court of Appeals in St. Luke's held that the reimbursement gap was an erroneous interpretation of the provisions that allow the Secretary to grant an upward adjustment to hospital-based SNFs.[8]

The Providers also claimed that the reimbursement gap in PRM §2534.5 can only be brought into legal effect by notice and comment rulemaking because it clearly modified the language and long-standing interpretation of the regulation at 42 C.F.R. §413.30. The Providers stated that PRM §2534.5 modified the language of the pre-existing regulation, which speak of exceptions as adjustments to the cost limits, not to some higher bar which must also be exceeded, and modified the long-established and frequently applied process by which atypical services exception request were administered for at least ten years. Because of this, the Providers argued, PRM §2534.5 falls under the rulings of Paralyzed Veterans of America v. D.C. Arena[9] and Alaska Professional Hunters Ass'n v. FAA.[10] The "gap" would also be invalid under the standards enunciated in American Mining Congress v. Mine Safety & Health Administration,[11] which held that four tests determine whether a rule was legislative, thus requiring notice and comment, or was interpretive, and exempt from notice and comment. The fourth test looks at whether the rule effectively amends a prior legislative rule. The Providers argued that because PRM §2534.5 creates a new gap, it is legislative.

Finally, the Providers noted that hospital-based SNF providers which provided atypical services relied on the Secretary's 15 year atypical exception process that paid additional reimbursement to qualifying SNFs from the routine cost limit, and that this reliance is shown by the substantial growth in number of hospital-based SNFs during the 1980s, and by comments made by the Secretary regarding cost limits in the Federal Register.[12]

The Center for Medicare commented, requesting that the Administrator reverse the Board decision. The Center for Medicare noted that §223 of the Social Security Amendments of 1972 authorized the Secretary to establish "limits on the direct and indirect overall incurred costs or incurred costs of specific items or services or groups of items or services" as a

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[8] St. Luke's Methodist Hospital v. Thompson, 315 F.3d 984, 988 (8th Cir. 2003).
[9] 117 F.3d 579 (D.C. Cir. 1997).
[10] 177 F.3d 1030 (D.C. Cir. 1999).
[11] 995 F.2d 1106, 1112 (D.C. Cir. 1993).
[12] See, e.g., 51 Fed. Reg. 11,234, 11,240 (Apr. 1, 1986) and 52 Fed. Reg. 37,098 (Oct. 2, 1987).

presumptive test of reasonable costs. Citing to the Committee Report associated with this section, the Center for Medicare noted that in establishing the cost limits and the exception process of payment of costs in excess of the limit, it was clearly Congress' intent to reimburse providers for only those costs incurred in the efficient delivery of needed health care.

The Center for Medicare noted that the implementing regulations, which are currently at 42 C.F.R. §413.30, established the general authority on the procedures for establishing limits and the establishment of an appeal mechanism regarding the applicability of the cost limits. The Center for Medicaid noted that prior to issuing the first set of cost limits effective October 1, 1979, CMS recognized that average per diem costs of hospital-based SNFs were higher than that of freestanding SNFs, and thus CMS established separate cost limits for these two SNFs that resulted in four distinct groupings: Hospital-based/Urban, Hospital-based/Rural, Freestanding/Urban, and Freestanding/Rural. These were published in a proposed Federal Register notice,[13] in which CMS stated that a portion of the cost difference between hospital-based SNFs and freestanding SNFs may be attributable to the Medicare cost allocation process. CMS solicited comments on the issue of separate cost limits, and these comments were discussed in the final Federal Register notice.[14] The Center for Medicare stated that most of the comments opposed to separate limits pointed out that all SNFs should meet the same standards as a condition of certification and, thus, there should not be differing cost limits. In establishing separate cost limits in the final 1979 notice, CMS stated that studies needed to be performed to determine the reasons for the cost differences.

The Center for Medicare cited to Congressional actions in implementing the Tax Equity and Fiscal Responsibility Act of 1982, in which Congress mandated that a single routine cost limit, based only on freestanding costs, should be applied to both hospital-based SNFs and freestanding SNFs. This provision was repealed, but various studies done from 1983 to 1984, released in a Report to Congress in 1985, indicated that only 50 percent of the cost differences between hospital-based SNFs and freestanding SNFs were actually due to intensity of care or case-mix. The Center for Medicare pointed out that as a result of these studies, DEFRA contained a provision to recognize 50 percent of the cost differences between hospital-based and freestanding SNFs in setting the hospital-based SNF limits.

The Center for Medicare commented on the exception process used by the Secretary, the first step being to determine if costs are reasonable, and the second step being determining that the costs in excess of the limit are due to being atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified. The Center for Medicare gave an example of how this exception process works.

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[13] 44 Fed. Reg. 29,362 (May 18, 1979).
[14] 44 Fed. Reg. 51,542 (Aug. 31, 1979).

The Center for Medicare noted that the Board misinterpreted CMS' intended policy objective of removing the costs associated with inefficiencies from the provider's costs under the methodology described in Chapter 25 of the Provider Reimbursement Manual (PRM), and noted that they disagreed with the Board's statement that the "gap" amount should be reimbursed. The Center for Medicare stated that the "gap" is precisely the amount of a hospital-based SNFs costs, as identified in past studies and legislative documentation, that is related to inefficiencies and which is an amount that Congress clearly did not intend the government to reimburse when establishing the cost limits or the exception process. In addition, the Center for Medicare found, the regulations allow for an exception "only to the extent that costs are reasonable", thus, the need for an adjustment which reduces a hospital-based SNFs costs by an amount associated with inefficiencies, i.e., unreasonable costs.

Finally, the Center for Medicare argued that over the years of implementing the provisions of Chapter 25 of the PRM, Congress has never introduced legislation directing CMS to recognize any of the "gap" amount as reasonable through the exception process. In addition, when replacing the cost limit payment system with the SNF prospective payment system in 1998, Congress did not recognize a substantial portion of hospital-based SNF costs by establishing a single Federal rate for both hospital-based SNFs and freestanding SNFs as an average of the average costs for freestanding and the average costs for all facilities combined.[15] Thus, under the current SNF PPS, Congress recognizes an amount far less than 50 percent of the difference between hospital-based SNFs and freestanding SNFs costs recognized under the cost limit payment system.

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. All comments timely submitted have been taken into consideration.

During the cost years at issue, Medicare reimbursed for SNF services largely on the basis of reasonable cost. Prior to 1972, §1861(v)(1) initially set forth that reasonable costs shall be determined, inter alia, in accordance with the regulations establishing the method or methods to be used.[16] Generally, providers were able to be reimbursed the cost of services to Medicare patients, unless such costs were found to be substantially out of line with those of similar institutions.

[15] See §1888 of the Act and 42 C.F.R. §413.337(b)(5).
[16] See Pub. L. No. 89-97.

However, in 1972, §1861(v)(1) of the Social Security Act, was amended by section 223 of the Social Security Amendments of 1972[17], to attempt to limit the amount a provider could be reimbursed by further defining reasonable cost. Section 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 costs.

Section 223 also amended §1861(v)(1) to authorize the establishment of limits on allowable costs that will be reimbursed under Medicare. Section 1861(v)(1)(A) authorized the Secretary to establish limits on the direct and indirect overall incurred costs of specific items or services or groups of items or services. 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 and are referred to as the routine cost limits or RCLs.

The regulations at 42 C.F.R. §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 C.F.R. §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.

The regulations at 42 C.F.R. §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 provider costs, including 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 exception process in the Federal Register.[18] Initially, separate reimbursement limits were implemented for hospital-based SNFs and freestanding SNFs. Reimbursement limits for hospital-based SNFs were higher than for freestanding 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. For cost reporting periods beginning on or

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[17] Pub. L. No. 92-603.

[18] 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).

after October 1, 1980, the cost limits were changed to 112 percent of the average per diem costs of each comparison group.[19]

However, 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 freestanding SNFs, mandating that Medicare pay no more to hospital-based SNFs than would be paid to the presumably more efficient freestanding SNFs. 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 freestanding SNFs, revising §1861(v) of the Act and adding a new §1888 to the Act, specifying the methodology for determining the separate cost limits.[20] 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. 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 allowed higher payments for hospital-based SNFs compared to the proposed payment methodology under TEFRA, but recognized 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.[21] Despite the Providers' contentions that Congress' reliance on this report is in doubt because of the Report's issue date, the results of this Report were

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[19] 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 September 29, 1982 schedule of single limits (required by Pub. L. 97-248), we published separate schedules. Under these schedules, the SNF cost limits for inpatient routine services 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.).

[20] 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.

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

communicated to Congress before enactment of DEFRA.[22] 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 further supported by three separate subsequent studies.[23]

In establishing the hospital-based SNF cost limit at the freestanding SNF limit plus 50 percent of the difference between the freestanding limit and the 112 percent of the mean hospital-based SNF routine service costs, Congress accepted the findings of this report. Congress thus mandated that the 50 percent difference in costs related to inefficiency, facility characteristics, and overhead allocations[24] were not reasonable costs and should not be reimbursed. This results in the reimbursement gap disputed by the Provider that is comprised of an amount that CMS recognizes as unreasonable and, thus, not allowable.

In addition to establishing dual limits for hospital-based and freestanding SNFs, DEFRA (1984), in subsection (b) of §1888, mandated that an additional amount be added to the hospital-based SNF limit to account for cost differences between hospital-based and

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[22] See Letters from Chronic Care Purchasing Policy Group, Providers' Revised Final Position Paper, Exhibit P-19, p. 2 and P-21, p. 3. See also St. Luke's Methodist Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D11.

[23] 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. See 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). 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. See 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. 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." See 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.

[24] 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.

freestanding SNFs that are attributable to excess overhead allocations resulting from Medicare reimbursement principles. However, this subsection was subsequently changed, pursuant to § 13503(a) of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66) (OBRA '93). Congress instead mandated that the Secretary **not** recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities limits attributable to excess overhead allocations.[25] This change further shows that Congress intended that the hospital-based SNF inefficiencies should never be recognized as reasonable and, likewise, 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 hospital-based SNF 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. Notably, Congress has never mandated the recognition of the cost differences between hospital-based and freestanding SNFs that are attributed to inefficiencies and facility characteristics.

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 C.F.R. §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.][26]

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[25] See Conference Agreement noting "Additional payments for excess overhead costs allocated to hospital-based facilities are eliminated, effective for cost reporting periods beginning on or after October 1, 1993." 139 Cong Rec H 5792 (Aug. 4, 1993).

[26] See also 44 Fed. Reg. 31804 (June 1, 1979), adopting language at 42 C.F.R. §405.460(f) stating that: "An adjustment will be made only to the extent the costs are reasonable, attributable to 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 be examined to determine 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 provider's 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.[27] 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

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

PRM explains the methodology CMS developed to quantify the peer group comparison that is part of the test for reasonableness:

> 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…
>
> 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.
>
> 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 C.F.R. § 413.30 entitle all

SNFs to be paid the full amount by which their costs exceed the applicable RCL.[28] 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 that have existed in the regulation since at least 1979.

Furthermore, the Administrator finds use of the methodology set forth in §2534.5 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, §2534.5 did not affect a change in CMS policy. Although Congress changed the RCLs for hospital-based SNFs in 1984, the published cost limits since 1980[29] 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.[30]

Notably, §2534.5 refers to the "cost 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

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[28] While the Board noted that its decision in this case was consistent with its decision in several other cases, the Board failed to note that it previously reached the opposite conclusion in several other cases on this issue. See Mercy Medical Skilled Nursing Facility, PRRB Dec. No. 1999-D61; Riverview Medical Center Skilled Nursing Facility, PRRB Dec. No. 1999-D67; St. Luke's Methodist Hospital- SNF, PRRB Dec. No. 2000-D11; New England Rehabilitation Hospital , PRRB Dec. No. 2000-D53; Fort Bend Community Hospital-SNF, PRRB Dec. No. 2000-D86; San Joaquin Community Hospital-SNF, PRRB Dec. No. 2001-D17; Centennial Medical Center-SNF, PRRB Dec. No. 2001-D54; Colleton Regional Hospital-SNF, PRRB Dec. No. 2002-D8; Alameda Hospital SNF, PRRB Dec. No. 2002-D46; Providence Hospital-Central SNF, PRRB Dec. No. 2002-D50.

[29] 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 (1981); 51 Fed. Reg. 11,234 (1986).

[30] 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.")

freestanding SNFs and hospital-based SNFs. After June 1984, the freestanding 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, §2534.5 uses the term of cost limit to refer to 112 percent of the freestanding SNF mean per diem cost, but cannot use the same term for the hospital-based SNFs. Section 2534.5 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.

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 U.S.C. §552. 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 C.F.R. §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.[31] Rather, the Intermediary is required to make a determination on the exception request, applying the existing reasonable cost statute, controlling regulations, and any further guidance that CMS has issued. Notably, the regulation instructing the payment of reasonable cost only where an exception is granted has been in place since 1979. 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.[32] The methodology

[31] See Shalala v. Guernsey Memorial Hospital, 514 U.S. 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 U.S. 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).).

[32] 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.

also is specifically in accordance with the directive of Congress in OBRA '93 to not recognize as reasonable certain differences in hospital-based and freestanding SNFs caused by inefficiencies.[33]

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.[34] 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[35]:

> 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.

This exact language can also be seen in exhibits provided by the Providers' in this case, in letters dated 1993 and October 1994 in response to exception requests submitted by Seventh Ward General Hospital-SNF,[36] and in a letter dated March 22, 1993 in response to an exception request submitted by Fairmont Hospital-SNF.[37] Thus, the record does not support a finding that CMS had not applied this methodology in the 15 years prior to the implementation of HCFA Transmittal No. 378.

Further, even if HCFA Transmittal No. 378 constituted a new methodology to determine the reasonable cost that could be allowed under the exception process, such a methodology was based upon new facts demonstrating that certain hospital-based SNF costs above the limit were per se unreasonable. As distinguished from the court's holding in Alaska Professional Hunters Ass'n,[38] the Court of Appeals in the District of Columbia in Hudson v. FAA,[39] rejected the argument that an agency had impermissibly changed its interpretation of the

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[33] See §1888(b) of the Act.
[34] North Coast Rehabilitation Center, PRRB. Dec. No. 1999-D22 (June 23, 1998), p. 2-3.
[35] New England Rehabilitation Hospital, PRRB Dec. No. 2000-D53 (April 13, 2000), p. 4.
[36] Providers' Revised Final Position Paper, Exhibit P-17, p. 127 and 136.
[37] Providers' Revised Final Position Paper, Exhibit P-15, p. 182.
[38] 117 F.3d 579.
[39] 192 F.3d 1031 (D.C. Cir. 1999).

regulation. In that case, the court found the agency was entitled to apply the regulation to a new understanding of the facts without violating the principles set forth in Alaska Professional Hunters Ass'n or Paralyzed Veterans of America.[40] In this instance, the Secretary's application of the longstanding reasonable cost criteria reflects the factual findings that hospital-based SNFs systemically have unnecessarily high costs due to inefficiencies. These unreasonable costs are reflected in the 50 percent difference between the hospital-based SNF cost limit and the 112 percent peer group mean per diem cost for hospital-based SNFs.[41] Thus, the Secretary's alleged new methodology was implemented as a result of a new understanding of the cost inefficiencies affecting hospital-based SNFs.

Accordingly, after review of the record and applicable law, the Administrator finds that the methodology set forth in §2534.5 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 C.F.R. §413.30. The Intermediary properly applied the methodology at §2534.5 of the PRM in partially denying the Providers' requests for an exception to the RCL.

[40] 177 F.3d 1030.

[41] In addition, the exceptions for the routine cost limits have been in place since 1979 (See, e.g., 44 Fed. Reg. 31, 802 (1979)) and initially covered a broad spectrum of providers and were not specific to SNFs. Thus, the wide prescription in the regulation that all costs allowed pursuant to the granting of an exception must be reasonable is consistent with the various types of providers to which the cost limits were applied.

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: 8/2/2010

/s/

Marilynn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services