CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Canonsburg General Hospital **Provider** **vs.** **BlueCross BlueShield Association** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Year Ending: 6/30/96** **Review of:** **PRRB Dec. No. 2009-D37** **Dated: August 20, 2009**

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. CMS submitted comments requesting that the Administrator reverse the Board's decision. The Provider submitted comments requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue was whether CMS' methodology for determining the Provider's exception to the hospital-based skilled nursing facility (HB-SNF) routine cost limits was proper.

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

The Board stated that the regulation at 42 CFR § 413.30(f)(1) permits a provider to request from CMS an exception to the cost limit because it provided atypical services. CMS 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. This requirement was also established as Provider Reimbursement Manual (PRM) (HCFA Pub. 15-1) §2534.5. The 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 "discount factor" 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.

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.[1]

In addition, the Board found that there is nothing in the statute or regulation that authorizes the "discount factor" 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 discount factor 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[2] 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 Provider commented, requesting that the Administrator affirm the Board's decision. The Provider noted that the Board's decision was in accordance with applicable statute and regulations and conforms to controlling court interpretations that the discount factor methodology inserted in the "exceptions" process set forth at section 2534.5 of the PRM represented an illegal rule-making, violated the APA, and is contrary to law.

The Provider challenged the comments and submissions by CMM and specifically stated that CMM's comments were not supported by the facts. The Provider asserts that the Deficit Reduction Act of 1984 ("DEFRA 84") does not authorize PRM Section 2534.5, and therefore, did not amend, or seek to amend, the "exceptions" process. Although there was some distinguishing characteristics between the hospital-based and freestanding SNFs with respect to calculating routine cost limits, Congress did not express a need to distinguish between two types of SNFs in reimbursement for atypical costs.

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[1] 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).

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

CMM submitted comments stating that the Administrator should affirm the Board's decision. CMM stated that the Provider and the Board misinterpreted the existing policy objectives of removing the costs associated with inefficiencies from the provider's costs under the methodology described in Chapter 25 of the PRM. CMM disagrees with the Board's conclusion that the "discount factor" amount should be reimbursed. The difference as the Board refers to as the "gap" amount, CMM stated was in fact a discount factor. This discount factor is the amount of the hospital-based SNF's costs, as identified in the legislative history and documentation, that is related to inefficiencies – an amount that the Congress clearly did not intend the government to reimburse when establishing the cost limits or the exception process under Section 223 of the Social Security Amendments of 1972.

In addition, the regulation allows CMM to grant an exception "only to the extent that costs are reasonable". Therefore, the adjustment to reduce a hospital-based SNF's costs by an amount associated with inefficiencies is within the Congress' intent to "limit reimbursement to the costs that would be incurred by a reasonable prudent and cost-conscious management".

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.

For the entirety of fiscal year 1996, the Provider operated an urban hospital-based SNF, which was to be reimbursed on a reasonable cost basis, subject to the routine cost limits. As a new provider, the Provider's SNF received an exemption from the RCLs for the fiscal years ending June 30, 1984, 1985 and 1986. For every fiscal year thereafter, through and including FY 1996, the Provider's costs exceeded the SNF-RCLs. Accordingly, the Provider sought SNF-RCL exception relief for every fiscal year from FY 1987 through FY 1996.

During FY 1996, the Provider's HB-SNF costs were atypical because (1) the Provider's SNF patients had a high illness acuity level; (2) the Provider's SNF Medicare patient load was higher than other area hospital-based SNFS; (3) the Provider's registered nurse hours per patient day were significantly higher than other area hospital-based SNFS; and (4) the Provider's SNF average length of stay was much shorter than other area hospital-based SNFs.

Throughout FY 1996, the Provider contended that its more acutely ill Medicare SNF patient population required more registered nurses and associated costs than were reflected in the RCL. The competitive nature of hiring and retaining skilled nurses in the Pittsburgh, Pennsylvania standard metropolitan statistical area generated atypical nursing labor costs, and the Provider's atypical nursing hours led to atypical indirect costs that exceeded the indirect costs reflected in the RCLs.

The Intermediary partially allowed the Provider's RCL exception request by letter dated May 4, 1998 as part of the Notice of Program Reimbursement (NPR) for FY 1996.[3] The Provider timely filed its FY 1996 cost report, noting its self-disallowance, under protest, of $470,528: the amount of costs which exceeded its RCL, but were less than 112 percent of the mean *per diem* routine service costs for its peer group of hospital-based SNFs. The Intermediary disallowed all such costs per the FY 1996 NPR issued on May 4, 1998.[4]

The Intermediary also disallowed $46,765 of the Provider's costs which were above 112 percent of the mean *per diem* routine service costs for its peer group of hospital-based SNFs. This disallowance was the result of the off-set of these costs against three categories of the SNF's indirect costs (*i.e.*, laundry, dietary and nursing administration) which the Intermediary calculated as falling below 112 percent of the mean *per diem* routine service costs for its peer group of hospital-based SNFs.[5] (That is, the Intermediary reduced the amount of the exception request by those category of costs which were below the 112 percent measure.)

In total, of the $529,943 disallowed by the Intermediary, the Provider has appealed $526,293 of the Provider's costs.[6] The Intermediary's denial of $526,293 of these atypical costs was based (directly for the amount of $470,528, and indirectly for the amount of $46,765) on PRM section 2534.5, which directs intermediaries to approve routine cost limit exceptions for atypical costs of hospital-based SNFs only for those amounts exceeding 112 percent of the mean *per diem* routine service costs for hospital-based SNFs.

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[3] See, Provider's Exhibit P-1 and Exhibit P-5.

[4] Provider's Exhibit P-1 Intermediary's demand letter at Exhibit 3 to attached NPR, which may also be found at Exhibit P-4, and also at Exhibit P-5 at page 8, adjustment #811.

[5] Provider's Exhibit P-4 at line 3, as well as at Exhibit P-5, Intermediary's Audit Adjustment Report at the Work Sheet entitled "Computation of peer Group Per Diem Amounts using the Constituents of the Routine Cost Center from the Data Base Used to Develop the October 1, 1992 Cost Limits."

[6] Provider's Exhibit P-4 at line 14, as well as at Exhibit P-1 Intermediary's demand letter at Exhibit 3 to attached NPR.

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.[7] 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.

However, in 1972, Section 1861(v)(1) of the Social Security Act, was amended by section 223 of the Social Security Amendments of 1972[8], 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 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.

The regulations 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.

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[7] See Pub. L. No. 89-97.
[8] Pub. L. No. 92-603.

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.[9] 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.[10] 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.[11]

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.[12] Section 1888(a) states that

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[9] 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).

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

[11] 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.).

[12] 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.

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.[13] The results of this report were communicated to Congress before enactment of DEFRA.[14] 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.[15]

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

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

[15] 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

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.[16] Congress thus mandated that the 50 percent difference in costs related to inefficiency, facility characteristics, and overhead allocations[17] were not reasonable costs and should not be reimbursed. This results in the reimbursement discount factor disputed by the Provider that is comprised of an amount that CMS recognizes as unreasonable and, thus, not allowable.

Section 13503(a) of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66) made several changes to §1888 of the Social Security Act. Most notably, this provision repealed the add-on for excess overhead allocations for hospital-based facilities which had been set forth at §1888(b). Prior to OBRA 1993, Section 1888(b) required 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 thus recognized that this cost difference would not otherwise be recognized as reasonable but for this provision in setting the hospital based SNF limit. Subsequently, as a result of OBRA, Congress mandated that the Secretary may not recognize that even those costs are "reasonable." Thus, it is not unreasonable for CMS to further conclude that all the costs associated with this cost difference should not be recognized as reasonable, and should not be paid pursuant to the exception methodology which was subsequently issued, shortly thereafter, in Trans. 391 in 1994. If CMS were to allow hospital-based SNFs costs that fell within this difference 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 most specifically instructed it not to pay in 1993.

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

Wiener, Korbin Liu, and Pamela Doty, Health Care Financing Review, Fall 1986, Volume 8, Number 1, p. 83.

[16] The Provider challenges the assumption that Congress relied upon this Report. The Administrator finds that inter alia the distinctive formula for determining HB-SNF that was mandated by Congress that also corresponds to the finding of the Report, lends support to CMM's contentions.

[17] 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.

> 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) (1996) 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.][18]

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. For hospital-based SNFs, the Secretary has determined that the costs between the hospital-based limit and 112 percent of the hospital based peer group mean costs represent inefficiencies, etc. and thus by definition are unreasonable and must be removed as a "discount factor." The Secretary determines the atypicality of the costs by using a peer group comparison, i.e., historically, the 112 percent threshold. A hospital-based SNF's costs are thus

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[18] See also 44 Fed. Reg. 31804 (June 1, 1979), adopting language at 42 CFR §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].

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.

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 more guidance on the SNF cost limits under § 1888 of the Act, CMS issued Transmittal No. 378.[19] 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:

> 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,

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

> 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). 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 that have existed in the regulation since at least 1979.

Furthermore, the Administrator finds that 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. Although Congress changed the RCLs for hospital-based SNFs in 1984, the published cost limits since 1980[20] reflect that CMS had previously used a methodology under which the

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[20] 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

SNFs' per diem costs were compared to 112 percent of the peer group mean diem cost.[21]

Notably, § 2534.5B 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 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, § 2534.5B 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 2534.5B simply recognizes that, after July 1, 1984, the term "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.

In accordance with the methodology described in Chapter 25 of the PRM, CMS properly divided 112 percent of the peer group mean per diem costs for hospital-based SNFs into constituent cost centers. The Provider's actual cost per diems, as reported by cost center on the affected Medicare cost report, were then compared to the peer group mean per diem cost. By using 112 percent of the mean per diem costs instead of the cost limit, CMS properly removed the costs associated with inefficiencies before comparing the Provider's actual costs by constituent cost center. The result, in total, is mathematically equivalent to comparing the Provider's actual costs less the costs associated with inefficiencies to the

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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).

[21] 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.")

Provider's cost limit and hence the more accurate characterization of these costs related to inefficiencies as the "discount factor" and not a "gap."[22]

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

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[22] CMM demonstrated in its Comments, the administrative ease and accuracy of this methodology, stating that:

	Freestanding SNFs	Hospital-based SNFs
Per Diem:		
112 Percent of Mean Costs	$90	$140
Cost Limit	$90	$115*
Provider's Actual Costs	___	$195

*Freestanding Limit ($90) plus 50 percent of the difference between the freestanding limit ($90) and 112 percent of hospital-based mean costs ($140) or 50 percent of $50 equals $25. Therefore, the hospital-based cost limit is $90 +$25 or $115. For the example below, the remaining cost difference of $25 is the cost associated with inefficiencies that we will identify as the discount factor (the PRRB identified this as the "discount factor" amount).

1. Using the Chapter 25 methodology, the Provider's actual costs ($195) is compared to 112 percent of hospital-based mean costs ($140). This would result in maximum exception amount of $55 ($195-140).

2. On the other hand, if the Provider's actual costs ($195) reduced by the discount factor of $25, that is, $170 is compared to the cost limit of $115, the results would also be a maximum exception amount of $55.

   Since the comparison of the Provider's actual costs to the peer group costs is on a constituent cost center basis, the methodology under Chapter 25 is the easiest and most accurate method to administer the exception process, rather than reducing the Provider's actual costs for each cost center by some proportional cost center based discount factor before comparing to the cost limit.

USC § 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 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.[23] 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.[24]

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,[25] the Court of Appeals

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[23] 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).).

[24] 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 prior to its use in the PRM in July, 1994. See, Quality 89-92 Hospital Based SNF Group, Admin. Dec. No. 2009-D8, pg. 13 – 14. (Setting forth examples of CMS' use of this methodology.)

[25] 117 F.3d 579.

in the District of Columbia in Hudson v. FAA,[26] rejected the argument that an agency had impermissibly changed its interpretation of the 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.[27] 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.[28] 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 § 2534.5B 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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[26] 192 F.3d 1031 (D.C. Cir. 1999).

[27] 177 F.3d 1030.

[28] 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: 10/14/2009

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services