PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2000-D53

PROVIDER -
New England Rehabilitation Hospital
Woburn, MA

Provider No. 22-3026; 22-5190

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Massachusetts d/b/a C&S Administrative Services for Medicare

DATE OF HEARING-
April 13, 2000

Cost Reporting Period Ended -
August 31, 1985

CASE NO. 88-0649

INDEX

Was the Health Care Financing Administration=s ("HCFA") methodology for measuring the entitlement of hospital-based skilled nursing facilities ("HB-SNF") to exception relief under 42 C.F.R. ' 413.30 (f) and HCFA=s denial of the Provider=s fiscal year ("FY") 1985 exception request proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

New England Rehabilitation Hospital ("Provider") is a private, for profit, rehabilitative care hospital located in Woburn, Massachusetts. The appeal in this case is taken from a determination by HCFA denying the Provider a routine cost limit ("RCL") exception for services provided in the fiscal year ended August 31, 1985 ("FY 1985") by the Provider=s HB-SNF. On March 25, 1992, the Provider applied for an exception to the RCLs under 42 C.F.R. ' 413.30 (f)(1) based upon the atypical nature of social services and medical records costs associated with the service needs of its long term patients.[1] HCFA had earlier granted the Provider an exception to the RCLs due to atypical nursing services based on audited data and established RCLs available at the time of this initial exception request.[2] However, with respect to the subsequent exception relief sought for atypical social services and medical records costs, HCFA issued a final determination on February 23, 1993 denying the requested exception for these indirect cost centers.[3] HCFA=s determination was forwarded to the Provider by C&S Administrative Services or Medicare[4] ("Intermediary") under cover of a letter dated March 9, 1993.[5]

In its letter denying the Provider=s exception request, HCFA explained that its initial review of the Provider=s FY 1985 cost data was based on an "as submitted" version of the cost report. However, since that initial review when an exception for atypical nursing services was granted, the FY 1985 cost report had been settled and the Provider=s costs have changed so substantially that the Provider=s adjusted per diem cost no longer exceeds the peer group per diem cost. Accordingly, HCFA determined that an exception for atypical social services and medical records costs was not warranted for FY 1985. HCFA reached this outcome after applying a peer group comparison method which it explained as follows:

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1 See Provider Exhibit P-1/Intermediary Exhibit I-5.

2 See HCFA=s response dated May 10, 1991 - Intermediary Exhibit I-2/Provider Exhibit P-4.

3 See Provider Exhibit P-2/Intermediary Exhibit I-3.

4 C&S Administrative Services for Medicare terminated its role as a fiscal intermediary with the Medicare program, and has been succeeded by Blue Cross and Blue Shield of Maine d/b/a Associated Hospital Service of Maine.

5 See Provider Exhibit P-3.

> The peer group developed by HCFA for evaluating exceptions to the cost limits for hospital-based SNFs is set at 112 percent of the mean hospital-based inpatient routine service costs and not at the hospital-based SNF cost limit. HCFA compares the hospital-based SNF=s costs to those of the typical facility to determine the amount of its costs that are atypical. As a result, a hospital-based SNF is only eligible for an exception for atypical services for the amount that its actual costs exceeds 112 percent of the mean costs of hospital-based SNFs and not by the amount that its actual costs exceeds its cost limit. . . . For the present time, however, we will permit an exception for atypical nursing services notwithstanding the above limitation.

Provider Exhibit P-2, p. 2.

HCFA=s letter further explained that in the case of indirect costs like medical records and social services, exception relief was "limited to the amount by which the sum of costs in excess of the peer group exceeds the sum of costs below the peer group." Id. Thus, unless the applicant=s total per diem cost exceeds the peer group=s total per diem amount, no relief for individual cost categories is permitted. The Provider wrote to HCFA on May 10, 1993 to protest the use of the peer group standard, as apposed to the RCL level itself, as the threshold for exception relief.[6] By letter dated August 10, 1993, HCFA explained the consistency of the AUniform Peer Group Analysis@ and reconfirmed its exception review policy.[7] HCFA asserted that its RCL review policy is required by Section 2319 of the Deficit Reduction Act (ADEFRA@) of 1984 stating the following:

> Section 2319 of the Deficit Reduction Act of 1984 (Pub. L. 98-369) provides that for cost reporting periods beginning on or after July 1, 1984, the routine service cost limits for hospital-based SNFs are set at the appropriate freestanding limit plus 50 percent of the difference between the freestanding limit and 112 percent of the mean hospital-based inpatient routine service costs for both urban and rural SNFs. Since the routine service cost limits for hospital-based SNFs are not set at 112 percent of the mean hospital-based inpatient routine service costs, it is apparent that Congress= intent was that HCFA not recognize as reasonable the remaining 50 percent of the difference between the freestanding limit and 112 percent of the mean hospital-based inpatient routine service costs.

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[6] See Provider Exhibit P-5/Intermediary Exhibit I-6.

[7] See Provider Exhibit P-6/Intermediary Exhibit I-7.

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> As a result, a hospital-based SNF is only eligible for an exception for atypical services for the amount that its actual cost exceeds 112 percent of the mean costs of hospital-based SNFs and not by the amount that its actual cost exceeds its limit.

Id.

The Provider appealed the final settlement of its cost report as well as HCFA=s denial of its exception request for atypical social services and medical records costs to the Provider Reimbursement Review Board ("Board"). The Board ruled that the Provider=s appeal was filed pursuant to 42 C.F.R. '' 405.1835-.1841, and that it had jurisdiction under the requirements set forth under those regulations. The Provider was represented by Mark A. Borreliz, Esquire, of Choate, Hall & Stewart. The Intermediary=s representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association. The estimated amount of Medicare reimbursement in controversy is $134,000.

PROVIDER=S CONTENTIONS:

The Provider contends that the Medicare program is required to pay providers for services furnished to beneficiaries on the basis of reasonable costs as set forth under 42 U.S.C. ' 1395x(v)(1)(A) and the regulatory provisions of 42 C.F.R. '' 413.1 and 413.9. Reasonable costs include costs actually incurred in providing needed health services which must be recognized in order that the necessary costs of efficiently delivering covered services to patients covered by Medicare will not be borne by individuals not so covered. The Provider argues that the prohibition against cost-shifting between Medicare and non-Medicare patients is at the core of many Medicare cost-finding and reimbursement principles. Through an invalid interpretation of 42 C.F.R. ' 413.30 (f)(1), HCFA violated this prohibition against cost-shifting when it refused to recognize the Provider=s atypical social services and medical records costs for FY 1985. The Provider asserts that neither law nor reason support HCFA=s evaluation of its exception request, and that the methodology applied (1) contravenes statutory and regulatory requirements; (2) is inconsistent with the directives in the Provider Reimbursement Manual ("HCFA Pub . 15-1"); and (3) confuses the cost of atypical specific services with atypical overall costs.

The Provider contends that HCFA=s evaluation methodology belies Congressional intent and the requirements established in the regulations. The RCLs for HB-SNFs established by Congress in 42 U.S.C. ' 1395yy(a) are not absolute amounts, and that the statute actually states that the Secretary shall not recognize the described costs as reasonable Aexcept as otherwise provided in this section.@ Further, the statute at 42 U.S.C. ' 1395yy (c) authorizes the Secretary to make adjustments in the limits based

upon case mix or circumstances beyond the control of the facility. The Provider also cites the conference committee report on DEFRA wherein Congress makes it clear that it did not intend the SNF limits as absolute ceilings, but instead expected the Secretary to recognize other costs as fairness required:

> Cost differences between hospital-based and freestanding facilities attributable to excess overhead allocations resulting from Medicare reimbursement principles would be recognized as an add-on to the limit.
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> . . . . Exceptions [to the cost limits] 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. No. 369, 98th Cong., reprinted 1984 U.S.C.C.A.N. 1984.

Consistent with Congress= authorization, the Secretary promulgated the regulations at 42 C.F.R. ' 413.30 (f) which provide for upward adjustments to the RCLs, and make clear that a provider is entitled to an exception where: (1) the actual cost of items or services exceed the applicable limit because those items or services are not typical in nature or scope for similarly classified providers; and (2) the atypical items or services are warranted by the special needs of the provider=s patients. The Provider argues that HCFA=s methodology of allowing a HB-SNF an exception to the RCLs only to the extent that the HB-SNF=s total per diem costs exceed 112 percent of the mean per diem routine service costs of HB-SNFs directly conflicts with the above-cited Congressional, statutory and regulatory mandates. The references to Aitems and/or services@ rather than to Aaggregate or total costs@ of the provider=s peers make clear that the focus of the exception is on the costs of individual categories of items or services in relation to the costs of similar individual categories of the provider=s peers. HCFA=s approach would only grant atypical services exception relief where a HB-SNF=s total per diem costs exceed 112 percent of the mean per diem routine service costs of HB-SNFs and, thus, would deny relief notwithstanding the explicit concession in 42 C.F.R. ' 413.30(f) that a provider=s costs of atypical services are reasonable. Accordingly, HCFA exceeded its authority in holding the Provider to exception standards never intended by Congress or embodied in 42 C.F.R. ' 413.30 (f).

The Provider also contends that HCFA=s evaluation methodology is inconsistent with the methodology explicitly set forth in HCFA Pub. 15-1. In July of 1994, HCFA incorporated the evaluation methodology employed in the instant case in HCFA Pub. 15-1 ' 2534.10.[8] This manual provision explains the atypical services exception codified in 42 C.F.R. ' 413.30 (f)(1), and explicitly sets forth the standards for exception relief for atypical medical records and social services costs as follows:

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[8] See Provider Exhibit P-9.

> K. Atypical Medical Records Cost. -- An exception is granted based on a demonstrated lower than average length of stay and/or higher than average Medicare utilization. The exception is computed as the provider=s medical record per diem cost in excess of the peer group medical record per diem cost.
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> L. Atypical Social Service Cost. -- An exception is granted based on a demonstrated lower than average length of stay and/or higher than average Medicare utilization. It is computed as the provider=s social service per diem cost in excess of the peer group social service per diem cost.

HCFA Pub. 15-1 ' 2534.10 K and L.

The Provider contends that the comparison requirement in the manual makes clear that exception relief should be granted when the provider=s per diem costs in a particular cost center exceed the peer group=s mean per diem costs for that same cost center. If the "aggregate cost" approach relied upon by HCFA to deny relief to the Provider was a correct one, the manual provisions would be nonsensical and invalid. Notwithstanding their issuance in 1994, the Provider asserts that the provisions embody what has always been the correct interpretation of 42 C.F.R. ' 413.30, and confirm the approach that should have been applied to the Provider=s exception request. The extra requirement that the Provider=s overall costs also exceed the peer group mean is not mentioned because it is not, and never has been, a legally operative requirement.

It is the Provider=s position that HCFA=s method of calculating relief based on comparisons of total costs bears no rational connection to the costs of atypical services or items that entitle a provider relief. If HCFA was free to throw together all of a provider=s costs, using below-average cost items to offset atypically high ones, the peer group comparison would no longer serve to quantify the cost of the provider=s atypical services. Rather than focusing on discrete "items or services," HCFA=s exception process would devolve into a wholesale comparison of total routine costs among providers, exactly replicating what is accomplished in the first instance by the routine cost limits themselves. The Provider believes it is illogical to reduce the exception further to the extent that other service areas had costs under the 112 percent level. The Provider notes that this point was well-made in the Board=s decision 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 ("St. Francis") wherein the Board reasoned as follows:

> The Board also finds that HCFA=s comparison of a provider=s routine service cost per diem to the 112 percent level is inconsistent with the intent of the comparison included in 42 C.F.R. ' 413.30 (f)(1)(i) and,

> as a result, produces results that should not be used to reject a provider=s request for an exception. Regulation 42 C.F.R. ' 413.30 (f)(l)(i) is intended to determine whether or not a provider is furnishing atypical items or services as a condition of qualifying for an exception. To achieve this goal, the rule requires that the items and services furnished by a provider requesting an exception be compared to the items and services typically furnished by similar providers.
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> * * * * *
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> HCFA=s comparison of per diem costs will not produce the desired result. HCFA=s comparison will indicate only that a provider=s costs are atypical with respect to the presumptive norm represented by the 112 percent level. HCFA=s comparison will not, however, present substantive information regarding the items and services furnished by the provider which is the fundamental issue and the professed reason for the excess costs.
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> * * * * *
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> HCFA=s methodology confuses the concept of atypical costs and the concept of the cost of atypical services.

St. Francis, Medicare & Medicaid Guide (CCH) **&** 45,159 at 53,322.

The Provider is aware that an Ohio district court[9] upheld the HCFA Administrator=s reversal[10] of the Board=s decision in St. Francis. However, the Provider believes the district court=s rationale is unpersuasive and is contradicted by HCFA=s own documentation on this matter. In St. Francis, the provider=s total per diem costs exceeded the RCL, but fell below the HB-SNF=s 112 percent level. The provider sought reimbursement for all costs that it incurred between the RCL and HB-SNF=s 112 percent level so long as those costs were reasonably incurred to provide atypical services. Although the Board granted this relief in St. Francis, the district court ruled that HCFA correctly construed the provisions of 42 C.F.R. ' 413.30(f)(l) in refusing to reimburse any excess costs where the provider=s

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[9] St. Francis Health Care Centre v. Shalala, Case No. 3:97 CV 7559 (N.D. Ohio) - Provider Exhibit P-11.

[10] St. Francis Health Care Centre v. Community Mutual Insurance Company, Administrator Dec., May 30, 1997, Medicare & Medicaid Guide (CCH) **&**45,545 - Provider Exhibit P-12.

total per diem costs did not exceed the HB-SNF=s 112 percent level. The district court reasoned that to compare the costs of discrete cost centers would be burdensome and costly stating the following:

> The case-by-case approach proposed by Plaintiff could impose enormous costs on the Medicare reimbursement system. First, since the vast majority of HB-SNFs have costs between the RCL and the HB-SNF 112% level, it is predictable that many providers would seek individual review, which would impose the need for numerous individual determinations, with their attendant administrative costs. Second, since virtually every SNF provides a combination of typical and atypical services, those atypical services are to some extent included in the RCL, and it would be prohibitively difficult to compare providers to determine what portion of the atypical services provided by any given SNF were truly in excess of the norm.

St. Francis v. Shalala, at *5.

The Provider points out that the district court=s argument is flatly undermined by information and charts in HCFA=s possession and used by HCFA in evaluating each exception request. The St. Francis court appears to have underestimated the detail of the data base (The Uniform National Peer Group) available to HCFA, and to have assumed a much less sophisticated level of analysis than HCFA in fact brings to bear upon the cost profile of a provider who seeks an RCL exception.[11] On each exception application, HCFA requires the provider to disaggregate its costs by cost center. For example, in the Provider=s application for atypical services relief, it set forth, both for social services and medical records, respectively, its own cost per diem in comparison to the peer group cost per diem (See Provider Exhibit P-1.) The Provider also sets forth its method of determining its peer group as well as an explanation of how its program is atypical and meets the special needs of its patients. Id. HCFA then compiled this information into a cost matrix chart. (See Provider Exhibit P-2, A-1.) This chart disaggregates by constituent cost center the Provider=s actual per diem costs and the peer group mean per diem costs. Id. It then sets forth the amount by which the Provider=s actual cost by constituent cost

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[11] The district court in St. Francis had little reason to probe or analyze the sophistication of HCFA=s data base, because the provider in that case sought to have all of its excess costs reimbursed simply because they exceeded the RCL and not because, on a cost-by-cost basis, they could be shown in addition to exceed the peer group average for HB-SNF=s. It should be noted that most of the court=s reasoning in St. Francis has little bearing on the present case. On analysis, the Board will find that much of the reasoning that prompted the Board to rule as it did in St. Francis has undiminished force and vitality in the context of a "disaggregated cost" approach to the routine cost limits like that presented in the present appeal.

center differs from the peer group mean cost for that cost center. Id. Contrary to the district court=s assertion in St. Francis, HCFA has at hand the means necessary to engage in a comparison of actual costs by constituent cost center. In the instant case, HCFA already has engaged in such a comparison. Therefore, the rationale for the district court=s refusal to engage in an item-by-item cost comparison should ring hollow here. Certainly, it cannot provide a compelling basis to disregard the regulatory mandate and manual direction as well as logic and reason.

The Provider concludes that the Board should invalidate HCFA methodology of measuring exception relief by the aggregate cost comparison methodology, and restore the provisions of the 42 C.F.R. ' 413.30 (f)(l) to their intended function.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that HCFA appropriately determined that the Provider did not warrant additional atypical exception amounts under the provisions of 42 C.F.R. ' 413.30. The Intermediary points out that the Provider had already been granted exceptions for atypical nursing services for FY 1985. Subsequent to HCFA granting those exceptions, several revisions to the Provider=s cost report were made based on updated audited data. These updates changed the Provider=s total reimbursable costs and, when broken down on a per diem basis, the Provider=s actual per diem costs per cost center decreased.

Concurrent with the decrease in the Provider=s costs, the RCLs for FY 1985 increased since the Provider=s original exception request. This change increased the RCLs= peer group standard used to compare reasonable per diem costs by cost center. The Intermediary states that the combination of the audited costs changes and increase in the RCLs resulted in the Provider=s costs being below the peer group limits in total for FY 1985.

In consideration of the above cited factors and the relevant law and facts presented in this case, the Intermediary respectfully requests that the Board uphold HCFA=s decision to deny additional exception amounts requested by the Provider for atypical social services and medical records costs.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

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

2. Regulations - 42 C.F.R.

'' 405.1835-.1841	-	Board Jurisdiction
' 413.1	-	Introduction -Reasonable Costs
' 413.9	-	Cost Related to Patient Care
' 413.30 et seq. (formerly ' 405.460)	-	Limitations on Reimbursable Costs

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

' 2534 et seq.	-	Request for Exception to SNF Cost Limits

4. 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 Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18, 1999, Medicare & Medicaid Guide (CCH) & 80,158, modif=d HCFA Administrator, April 15, 1999, Medicare & Medicaid Guide (CCH) & 80,195.

Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D61, August 20, 1999, Medicare & Medicaid Guide (CCH) &80,320.

Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D67, September 2, 1999, Medicare & Medicaid Guide (CCH) & 80,311.

5. Other:

Deficit Reduction Act of 1984 ' 2319. (P.L. 98-369).

H. Conf. Rep. No. 369, 98th Cong., reprinted 1984 U.S.C.C.A.N. 1984.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, parties= contentions and evidence presented, finds and concludes that the methodology applied by HCFA in denying the Provider=s exception request for atypical social services and medical records costs was an appropriate application of policy in accordance with the statutory and regulatory provisions set forth under 42 U.S.C. ' 1395yy et seq. and 42 C.F.R. ' 413.30 et seq..

Pursuant to DEFRA of 1984, the Secretary was given broad discretion in authoring adjustments to the RCLs. The Board majority finds that Section (c) of the statute gives HCFA great flexibility in setting limits stating as follows:

> [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).

Consistent with the foregoing statute and the reasonable cost provisions of 42 U.S.C ' 1395x(v)(1)(A), the regulations at 42 C.F.R. ' 413.30 et seq. provide for an adjustment to the cost limits where a provider furnishes atypical services as compared to the items or services furnished by similarly classified providers. The regulation at 42 C.F.R. ' 413.30(f) provides for exceptions to the RCLs to the extent that costs are reasonable, attributable to the circumstances specified, separately identified and verifiable. The Board majority finds that the regulation affords HCFA a two prong test in which it can compare costs and types of services. Accordingly, the policy set forth in the regulations requires an examination of both the reasonableness of the amount that a provider=s actual cost exceeds the applicable cost limit, and the determination of the atypicality of the costs by using a peer group comparison.

The peer group developed by HCFA for evaluating exceptions to the RCLs for HB-SNFs is set at 112 percent of the mean hospital-based inpatient routine service costs, and not at the HB-SNF=s cost limit. HCFA compares the HB-SNF=s costs to those of the typical facility to determine the amount of its costs that are atypical. Under this methodology, if a HB-SNF can establish that its costs are reasonable and atypical in relation to its peer group, the provider is given an opportunity to demonstrate that its atypical costs are related to the special needs of its patients. Although this peer group criterion for exception eligibility exceeds the RCLs established for HB-SNFs, the Board majority believes the 112 percent peer group level is a practical standard for measuring the atypical nature of a provider=s services. Further, it is the same level used to determine the amount of exceptions for freestanding SNFs, and is a standard based entirely upon HB-SNF data as opposed to the HB-SNF cost limit

which is heavily based upon freestanding SNF data.

The majority of the Board further finds that it was reasonable for HCFA to aggregate all of the indirect cost centers in determining the overall efficiency of the Provider=s operation. Since HCFA uses uniform peer groups to evaluate and quantify providers= exception requests for atypical services related to indirect cost centers, the aggregation of such costs is necessary because a provider=s classification of indirect costs may not be consistent with proportions prescribed by the peer group.

The Board further notes that HCFA=s methodology of using the standard of 112 percent of the HB-SNF peer group mean when reviewing exception requests is clearly set forth in a subsequent publication of HCFA Pub. 15-1 ' 2534.5, as adopted in Transmittal 378 (July 1994). This transmittal explained that new manual sections were being issued to provide detailed instructions for SNFs to help them prepare and submit requests for exceptions to the inpatient routine service cost limits. Based on its analysis of the statute, regulations and program instructions, the Board majority concludes that it was not unreasonable for HCFA to use the 112 percent peer group level as the standard for reviewing exception requests for HB-SNFs.

Finally, the Board majority acknowledges the Provider=s reliance upon the previous Board=s decision in St. Francis to help support its position and arguments. The majority of this Board notes that its findings are consistent with the Ohio district court=s ruling which upheld the HCFA Administrator=s reversal of the Board=s decision in St. Francis, and subsequent decisions rendered by a majority of the Board in the following cases:

- North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D-22, February 18, 1999, Medicare & Medicaid Guide (CCH) & 80,158, modif=d HCFA Administrator, April 15, 1999, Medicare & Medicaid Guide (CCH) & 80,195.

- Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D61, August 20, 1999, Medicare & Medicaid Guide (CCH) & 80,320.

- Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D67, September 2, 1999, Medicare & Medicaid Guide (CCH) & 80,311.

DECISION AND ORDER:

HCFA=s methodology for measuring the entitlement of HB-SNFs= to exception relief under 42 C.F.R. ' 413.30(f) and HCFA=s denial of the Provider=s FY 1985 exception request were proper. HCFA=s determinations in these areas are affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire (Dissenting Opinion)
Charles R. Barker
Stanley J. Sokolove

FOR THE BOARD

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover Jr.

I respectfully dissent:

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 C.F.R. ' 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 notes that section 42 U.S.C. '1395 yy(c) et seq. gives the Secretary great flexibility in setting limits. The Board majority refers to 42 U.S.C. '1395yy(c) 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 the 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