PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D61

PROVIDER - Mercy Medical Skilled Nursing Facility - Daphne

Provider No. 01-5049

vs.

INTERMEDIARY - Mutual of Omaha Insurance Company

DATE OF HEARING-
May 13, 1999

Cost Reporting Period Ended - December 31, 1994

CASE NO. 97-2340

INDEX

ISSUES:

1. Was HCFA's methodology as set forth in Transmittal 378 for determining the amount of the exception from the routine cost limits for hospital-based skilled nursing facilities, and as applied by the Intermediary to the Provider for FYE December 31, 1994, a proper interpretation of the Medicare statute and regulations?

2. Did the Intermediary properly deny the Provider a rollover interim exception for FYE December 31, 1994?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy Medical Skilled Nursing Facility - Daphne ("Provider") is a hospital-based skilled nursing facility ("HB-SNF") located in Daphne, Alabama. For its cost reporting period ended December 31, 1994, the Provider requested and obtained an exception to Medicare's routine service cost limits ("RCLs") based upon the provision of atypical services. However, in evaluating the Provider's request and calculating the amount of the exception to which the Provider was entitled, Mutual of Omaha Insurance Company ("Intermediary") applied program instructions contained in Transmittal No. 378 that was issued by the Health Care Financing Administration ("HCFA") in July 1994. As a result, the amount of the exception ultimately granted the Provider was significantly less than the Provider had sought.[1]

The Provider's request for an exception to the limits, dated March 22, 1995, reflects an exception in the amount of $309,079. This calculation is based upon the difference between the Provider's routine service cost per day ($161.75) and the applicable RCL ($120.66 per day), or $41.09 per day, which is multiplied times the number of Medicare patient days occurring during the period (7,522). The Intermediary's response to this request, dated July 12, 1995, indicates that the Provider has a potential RCL exception in the amount of $15.16 per day. However, the Intermediary's response also explains that Transmittal No. 378 limits RCL exceptions for HB-SNFs to the difference between a provider's routine service cost per day and 112 percent of the peer group mean cost rather than the RCL. As a result, the exception amount allowed for the Provider's 1994 cost reporting period was $.89 per patient day.[2]

On October 12, 1995, the Provider advised the Intermediary that it believed the application of Transmittal No. 378 to its 1994 exception request was unlawful and impermissible. In addition, the Provider suggested that, in any event, it qualified for a rollover interim exception in accordance with an August 11, 1994

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[1] Provider's Position Paper at Introduction

[2] Intermediary's Position Paper at 2. Exhibits I-2 and I-3.

memorandum issued by HCFA Central Office. On November 29, 1995, however, the Intermediary advised the Provider that its request for an interim rollover exception was denied because the Provider did not expressly request the rollover prior to July 20, 1994--the effective date of Transmittal No. 378.[3]

On February 3, 1997, the Intermediary issued a Notice of Program Reimbursement ("NPR") effectuating final settlement of the subject cost reporting period. The NPR was accompanied by a worksheet that applied the RCL exception to the Provider's settlement in accordance with Transmittal No. 378. On May 12, 1997, the Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R.§§ 405.1835-.1841, and met the jurisdictional requirements of those regulations.[4] The amount of Medicare reimbursement in controversy is approximately $ 303,000.

The Provider was represented by Thomas C. Fox, Esq., of Reed Smith Shaw & McClay, LLP. The Intermediary was represented by Tom Bruce, Senior Consultant, Mutual of Omaha Insurance Company.

STIPULATION OF FACTS:

The Provider and Intermediary entered a Joint Stipulation to assist in the review of this case. As noted below, the parties agreed to certain material facts pertinent to the case as well as certain basic facts relating to the validity of Transmittal No. 378, which is at issue. Moreover, the parties narrowed the legal issues by agreeing to certain basic facts relating to the interpretation and effects of Transmittal No. 378. The specific stipulations agreed upon by the parties include the following:[5]

1. Mercy Medical Hospital ("Mercy") is a non-profit Alabama corporation which is owned and operated by the Sisters of Mercy of the Regional Community of Baltimore. Mercy is part of Eastern Mercy Health System.

2. Mercy is located in Daphne, Alabama, is licensed by the Alabama Department of Health, and is certified as a specialized rehabilitation hospital by Medicare under Provider No. 01-3027.

3. Mercy is accredited by the Joint Commission on Accreditation of Healthcare Organization as a specialized rehabilitation hospital, hospice, HB-SNF, and home health service provider.

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[3] Provider's Position Paper at 6.

[4] Intermediary's Position Paper at 1.

[5] Some items contained in the actual Joint Stipulation submitted by the parties are omitted from the listing included herein since they would reiterate facts contained in the "Statement of the Case and Procedural History" portion of this decision.

4 As part of Mercy, Mercy-Daphne [the Provider] is licensed, certified, and accredited as a HB-SNF. For the time period at issue in this appeal, Mercy-Daphne was certified by Medicare under Provider No. 01-5049 to furnish HB-SNF services.

5. The mission of Mercy and Mercy-Daphne is to provide intensive rehabilitation to patients, enabling them to achieve the highest possible level of independence and helping them return to normal activities of daily living.

6. Because of its emphasis on patient rehabilitation as opposed to patient maintenance, Mercy-Daphne incurs comparatively high per diem costs and has atypically high nursing hours, lower than average lengths of patient stays, and higher than average Medicare utilization. As a result of Mercy-Daphne's unique services and costs, it has, historically, requested and received exceptions to the RCLs applied to SNFs by the Medicare program.

7. For each cost reporting period from June 30, 1983, through December 31, 1993, Mercy-Daphne's actual costs exceeded the applicable RCL for urban freestanding SNFs ["FS-SNFs"]. Mercy-Daphne requested an exception to the RCL for each of these periods, and Mutual [of Omaha Insurance Company] recommended approval of -- and HCFA approved -- the exception request for each period. As a result, although Mercy-Daphne's occupancy adjusted routine per diem costs exceeded the applicable RCL, per patient day, the facility was reimbursed for the difference.

8. By letter dated July 12, 1995, Mutual informed Mercy-Daphne that it qualified for an interim exception amount for its fiscal year ended December 31, 1994, in the amount of $.89 per patient day. Mutual explained that Mercy-Daphne's request for exception for this period was evaluated in accordance with Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") §§ 2530-2541 as contained in HCFA Transmittal No. 378, dated July, 1994.

9. Under these provisions, for RCL exception requests submitted to intermediaries on and after July 20, 1994, Medicare fiscal intermediaries are to determine the amount of a HB-SNF's exception, if any, to the RCL by subtracting 112 percent of the peer group mean cost (rather than the RCL) from the provider's actual allowable costs.

10. Mercy-Daphne's earlier requests for exceptions to the RCLs for previous periods were not calculated on such a basis and were not subject to Transmittal No. 378. In this instance, this meant that $160.93 (112 percent of the peer group mean per diem cost), rather than $120.66 (the applicable RCL), was subtracted from Mercy-Daphne's actual allowable adjusted costs of $161.82 per patient day in determining Mercy-Daphne's exception amount for the fiscal year ended December 31, 1994. As a result, Mercy-Daphne qualified for an exception amount of $.89 per patient day rather than $41.16 per patient day.

11. Prior to HCFA Transmittal No. 378, HCFA Pub. 15-1 did not contain any provisions specifically addressing RCLs and RCL exception requests for SNFs, as opposed to RCLs and RCL exception

requests generally for various types of providers. Such requests were handled by the Secretary [of Health and Human Services] and Medicare fiscal intermediaries pursuant to relevant provisions of the Medicare statute (42 U.S.C. §§ 1395x(v)(I) and 1395yy), the Secretary's published regulations (42 C.F.R. § 413.30, formerly, 42 C.F.R. § 405.460), and information published in the Federal Register when the actual RCLs for SNFs were periodically updated.

12. For cost reporting periods prior to and not covered by HCFA Transmittal No. 378, the Secretary and Medicare fiscal intermediaries calculated the amount of any RCL exception for a HB-SNF from the applicable RCL itself.

13. HCFA Transmittal No. 378 included HCFA Pub. 15-1 § 2534.5 ("Determination of Reasonable Costs in Excess of Cost Limit or 112 Percent of Mean Cost") which summarizes the difference between the pre- and post- HCFA Transmittal No. 378 RCL exception principles.

14. HCFA Transmittal No. 378 differentiates the RCL principles based upon whether a HB-SNF's cost reporting period begins prior to or on and after July 1, 1984. HCFA Transmittal No. 378 is only effective for exception requests submitted to intermediaries on and after July 20, 1994.

15. HCFA Transmittal No. 378 was not mandated by any explicit statutory directive from Congress or any express legislative history requiring that any RCL exception for HB-SNFs be measured from 112 percent of the peer group mean per diem cost as opposed to the actual RCL itself.

16. HCFA Transmittal No. 378 was not promulgated pursuant to notice and comment rulemaking under the federal Administrative Procedure Act, 5 U.S.C. § 553.

17. The Secretary's regulations on the RCLs, 42 C.F.R. § 413.30 (formerly, 42 C.F.R. § 405.460), and the various amendments to the regulations have not specified the exact formula(e) used to set the RCLs for SNFs.

18. HCFA Transmittal No. 378 was not mandated by any explicit regulation of the Secretary or by any express change in the Secretary's regulations specifically requiring that any RCL exception for HB-SNFs be measured from 112 percent of the peer group mean per diem cost as opposed to the actual RCL itself.

19. Although the Secretary has published the actual SNF RCLs periodically since 1979, the principles contained in HCFA Transmittal No. 378, as they relate to calculation of the amounts of any RCL exceptions for HB-SNF exception requests submitted on and after July 20, 1994, are not mandated by or even reflected in any of those publications of the actual RCLs.

20. As a result of HCFA Transmittal No. 378 and for cost report periods to which it is applied, any exceptions to the RCLs for HB-SNFs are not calculated from the applicable RCLs. However, for the same periods, any exceptions to the RCLs for FS-SNFs are computed from the applicable RCLs for those

facilities.

21. Because the applicability of HCFA Transmittal No. 378 depends upon the date of submission of the RCL exception request, similarly situated HB-SNFs with the same fiscal years and identical costs could have their RCL exception amounts differ based solely on the dates when their RCL exception requests were submitted.

22. For exception requests governed by HCFA Transmittal No. 378, HB-SNFs qualifying (or otherwise qualifying) for exceptions to the RCLs may never recover or be reimbursed by Medicare for any portion of their incurred costs between the hospital-based RCLs and 112 percent of the applicable mean per diem routine service costs for HB-SNFs.

23. For the HB-SNF exception requests to which it applies, HCFA Transmittal No. 378 creates an irrebuttable presumption that any and all portions of the incurred costs between the hospital-based RCLs and 112 percent of the applicable mean per diem routine service costs for HB-SNFs are unreasonable.

24. Hospital-based SNFs subject to HCFA Transmittal No. 378 are the only type of provider for which the amount of any exception to the RCL is not measured from the relevant RCL but from a different, higher number than the RCL.

25. Mutual has not granted any HB-SNF the rollover interim exception permitted under HCFA's August 11, 1994 memorandum.

26. HCFA Transmittal No. 378 is not utilized in calculating the amount of any Medicare reimbursement paid to a HB-SNF that qualifies for an exemption from the routine cost limits as a new provider.

Issue No. 1:

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's calculation of its exception to the RCL is improper because it was based upon instructions contained in HCFA Transmittal No. 378, which is invalid. The Provider asserts that the parties to this case, i.e., itself and the Intermediary, agree that the validity of Transmittal No. 378 is the same issue that was decided in St. Francis Health Care Centre v. Community Mutual Insurance Company, PRRB Dec. No. 97-D38, March 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,159, rev'd, HCFA Administrator, May 30, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,545, aff'd St. Francis Health Care Centre v. Shalala, Case No. 3:97 CV 7559 (N.D. Ohio) ("St. Francis"), where the Board ruled in favor of the provider.[6]

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[6] Provider's Position Paper at 18.

The Provider asserts that in St. Francis the Board ruled that HCFA's methodology for computing HB-SNF RCL exceptions under Transmittal No. 378 is improper.[7] The Board reasoned that utilizing the 112 percent level, rather than the actual RCL, is "inconsistent with both the statute and regulation." Medicare and Medicaid Guide (CCH) § 45,159 at 53,321. The statute, 42 U.S.C. § 1395yy(a), specifies that the Secretary is not to recognize costs in excess of the statutorily prescribed RCLs as reasonable except as otherwise allowed through the exceptions and exemptions process. Under 42 U.S.C. § 1395yy(c), the Secretary may make exceptions and exemptions adjustments in the statutorily specified RCLs. Obviously, the statute envisions exceptions and exemptions being measured from the actual RCLs, not some other higher standard that is not even specified. Here, the Secretary's absolute refusal even to consider that HB-SNF costs between the RCLs and the 112 percent level might be reasonable and related to exceptional circumstances, such as atypical services, flatly contravenes the statute.

Likewise, the Board emphasized in St. Francis that Transmittal No. 378 cannot be squared with the language of the applicable regulation.[8] Under 42 C.F.R. § 413.30(f), upwards adjustments may be made to the RCLs "under the circumstances specified in paragraph (f)(1) through (f)(8) of this section" -- the exceptions and exemptions. As the Board explained, the adjustments are not to be computed from some unstated benchmark; rather, they are supposed to be derived from the RCLs themselves:

> [c]learly, the cost limits established by Congress and implemented at 42 C.F.R. § 413.30 are the gauge for evaluating the routine service costs of a SNF, and represent the upper most per diem amount a SNF can be reimbursed absent an exception.

St. Francis, Medicare and Medicaid Guide (CCH) § 45,159 at 53,321.

The Provider asserts that the Board, in the same fashion, rejected the notion that there was any "authoritative basis" to support the use of the 112 percent level as the proper measuring stick.[9] HCFA argued that the Secretary had issued a report to Congress in 1985, entitled Study of the Skilled Nursing Facility Benefit Under Medicare, recognizing several studies suggesting that about 50 percent of the differences in the costs of HB-SNFs and FS-SNFs can be accounted for by case mix differences while the remaining 50 percent relates to provider efficiency, facility characteristics, overhead allocations, and similar factors. Nonetheless, Congress did not alter the RCLs or the exceptions to elevate the 112 percent level to definitive status:

> [r]eliance upon the 112 percent level effectively increases the amount or level a provider's costs must exceed before

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[7] Provider's Position Paper at 20.

[8] Id.

[9] Provider's Position Paper at 21.

> it may be granted an exception. The Board finds it inappropriate for HCFA to establish and rely upon an amount greater than the limit established by Congress as it would find it inappropriate for HCFA to introduce a methodology that would effectively reduce the limits set by Congress. . . . Congress has superseded HCFA's authority to establish cost limits with respect to SNFs by statutorily mandating them.

St. Francis, Medicare & Medicaid Guide (CCH) ¶ 45,159 at 53,321. See also Id. at 53,323 (no evidence that Congress intended atypical service HB-SNFs to bear the financial losses created by Transmittal No. 378).

Further, the Board concluded that HCFA's inflexible use of the 112 percent level is inappropriate and indiscriminate as a means of determining reasonable costs. Id. at 53,322. This policy is especially illogical because it assumes irrebuttably that HB-SNF costs between the RCL and the 112 percent level are unreasonable but that higher costs above the 112 percent level become reasonable thereafter if the facility qualifies for an exception. Id. at 53,323. Moreover, Transmittal No. 378 is inequitable because it permits a FS-SNF to be paid more than a HB-SNF for providing the same services at the same cost. Where the FS-SNF has costs greater than the HB-SNF RCL, it will qualify for payment of all of its costs if it obtains an exception; meanwhile, a HB-SNF with the same costs will be limited to the RCL plus only the amount, if any, over the 112 percent level if it is granted an exception. Id. In this regard, it is worth noting the Intermediary's concessions here that: (1) HB-SNFs are the only type of provider for which the RCL does not control the amount of any exception; (2) because of Transmittal No. 378's effective date, identically situated providers could have different exception amounts for the same period and the same services and costs based solely on the date when the request was made; and (3) exempt HB-SNFs are not subject to the policy.

The Provider explains that it agrees with the Board's analysis in St. Francis and incorporates the Board's reasoning and the facility's arguments in that case by reference herein.[10] Moreover, the Provider asserts that the accuracy of this analysis is further underscored by the parties' stipulation that Transmittal No. 378 is not the product of any express statutory or regulatory mandate. In sum, HCFA Transmittal No. 378 is at odds with the statute and regulations and establishes a policy that is arbitrary and irrational.

The Provider also contends that the Administrator's reversal of the Board's decision in St. Francis is not persuasive or controlling, nor does it withstand scrutiny or provide a convincing basis for the Board to alter its position.[11]

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[10] Provider's Position Paper at 22.

[11] Provider's Position Paper at 23.

The Provider asserts that the Administrator, in his decision, found that the exception guidelines under HCFA Transmittal No. 378 are reasonable and appropriate because: (1) they "closely adhere" to the mandate of 42 U.S.C. § 1395yy(a); (2) they are "within the scope" of the Secretary's discretionary authority under 42 U.S.C. § 1395yy(c) to make adjustments (i.e., exceptions and exemptions) to the RCLs to the extent deemed appropriate; and (3) they conform with the Secretary's obligation under 42 C.F.R. § 413.30(f) to make such adjustments only to the extent that the underlying costs are reasonable. Medicare and Medicaid Guide (CCH) ¶ 45,545 at 54,758. The Provider argues that this reasoning is seriously flawed, as follows:

• First, it is hard to see how the imposition of the 112 percent level under Transmittal No. 378 represents close adherence to the requirements of 42 U.S.C. § 1395yy(a). This statutory provision sets the RCLs for HB-SNFs at one level while Transmittal No. 378 effectively rewrites this congressional mandate to establish those RCLs at a different, higher level. In plain terms, HCFA has simply defied Congress and is refusing to carry out an express statutory mandate.

• Second, the Secretary's authority under 42 U.S.C. § 1395yy(c) to make adjustments to the RCLs in appropriate circumstances is not the authority to determine the RCLs themselves. That determination has been made by Congress under 42 U.S.C. § 1395yy (a) where the RCL formulae are detailed. Rather, the Secretary's authority to make appropriate adjustments relates simply to defining the circumstances and criteria needed to qualify for an exception or exemption (e.g., atypical services, new provider status, extraordinary circumstances, unusual labor costs, etc.).

• Finally, the Secretary's duty under 42 C.F.R. § 413.30(f) to make adjustments to the RCLs only where the costs are reasonable is similarly circumscribed. This regulatory duty is based upon the statutory authority at 42 U.S.C. § 1395yy(c), and the regulations cannot be used as a bootstrapping device to enlarge the Secretary's power beyond that conferred in the statute. As such, the Secretary's obligation to determine reasonable costs is not the ability to impose the agency's own version of RCLs; Congress has preempted that. Instead, it is simply the power to define the criteria for an RCL adjustment through rulemaking (which the Secretary did not employ here) and then to apply published regulatory criteria on a case-by-case basis to ensure that only reasonable costs are reimbursed. The use of the agency's own RCLs to deny or limit, on a wholesale basis, exceptions and exception amounts mandated by the statute and regulations is a perversion, rather than a legitimate exercise, of the Secretary's limited authority.

The Provider contends that there are other reasons why HCFA Transmittal No. 378 is unlawful that were not considered by the Board or the Administrator in St. Francis.[12]

Specifically, HCFA's implementation of Transmittal No. 378 violates the notice and comment rulemaking procedures of the Administrative Procedure Act ("APA"), 5 U.S.C. § 553. The instructions contained in

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[12] Provider's Position Paper at 24.

Transmittal No. 378 represent an about-face from HCFA's long standing policy of granting HB-SNF exceptions to the RCLs based upon the RCLs themselves. See Samaritan Health Service v. Bowen, 811 F. 2d 1524, 1529 (D.C. Cir. 1987). As the Supreme Court explained:

> [a]n Agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is "entitled to considerably less deference than a consistently held agency view."

INS v. Cardoza Fonseca, 480 U.S. 421, 446 n.30 (1987) (quoting Watt v. Alaska, 451 U.S. 259, 273 (1981)). See also New York City Health and Hospitals v. Perales, 954 F.2d 854, 861 (2d Cir.), cert. denied, 506 U.S. 972 (1992).

Moreover, Transmittal No. 378 runs counter to plain statutory language. Therefore, it deserves little or no deference as an agency interpretation of the statute:

> [where an issue is a question of law involving statutory construction and analysis of congressional intent and the meaning of the statute is clear, an agency interpretation is entitled to less deference.

Perales, 954 F. 2d at 861. See Cardoza Fonseca, 480 U.S. at 446-48; Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844 (1984).

And, Transmittal No. 378 is invalid since it was not implemented according to the APA's notice and comment rulemaking procedures. Under the APA, 5 U.S.C. § 553, federal agencies must publish general notice of a proposed rule in the Federal Register, furnish interested parties with an opportunity to comment, and incorporate a concise general statement of basis and purpose in the rules. Id. National Association of Home Health Agencies v. Schweiker, 690 F. 2d 932, 948-49 (D.C. Cir. 1982). For such purposes, a rule is defined as "an agency statement of general or particular applicability and future effect designed to implement, interpret or prescribe law or policy....." 5 U.S.C. § 551(4). Clearly, Transmittal No. 378 is a rule, particularly insofar as it seeks to engraft a new and previously unstated limitation onto the existing statute and regulations for future purposes. Equally clearly, HCFA did not engage in such rulemaking -- a fact conceded by the Intermediary.

Finally, the Provider contends that the Board is not bound by the Judgment Entry and corresponding Memorandum Opinion of the District Court for the Northern District of Ohio upholding the Administrator's reversal of the Board's decision in St. Francis. Moreover, the Memorandum Opinion incorporates flawed reasoning, false assumptions, and illogical conclusions, which demonstrate that the Board properly resolved

St. Francis and should similarly resolve the instant case.[13]

With respect to the impact of the Memorandum Opinion on the instant case, the Provider explains that federal district court opinions from one state are not accorded precedence in other states. Therefore, Judge Katz's opinion from the federal district court in Ohio has no impact on this case, i.e., since the Provider is located in Alabama.

To address the district court's flawed reasoning and HCFA's unpersuasive arguments, the Provider explains that Judge Katz presented five consolidated concepts in his Memorandum Opinion, which include: (1) Overbreadth; (2) Impermissible Distinction Between FS-SNFs and HB-SNFs; (3) Plain Language of the Statute and Implementing Regulations; (4) Public Policy; and (5) Notice and Comment. The Provider's response to each of these arguments is as follows:

1. Overbreadth

The district court claims that it is not unreasonable that Transmittal No. 378 declares costs between the FS-SNF 112 percent level and the HB-SNF 112 percent level unrecoverable. This is because, the court asserts, that Congress has recognized that these costs are the result of certain systematic inefficiencies associated with HB-SNFs and, therefore, these costs are unreasonable. However, the district court completely avoids taking its own reasoning to the logical end. If, as the court claims, Congress was attempting to target various costs of inefficiency, why would it carve a hole out of the middle of allowable costs? What is actually unreasonable -- and illogical -- is the theory advanced by HCFA and the district court that the costs of atypical services provided by a HB-SNF that are above the RCL are considered unreasonable, until, however, the costs exceed the 112 percent mean per diem level, when they become reasonable again. The district court does not explain why it believes that costs above the RCL up to the 112 percent mean are the result of more onerous inefficiencies, and are more unreasonable than costs above the 112 percent mean. Similarly, HCFA also fails to address this issue. In fact, the opposite is more likely to be true; that is, the costs above the 112 percent group are more likely to be unreasonable as they deviate further from the mean, and therefore are more likely to represent inefficiencies.

Likewise, the district court's attachment to its overbreadth argument ignores the fact that full and complete reimbursement of costs upon the grant of an exception is a fundamental assumption of the Medicare reimbursement scheme. As highlighted by the Board in St. Francis, this fact is well settled in case law and legislative history, as well as prior decisions of HCFA's Administrator, which the district court has also chosen to disregard.

In Sacramento Medical Center v. Blue Cross and Blue Shield Association, the Administrator held that "an

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[13] Provider's Response to the United States District Court's Memorandum Opinion and HCFA's Brief in St. Francis at 4.

exception to the cost limits may be granted upon the provider's demonstration that certain conditions are present. Regulation 42 C.F.R. § 405.460(f)(2) [redesignated as 413.30(f)(1)] provides for an exception for the cost of atypical services or items. . . . These "atypical services" may be reimbursed in full over and above the routine cost limits." Medicare & Medicaid Guide (CCH) ¶ 30,859. Similarly, the only relevant legislative history of the portion of the Medicare statute at issue provides that "facilities eligible for exceptions" from the RCL can receive all of their reasonable costs." Finance Com. 98th Cong., Senate Print 98-169, v. 1 at 947 (1984) (emphasis added).

In sum, the very concept of an "exception" incorporates the notion that the grantee will receive something not otherwise available if the exception was denied. Had Congress intended to target alleged inefficiencies associated with HB-SNFs and withhold reimbursement, they would have done so. Instead, the legislative history and relevant case law, as well as HCFA's earlier policy, demonstrates the contrary -- that the exceptions process was intended to fully reimburse providers for amounts exceeding the RCLs.

2. Impermissible Distinction Between FS and HB-SNFs

The court's finding that HB-SNFs have systematic inefficiencies to which FS-SNFs are not subject is inaccurate and insupportable. The district court claims that the disparate treatment of HB and FS-SNFs and the corresponding reimbursement gap is grounded in Medicare statute and the two-tiered system it has established, and that it is based on empirical findings that HB-SNFs are systematically more inefficient. To reach this conclusion, the district court misinterprets the purpose of the two-tiered system and the distinction between FS and HB-SNFs.

The distinction between FS and HB-SNFs is based on the undisputed fact that HB-SNFs generally treat patients with higher acuity, i.e., they require more intense utilization of resources. Accordingly, the Board in St. Francis noted that the Deficit Reduction Act of 1984 ("DEFRA") effectively increased HB-SNF cost limits over the levels that would have been effectuated by the preceding Tax Equity and Fiscal Responsibility Act ("TEFRA") because Congress was concerned that TEFRA limits would not adequately provide reimbursement to HB-SNFs.

As follows from this finding, there was no congressional intent to disadvantage HB-SNFs by imposing a reimbursement scheme that compensated for some type of "inefficiencies." Rather, the Board correctly concluded that Congress expected the Secretary to provide an exception process to fully reimburse providers under certain circumstances. As the legislative history of DEFRA indicates: "[e]xceptions [to RCLs] could be granted based upon case mix or circumstances beyond the control of the facility, be it either a freestanding or hospital-based facility." H. Conf. Rep. to P.L. 98-369 (1984).

In addition, while the district court implies that the two-tiered system was intended to treat FS and HB-SNFs differently and inequitably with respect to exceptions to the RCLs, the legislative history proves otherwise. When Congress implemented the two-tiered system in 1984, the exception methodology as set forth in the regulation (42 C.F.R. § 413.30, formerly 42 C.F.R. § 405.460) had already been in place for

several years. Moreover, at that time, HCFA was interpreting the regulation in the manner currently advanced by the Provider here and by the Board in St. Francis, i.e., that all costs above the applicable limit for atypical services could be reimbursed. Thus, Congress was fully cognizant that the regulation allowed reimbursement for all costs of atypical services in excess of the two-tiered cost limits it established. Had Congress wished to limit available reimbursement for all costs of atypical services in excess of the cost limit by the gap amount, it would have so provided in the two-tiered system by limiting HCFA's authority to grant the exception by the gap amount. It did not do so, and thus HCFA is not now free to interpret the regulation in a manner unsupported by Congress' statutory framework.

Moreover, the two-tiered reimbursement system was not designed to have a gaping hole in the middle of reasonable costs, as is asserted by the district court, without any supporting authority. On the contrary, a report from the Senate Finance Committee, which proposed the two-tiered system, notes:

> [u]nder this provision, both hospital-based and freestanding facilities could continue to apply for and receive exception from the cost limits. . . Facilities eligible for exceptions could receive, where justified, up to all of their reasonable costs.

Finance Com. 98th Cong., Senate Print 98-169, v. 1 at 947 (1984) (emphasis added).

3. Plain Language of the Statute and Implementing Regulations

The district court's finding that Transmittal No. 378 does not contradict the plain language of the Medicare Act and implementing regulations completely ignores the fact that Transmittal No. 378 represents a total about-face from HCFA's long-standing policy, and the fact that it was not mandated by any statutory directive. In search of support for this conclusion, the court notes that the statute and the regulations are "couched in permissive" terms and that the regulations grant the Secretary discretion in making adjustments. The underlying assumption of this argument is that discretion completely forecloses the possibility that Transmittal No. 378 could contradict the statute or regulation. This assumption is false and the district court's argument unpersuasive.

First, just because the Secretary was granted a certain amount of discretion in devising a methodology for granting exceptions does not mean that any method devised would be automatically sanctioned as consistent with the statute. Rather, the method would still be subject to the plain language, scope, intent, and purpose of the statute, and limited accordingly.

Second, it is incorrect to argue, as HCFA did, that because the statute and regulations are silent with respect to the precise methodology that should be used in recognizing exceptions to the cost limits for HB-SNFs, that basically any method devised thereunder could not conflict with the statute or regulations. Even the district court recognized that the statute addresses this issue, albeit, in terms that are couched in permissiveness. Rather, the statute grants the Secretary the authority to adjust the RCLs as appropriate and requires that the criteria for any adjustment be published. 42 U.S.C. §

1395yy. A regulation promulgated by the Secretary utilizing this authority, 42 C.F.R. § 413.30, sets forth the relevant criteria for the adjustment and the corresponding methodology. More specifically, an upward adjustment may be made if the actual costs of atypical services are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary. 42 C.F.R. § 413.30(f).

Third, the legislative history reveals the intent of Congress -- that all SNFs should be eligible to receive full reimbursement of reasonable costs. The legislative history of the only relevant statute notes that both HB and FS-SNFs "eligible for exceptions could receive, where justified, up to all of their reasonable costs." Finance Conn. 98th Cong., Senate Print 98-169. In other words, inequitable, differential, treatment between FS and HB-SNFs was never intended by Congress. Accordingly, the district court and HCFA's assertion that Transmittal No. 378 is not and cannot conflict with the enabling statute and regulation is erroneous.

4. Public Policy

The first reason proffered by the district court for its dismissal of the Provider's public policy argument as "unavailing,"is that it is unsure whether it is appropriate for the court to consider policy arguments. The court continues, stating that "this is simply the wrong forum in which to make public policy arguments." The district court uses this reasoning in order to ignore further errors in its logic and to divert focus from its misinterpretation of statutes and legislative history, on which it relied in its decision.[14] The Provider submits that any decision maker must attempt to ascertain the context in which the decision is being made. The district court's total disregard as to the effects of its decision indicates that the court did not consider the larger context in which its decision was rendered. See Brown v. Allen, 344 U.S. 443, 537 (1953) (Jackson, J., concurring) (cited by the district court in its Memorandum Opinion). Thus, instead of recognizing that Transmittal No. 378 was merely a small component in a much larger health care system, the district court dismisses the Provider's arguments and ignores the impact of its decision on the Medicare program. In St. Francis, the Board noted that one of the reasons that HCFA's methodology in Transmittal No. 378 was improper and not supported by any legislative history is because identically situated HB and FS-SNFs would be reimbursed inequitably due to the gap created by HCFA.

The second reason the district court characterizes the Provider's policy arguments as unavailing is because it believes that HB and FS-SNFs are systematically under compensated in the exact same manner, and hence, there is no disincentive for HB-SNFs to provide atypical services. However, this statement is not supported by the record in St. Francis, or the stipulations in this case. In St. Francis the Board stated:

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[14] Provider's Response to the United States District Court's Memorandum Opinion and HCFA's Brief in St. Francis at Exhibit 1 at 12.

> [t]he Board also questions the equity within HCFA's methodology, in that it allows FS-SNFs to be reimbursed more than HB-SNFs under identical circumstances. In the case where two SNFs, one freestanding and the other hospital-based, provide identical services at the exact same cost, and that cost is greater than the HB-SNF limit but is less than the 112 percent level, the freestanding SNF would be paid its entire per diem under HCFA's exception methodology. However, the hospital-based facility would not be paid the entire amount of its per diem cost, although identical to that of the freestanding facility, because of the gap created by HCFA's methodology.

Medicare & Medicaid Guide (CCH) ¶ 45,545.

5. Notice and Comment

The district court points out that Provider Reimbursement Manual provisions are interpretive rules exempt from the notice and comment requirements of the APA. The court continues that since Transmittal No. 378 is codified in this manual, it therefore is an interpretive rule not subject to notice and comment rulemaking. In support of this conclusion, the district court cites numerous cases which have held that reimbursement manual provisions are interpretive rules.

However, the district court failed to conduct the appropriate analysis to determine whether or not Transmittal No. 378 is, in fact, an interpretive rule. If the court had conducted this analysis it would have concluded that Transmittal No. 378 does not qualify as an interpretive rule because it effects a substantive change contrary to the enabling statute and regulations, and conflicts with a policy that had been well established for at least ten years.

The proper test is whether the manual provision adopts a "new position inconsistent" with existing laws and regulations. See Mt. Diablo Medical Center, PRRB Dec. No. 96-D-40 (July 1, 1996); see also Henry County Memorial Hospital v. Shalala, No. IP-92-1044-C (S.D. Ind. 1996). Transmittal No. 378 clearly establishes a new position inconsistent, not only with prior policy, but with the contemporaneous statute and regulations. Accordingly, these facts render Transmittal No. 378 impermissible under the APA, despite being a manual issuance.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly calculated the Provider's RCL adjustment. The Intermediary maintains that the calculation is based upon instructions contained in HCFA Transmittal No. 378, which is a proper interpretation of the Medicare statute and regulations, and particularly Congress' intent on reducing reimbursement for HB-SNFs.[15]

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[15] Intermediary's Supplemental Position Paper at 1.

The Intermediary explains that Congress set per diem limits for the routine service costs of extended care facilities at 42 U.S.C. § 1395yy(a). In part, the statute provides:[16]

> (1) With respect to freestanding skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in urban areas.
>
> (2) With respect to freestanding skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in rural areas.
>
> (3) With respect to hospital-based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in urban areas exceeds the limit for freestanding skilled nursing facilities located in urban areas.
>
> (4) With respect to hospital-based skilled nursing facilities located in rural areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in rural areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in rural areas exceeds the limit for freestanding skilled nursing facilities located in rural areas.

42 U.S.C. § 1395yy(a).

The Intermediary explains that 42 U.S.C. § 1395yy(c) provides for an exception to the cost limits described above, as follows:[17]

> [t]he 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.

42 U.S.C. § 1395yy(c).

The regulation governing exceptions to the routine cost limit for atypical services is published at

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[16] Intermediary's Position Paper at 5.

[17] Intermediary's Position Paper at 7.

42 C.F.R. § 413.30(f)(1). This regulation permits an adjustment to the RCL where the cost of items or services furnished by a provider are atypical in nature and scope compared to the items or services generally furnished by similarly classified providers.

The Intermediary maintains that in order to properly implement this regulation, HCFA issued Transmittal No. 378. This transmittal, among other things, requires a SNF to demonstrate that the actual cost of items or services it furnished exceeds the applicable peer group cost. The applicable peer group for the Provider is HB-SNFs, and 112 percent of the peer group mean per diem cost for HB-SNFs during the cost reporting period under appeal was $160.93. This amount was subtracted from the Provider's actual per diem routine service cost of $161.82 in order to calculate the adjustment amount of $.89.[18]

The Intermediary contends that this comparison is not explicitly mandated by 42 C.F.R. § 413.30(f), however, it is in accordance with the regulation.[19] Before an adjustment to the limit can be made for atypical services, 42 C.F.R. § 413.30(f)(1)(I) requires a comparison of items or services generally furnished by providers similarly classified. The peer group data gathered by HCFA serves this purpose. Moreover, HCFA's data forms a more accurate basis for comparing the items or services furnished by similarly classified providers than the congressionally mandated RCL set by 1395yy(a)(3). Factually, the RCL is only partially based upon cost data gathered from HB-SNFs. That is, HB-SNF cost data is only used to calculate the 50 percent difference between HB and FS-SNF routine service costs. In the main, the RCL is based upon cost data gathered by HCFA from FS-SNFs not HB-SNFs. Therefore, the 112 percent level, which is calculated from cost data gathered from HB-SNFs, is a more accurate benchmark for identifying atypical items and services than the RCL.

The Intermediary also asserts that Congress gave the Secretary a wide berth to decide the amount of adjustments to the cost limits.[20] As noted above, 42 U.S.C. § 1395yy(c) states: "[t]he 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. . ." The Intermediary maintains that the peer group comparison made by HCFA does not violate the authority that Congress delegated to the Secretary.

The Intermediary rejects the Provider's argument that where a FS-SNF has costs greater than the 112 percent level for a HB-SNF, that under Transmittal No. 378 the FS-SNF could be paid more than the HB-SNF for providing the same services at the same cost.[21] The data used to compute the FS-SNF

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[18] Intermediary's Position Paper at 8.

[19] Id.

[20] Intermediary's Position Paper at 9.

[21] Id.

RCL is based upon cost data gathered from other FS- SNFs, therefore, the amount of this RCL provides a basis for comparison that is fully in accordance with the regulatory requirement of 42 C.F.R. § 413.30(f)(1)(I). That is, the RCL is an accurate benchmark for determining whether a FS-SNF furnished atypical items and services. In contrast, the HB-SNF RCL, as argued above, is only partially based on data gathered from other HB-SNFs and, for this reason, is not an accurate benchmark.

The Intermediary also contends that the Medicare statute does not prescribe or even require any particular exceptions methodology.[22] The Secretary's regulations at 42 C.F.R. § 413.30(f) are also plainly ambiguous with respect to the calculation of an exception amount.

The Intermediary asserts that cost limits implemented by the Secretary have traditionally been constructed by reference to a peer group, and that they are based on the assumption that costs generally incurred by the group are reasonable and necessary.[23] While this assumption applies to FS-SNF cost limits, it is not true of the HB-SNF limits. In setting this limit, Congress explicitly determined that normal peer group costs, 112 percent of the peer group mean for HB-SNFs, were not reasonable but included unjustified costs presumed to be due to HB-SNF inefficiencies. These unjustified costs, or discount factor, are represented by 50 percent of the difference between 112 percent of the peer group mean cost for HB-SNFs and the FS-SNF cost limit. The existence of these unjustified costs necessitated the creation of a two-tiered system of cost limits reflected at 42 U.S.C. § 1395yy. Respectively, the methodology set forth in Transmittal No. 378 is simply a means of eliminating these unjustified costs before reimbursing costs due to atypical items and services through the exceptions process. This is not the same as imposing a new and higher cost limit but simply a subtraction of the costs that Congress identified as unreasonable prior to comparing the remaining costs to the routine cost limit.

The Intermediary also asserts that the rationale for this methodology follows 42 U.S.C. § 1395yy(a).[24] Through Transmittal No. 378, HCFA merely implemented the congressional mandate that at least 50 percent of the difference in costs between FS and HB-SNFs not be reimbursed. Moreover, this manual provision is entirely consistent with 42 C.F.R. § 413.30(f) that regardless of whether an exception applies, "an adjustment is made only to the extent the costs are reasonable. . ." Id.

The Intermediary argues that it is unreasonable for the Provider to compare all of its costs, including those costs that Congress could not justify as reasonable, against this lowered cost limit for purposes of

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22 Intermediary's Supplemental Position Paper at 1. See also Intermediary's Position Paper at 9.

23 Id.

24 Intermediary's Supplemental Position Paper at 3.

receiving additional reimbursement through the exceptions process.[25] It is more logical to similarly adjust downward the Provider's request for additional reimbursement by the same discount that Congress used to lower 112 percent of the hospital-based peer group mean cost. In this way, the unreasonable costs incurred by the Provider and included in its routine operating cost are removed for the purpose of comparison to the routine cost limit.

The Intermediary contends that neither the statute nor the regulation prohibits HCFA from using total costs and a peer group comparison as a measure or proxy for both the reasonableness of the Provider's costs and the atypical nature of its items and services.[26] If a HB-SNF can establish that its costs are reasonable and atypical in relation to its peer group, the SNF then has the opportunity to demonstrate that its atypical costs are related to the special needs of its patients. If a HB-SNF is furnishing items and services that are atypical in nature and scope to its peers, thereby adding to its costs, one would expect the SNF's costs to exceed that of its peers. Conversely, if the SNF's costs are in fact not unusual as compared to its peers, there is little reason to find that the SNF has furnished items or services that are atypical in nature and scope calling for additional reimbursement.

The Intermediary concludes, that contrary to the Board's decision in St. Francis, such an approach does not blur the concept of atypical costs and atypical services.[27] Because the cost data available to HCFA, and from which both the cost limits and peer group costs were constructed, include both atypical and typical services and their costs, a strict separation of these concepts is neither desirable nor required. Thus, in constructing the 112 percent of the peer group mean, HCFA used an average of all HB-SNFs' costs based on their filed cost reports which included all costs, regardless of whether those costs might be deemed typical or atypical (See Exhibit I-5 at 32885). For this reason, both the cost limit and the 112 percent of the peer group mean already include and reflect the cost of atypical services furnished by SNFs and thus may be used to measure the degree by which an individual SNF furnished atypical services relative to its peers. Therefore, it is not unreasonable to conclude that a SNF whose total costs are entirely average, as in the case of the Provider, has not furnished items or services atypical in nature and scope as compared to its peers and therefore justifying greater reimbursement.

Issue No. 2:

PROVIDER'S CONTENTIONS:

The Provider contends that it should receive a rollover interim exception to the cost limits for its cost

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[25] Id.

[26] Id.

[27] Intermediary's Supplemental Position Paper at 4.

reporting period ended December 31, 1994, regardless of the fate of Transmittal No. 378.[28] The Provider asserts that it was denied a rollover exception based upon the Intermediary's construction of HCFA's August 11, 1994 memorandum as requiring a provider to have explicitly requested such an exception prior to July 20, 1994. The Provider maintains, however, there are several problems with the Intermediary's position.

First, the August 11, 1994 memorandum does not require providers to explicitly request the rollover exception. In pertinent part, the memorandum states:

> all exceptions currently being reviewed under the rules prior to Transmittal No. 378 will be allowed a rollover interim exception for only the first subsequent cost reporting period.

HCFA Memorandum, August 11, 1994.[29]

The Provider notes that the memorandum does not say that an explicit request for such an exception must have been made prior to July 20, 1994. Rather, it states that all exceptions reviewed under the pre-Transmittal No. 378 rules will be allowed for such an exception; the only reference in the memorandum regarding an actual request relates to a facility asking for an exception for more than one subsequent period. The memorandum notes that such requests should be denied, but it does not impose a standard of requiring an actual request for such an exception. Accordingly, the Provider concludes that its August 31, 1993 exception request seeking an RCL exception for various years, including its year ended December 31, 1993, should have sufficed to permit a rollover interim exception for the following (subject) cost reporting period.

In addition, the Provider argues that no one could have known to request a rollover interim exception before the concept was formulated.[30] As such, the interpretation developed by the Intermediary makes the existence of a rollover interim exception entirely illusory. Under these circumstances, agency action that leads to absurd or implausible results cannot be upheld. Motor Vehicles Manufacturers Association v. State Farm Mutual Automobile Insurance Co., 463 U.S. 29, 43 (1983). Rather, the memorandum should be read and applied in a common sense manner. See Hubbard v. United States, 514 U.S. 695 (1995). Doing so would mean that the Provider qualified for a rollover interim exception for its December 31, 1994 cost reporting period.

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[28] Provider's Position Paper at 26.

[29] See Exhibit I-9.

[30] The Provider notes that the Intermediary was unable to identify a single provider that obtained a rollover exception to the RCLs.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider is not entitled to a rollover interim exception for its cost reporting period ended December 31, 1994. Therefore, its request for such an exception was properly denied.[31]

The Intermediary asserts that Regional Intermediary Letter 94-18[32] describes the conditions that must be met before a SNF is entitled to a rollover interim exception. Applying these conditions to the current case, the Provider would have had to submit a rollover interim exception request prior to July 20, 1994. The Provider first submitted its exception request for the 1994 cost reporting period on March 22, 1995. See Exhibit 1-2. Since the request was made subsequent to July 20, 1994, the rollover provisions do not apply, and the request was properly evaluated according to the Transmittal No. 378 methodology.

The Intermediary disagrees with the Provider's assertion that the rollover interim exception is illusory since no such exceptions have ever been granted. The Intermediary maintains that the availability of a rollover interim exception is a fact. In the case under appeal, the Provider only needed to submit its request prior to July 20, 1994, nearly 7 months through the subject cost reporting period, to receive an exception. The Provider should have been aware by that time that it might be furnishing atypical items and services necessitating an adjustment to its RCL.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)	-	Reasonable Cost
§ 1395yy et. seq.	-	Payment to Skilled Nursing Facilities for Routine Service Costs

2. Law-5 U.S.C.:

§ 551(4)	-	Definitions-"Rule"
§ 553	-	Rule Making

3. Regulations - 42 C.F.R.:

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[31] Intermediary's Position Paper at 10.

[32] Exhibit I-9.

§§ 405.1835-.1841 - Board Jurisdiction

§ 413.30 et seq. (formerly § 405.460) - Limitations on Reimbursable Costs

4. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2530 et. seq. - Inpatient Routine Service Cost Limits for Skilled Nursing Facilities

§ 2531 et. seq. - Provider Requests Regarding Applicability of Cost Limits

§ 2534 - Request for Exception to SNF Cost Limits

5. Case Law:

St. Francis Health Care Centre v. Community Mutual Insurance Company, PRRB Dec. No. 97-D38, March 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,159, rev'd, HCFA Administrator, May 30, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,545, aff'd St. Francis Health Care Centre v. Shalala, Case No. 3:97 CV 7559 (N.D. Ohio).

North Cost Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18, 1999, modif'd HCFA Administrator, April 15, 1999.

Samaritan Health Service v. Bowen, 811 F. 2d 1524, (D.C. Cir. 1987).

INS v. Cardoza Fonseca, 480 U.S. 421 (1987).

New York City Health and Hospitals v. Perales, 954 F.2d 854 (2d Cir.), cert. denied, 506 U.S. 972 (1992).

Perales, 954 F. 2d at 861.

Cardoza Fonseca, 480 U.S. 421 (1987).

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, (1984).

National Association of Home Health Agencies v. Schweiker, 690 F. 2d 932, (D.C. Cir. 1982).

Sacramento Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 80-D56, August 1, 1980, Medicare & Medicaid Guide (CCH) ¶ 30,826, rev'd in part, aff'd in part, HCFA Administrator, September 29, 1980, Medicare & Medicaid Guide (CCH) ¶ 30,859.

Brown v. Allen, 344 U.S. 443 (1953).

Mt. Diablo Medical Center, PRRB Dec. No. 96-D40, July 1, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,495, decl'd rev HCFA Administrator, July 29, 1996.

Henry County Memorial Hospital v. Shalala, No. IP-92-1044-C (S.D. Ind. 1996).

Motor Vehicles Manufacturers Association v. State Farm Mutual Automobile Insurance Co., 463 U.S. 29 (1983).

Hubbard v. United States, 514 U.S. 695 (1995).

6. Other:

HCFA Transmittal No. 378.

HCFA Memorandum, August 11, 1994.

Regional Intermediary Letter 94-18.

Joint Stipulation.

Finance Com. 98th Cong., Senate Print 98-169 (1984).

H. Conf. Rep. to P.L. 98-369 (1984).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Issue No. 1:

The Intermediary used the methodology contained in HCFA Transmittal No. 378 to determine the amount of the exception to the RCLs the Provider was entitled. The Provider challenged the validity of this methodology based upon statutory and regulatory provisions controlling Medicare program cost limits applicable to SNFs.

In general, the Provider argues that 42 U.S.C. § 1395yy(a) sets the cost limits for SNFs and, if an exception to these limits is granted, a provider is entitled to each and every dollar that its allowable costs exceed the applicable limit. The Provider concludes, therefore, that the methodology contained in Transmittal No. 378 is invalid since it does not reimburse a HB-SNF's costs between the applicable cost limit and 112 percent of the peer group mean cost, in those cases where an exception is granted. Essentially, the Provider maintains that HCFA inappropriately changed the cost limits set by Congress.

The Board majority, however, finds that the methodology contained in HCFA Transmittal No. 378 is a proper interpretation of the governing laws and regulations. The Board majority agrees that 42 U.S.C. § 1395yy(a) establishes the cost limits applicable to FS and HB-SNFs. However, the Board majority notes that 42 U.S.C. § 1395yy(c) gives the Secretary broad discretion to adjust the limits. In part, the statute states:

> [t]he 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. . . . The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

42 U.S.C. § 1395yy(c).

The Board majority finds that following the intent of 42 U.S.C. § 1395yy(c), HCFA promulgated regulations at 42 C.F.R. § 413.30 which, in part, provide for an adjustment to the cost limits where a provider furnishes atypical services, as in the instant case. Provisions at 42 C.F.R. § 413.30(f)(1)(I) provide the basic rules for determining the amount of such an adjustment by explaining that a provider's actual costs are compared to the items or services furnished by similarly classified providers. In this regard, the Board majority finds that HCFA Transmittal No. 378 provides the instructions for performing the required comparison.

In addition, the Board majority finds the comparison contained in HCFA Transmittal No. 378 to be a sound approach for determining the amount of HB-SNF exceptions, and rejects the Provider's argument that such an approach is unreasonable. In particular, the Provider points out that the instructions contained in HCFA Transmittal No. 378 presume all HB-SNF costs that are above the limit to be unreasonable until they reach the 112 percent per group mean per diem cost level. The Provider asserts there is no logical basis for this "gap." The Board majority, however, believes the 112 percent peer group level is a practical standard for measuring the atypical nature of a provider's services. It is the same level used to determine the amount of exceptions for FS-SNFs, and is a standard based entirely upon HB-SNF data as apposed to the HB-SNF limit which is heavily based upon FS-SNF data.

Finally, the Board majority acknowledges the Provider's reliance upon the previous Board's decision is

St. Francis to help support its position and arguments. The majority of this Board notes that its findings are consistent with the decision rendered by a majority of the board in North Cost Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18, 1999, modif'd HCFA Administrator, April 15, 1999.

Issue No. 2:

The Provider argues that it should be granted a rollover exception to the RCLs for its 1994 cost reporting period, which would effectively allow the amount of its exception to be determined in accordance with procedures in effect prior to HCFA Transmittal No. 378. The Provider bases this argument on an August 11, 1994 memorandum issued by HCFA. This memorandum was not, however, placed into evidence by either the Provider or the Intermediary. Accordingly, the fundamental piece of evidence placed in the record regarding this matter is Exhibit I-9, Regional Intermediary Letter No. 94-18, entitled Instructions for Finalizing Interim Exception Amounts Determined Prior to the Implementation of HCFA Pub 15-1, Section 2530 ("RIL").

The Intermediary denied the Provider's request for a rollover exception maintaining that the Provider's request was filed late. The Intermediary explains that the Provider's request is dated March 22, 1995, which is after the requisite date of July 20, 1994. This Intermediary determination is consistent with the second paragraph of the Interim Exceptions - Hold Harmless Provisions section of the RIL, which states:

> [i]f a provider submitted an interim exception prior to July 20, 1994 (the implementation date of Transmittal No. 378), the exception will be reviewed under the rules in place prior to Transmittal No. 378. If the Provider submits its final exception after July 19, 1994, the final exception will be reviewed in accordance with the new rules in Transmittal No. 378.

Regional Intermediary Letter No. 94-18.

The Intermediary's denial of the Provider's request is, however, improper. The Provider properly sought a rollover exception, and the Intermediary's denial is based upon rules pertaining to interim exceptions. Reading further, the RIL states:

> [i]n addition, all exceptions currently being reviewed under the rules prior to Transmittal No. 378 will be allowed a rollover interim exception for only the first subsequent cost reporting period. If a provider files an exception request prior to July 20, 1994, and requests a rollover interim exception for [more] than one subsequent cost reporting period, the Health Care Financing Administration will consider an exception only for the first subsequent cost reporting period.

Id. (Emphasis added).

The Board finds that the Provider qualifies for this hold harmless provision since it had requested an interim exception for its 1993 cost reporting period in August 1993, and that request was currently under review by the Intermediary.

Significantly, the Board finds that the RIL provides two different ways in which a Provider may be held harmless from the effects of Transmittal No. 378. The first way, as relied upon by the Intermediary, provides hold harmless protection where a provider is operating under an interim exception at the time Transmittal No. 378 was issued. The second way is the "rollover" which extends the RIL's hold harmless protection to providers that were not operating under an interim exception when Transmittal No. 378 was issued, but are accustomed to requesting and qualifying for final exceptions. The Board believes the RIL clearly intends to provide all HB-SNFs accustomed to receiving an exception to the RCLs at least one years relief from Transmittal No. 378, as evidenced by the RIL's reference to the rollover to the first subsequent cost reporting period.

The Board finds its position supported by the plain language of the RIL. As noted above, the RIL states: "all exceptions currently being reviewed. . . will be allowed a rollover." Id. (Emphasis added). The RIL does not restrict this provision to interim exceptions but is open to all exceptions.

Moreover, the intent of hold harmless provisions would dictate that an application broader than one limited to interim exceptions is essential. In the case where a provider is operating under an interim exception, costs in excess of the RCL paid during the cost reporting period could result in a large overpayment if Transmittal No. 378 were applied after the cost reporting period ended. Therefore, a hold harmless provision applicable to interim exceptions is needed to protect this type of provider since the repayment of such large sums could disorder its operations. However, the same financial disruption is evident, perhaps to a lessor degree, in situations where providers are not operating under an interim exception but are expecting to receive exception payments at the time their cost reports are settled. Hence, the second provision of the RIL providing hold harmless protection for the first cost reporting period subsequent to "any exception request currently being reviewed" is necessary to protect these types of providers. The Board notes that the Provider at hand had requested and received an exception to the RCLs in every year since 1983, and was clearly expecting to obtain an exception for the subject cost reporting period.

The Board believes its position is also supported by the fact that the RIL was issued on August 16, 1994, which is after the July 20, 1994 due date relied upon by the Intermediary. Therefore, providers could not have known to submit a request for a rollover exception prior to the July 20th date since the RIL, which made known the existence of such an exception, had not yet been issued.

The Board, having concluded that there are two ways in which a provider may be held harmless from the effects of Transmittal No. 378, for at least one cost reporting period, also finds that the RIL does

not actually specify a date for the submission of rollover exception requests. Therefore, the Provider's March 22, 1995 submission also represents an acceptable request. In that submission the Provider specifically references HCFA Pub. 15-1 § 2534.3.A.4, Repeat Requests. Also, this submission was well within the timeliness requirements of HCFA Pub. 15-1 § 2531.1.

DECISION AND ORDER:

Issue No. 1

The methodology contained in HCFA Transmittal No. 378 for determining the amount of an exception to the routine service cost limits is a proper interpretation of Medicare laws and regulations. The Intermediary should use this methodology to determine the amount of exceptions, as applicable.

Issue No. 2

The Provider's request for a rollover exception was improperly denied. The Provider's exception to the cost limits is to be re-determined in accordance with the rules in effect prior to the implementation of Transmittal No. 378.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq. (Dissenting in part)
Charles R. Barker

Date of Decision: August 20, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover Jr., Esquire

I respectfully dissent to Issue no.1:

The Provider contends that it is entitled to be paid the entire amount of its costs in excess of the cost limit.

In part, 42 U.S.C. § 1395yy(a)(3) states:

> With respect to hospital based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for free standing skilled nursing facilities located in

> urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital based skilled nursing facilities located in urban areas exceed the limit for free standing skilled nursing facilities located in urban areas.

42 U.S.C. § 1395yy(a)(3)

The plain language of the statute establishes the cost limits for hospital based skilled nursing facilities located in urban areas.

The implementing regulation 42 CFR § 413.30(a)(2) states in part:

> HCFA may establish estimated cost limits....

This regulation appears to be, in my opinion, contrary and in conflict with the statute since the regulation grants to HCFA that which has heretofore been established.

The Board majority finds that section C of the statute gives the Secretary broad discretion to adjust limits. The Board majority refers to 42 U.S.C. § 1395yy which states:

> [t]he 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.

It is my opinion that this section is limiting rather than discretionary since only two types of adjustments are permitted, adjustments based upon case mix or circumstance beyond the control of the facility.

It is noted that in St. Francis Health Care Center v. Community Mutual Insurance Company, PRRB Dec. No. 97-D38, dated March 24, 1997, the Board found for the provider using in part the following:

> [t]he Board finds that the Provider's requests should not have been denied. HCFA's comparison of the Provider's routine service cost per diem to the 112 percent level is inconsistent with both the statute and regulation. In addition, HCFA's comparison confuses the concept of "atypical costs" with the concept of "the cost of atypical services," and produces results that are seemingly unsound.
>
> Contrary to HCFA's exception methodology, which fails to reimburse HB-SNFs for routine service costs that exceed the limit but are less than the 112 percent level (the gap), the Board finds that 42 U.S.C. § 1395yy entitles SNFs, either freestanding or hospital-based, to be paid the full amount by which their costs exceed the applicable cost limit. In

part, 42 U.S.C. § 1395yy(a) states:

> [t]he Secretary, in determining the amount of the payments which my be made under this title with respect to routine service costs of extended care services shall not recognize as reasonable. . . per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section . . .

42 U.S.C. § 1395yy(a).

The Board also finds there is no authoritative basis supporting HCFA's reliance upon the 112 percent peer group per diem to determine the amount of a HB-SNF exception. As discussed above, reliance upon the 112 percent level effectively increases the amount or level a provider's cost must exceed before it may be granted an exception. The Board finds it inappropriate for HCFA to establish and rely upon an amount greater than the limit established by Congress as it would find it inappropriate for HCFA to introduce a methodology that would effectively reduce the limits set by Congress.

The Board notes that 42 C.F.R. § 413.30 provides HCFA with the general authority to establish cost limits. In part, the regulation states "HCFA may establish limits on provider costs recognized as reasonable in determining program payments. . . . Id. The regulation goes on to state that "HCFA may establish estimated cost limits for direct overall costs or for costs of specific items or services. . . . Id. However, the Board finds that the cost limits applicable to SNFs are not presented in the regulations or in HCFA's manual instructions; Congress has superseded HCFA's authority to establish cost limits with respect to SNFs by statutorily mandating them.

St. Francis PRRB Dec. No. 97-D38.

I concur with the findings and conclusion of the Board in the St. Francis case.

It is my opinion that the methodology used by HCFA to determine the amount of the exception from the routine service cost limits for hospital based skilled nursing facilities is not proper and the denial by HCFA of the Provider's request for full exception to the routine service cost limits should be reversed.

Martin W. Hoover, Jr