PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D46

PROVIDER –
Alameda Hospital – SNF
Alameda, CA

Provider Nos. 05-0211

vs.

INTERMEDIARY – United Government Services, LLC – CA/Blue Cross and Blue Shield Association

DATE OF HEARING-
Live Hearing: January 28, 2000
Record Hearing: May 10, 2002

Cost Reporting Period Ended
December 31, 1995

CASE NO. 98-0460

INDEX

ISSUES:

Issue 1(A) - Did the Intermediary properly apply the low occupancy adjustment in Centers for Medicare and Medicaid Services ("CMS" formerly called the Health Care Financing Administration ("HCFA")) Transmittal No. 378, Section 2534.5.A?

Issue 1(B) - Was CMS' refusal to grant an exception for that portion of the Provider's per diem costs which do not exceed 112 percent of the total peer group mean cost proper? - on the record

Issue 2 - Was the Intermediary's adjustment eliminating the community education director's salary proper? - on the record

STATEMENT OF CASE AND PROCEDURAL HISTORY:

Alameda Hospital ("Provider") operates a 23-bed Medicare certified hospital-based skilled nursing facility ("SNF") in Alameda, California. For the fiscal year at issue the Provider exceeded all of the benchmarks established by CMS to determine whether it provided atypical services. The Provider had an average length of stay of 12.38 days compared to a national average of 132.34, Medicare utilization of 83.67 percent compared to a national average of 52.39 percent, and Medicare SNF ancillary per diem costs of $193.11 compared to a national average of $62.63. A lower than average length of stay, combined with a higher than average Medicare utilization and Medicare SNF ancillary costs all point to the provision of atypical services to higher acuity patients.

The regulation at 42 C.F.R. § 413.30(f)(1) permits the Provider to request from CMS an exception from its routine cost limit ("RCL") because it provided such atypical services. The Provider requested such an atypical services exception from CMS for the cost reporting period ending December 31, 1995. Both United Government Services - California ("Intermediary") and CMS recognized that the Provider had provided atypical services and granted first an interim, and then a final, atypical services exception request resulting in an exception of $166.67 per day.

Jurisdiction

The Intermediary objected to jurisdiction because CMS had never made a final determination on the Provider's SNF RCL Exception Request. The Board finds that the Intermediary objection is no longer relevant because CMS delegated this function to the Intermediary for periods after September 1999 and thus the Intermediary determination of the Provider's RCL request on October 11, 2000 was a final determination which the Board can review. See 64 Fed. Reg. 42610 (August 5, 1999).

The Provider was represented by Frank P. Fedor, Esquire, of Diepenbrock, Wulff, Plant and Hannegan, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue

Issue 1(A) - Low Occupancy Adjustment:

Issue 1(A) relates to the Intermediary's implementation of a low occupancy adjustment to the Provider's costs during the exception determination. The Intermediary "deemed" 24 hours of nursing care in each day, and most of the Provider's indirect costs, to be "fixed" costs, thereby making these fixed costs subject to the low occupancy adjustment. The Provider contends that these costs were in fact "variable" and that no low occupancy adjustment should have been made on variable costs under CMS' low occupancy instruction in the CMS Pub. 15-1 § 2534.5.A.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary and CMS violated CMS Pub. 15-1 § 2534.5.A by deeming certain of the Provider's costs to be fixed costs when these costs were clearly variable costs under standard accounting practices.

CMS Pub. 15-1 § 2534.5.A states CMS' rule for low occupancy adjustments in determining SNF exception requests. It reads in relevant part as follows:

> (A) Low Occupancy.-- If a provider's occupancy rate is lower than the average occupancy rate of the provider used to develop the cost limits, an adjustment to the provider's per diem cost may be made . . . . For the purpose of this adjustment, fixed costs are defined as those costs considered fixed by standard accounting practices and those costs that must be incurred by all SNFs in order to meet the conditions of participation in the Medicare program. The provider must identify and quantify all per diem costs, by cost center, that vary with occupancy and, accordingly, must be excluded from the adjustment for low occupancy. In the absence of a specific identification, all per diem costs are deemed fixed and adjusted accordingly . . . .

CMS Pub. 15-1 § 2534.A (emphasis added).

The Provider points out that the stated purpose of the low occupancy adjustment is to avoid the reimbursement of unreasonable per diem costs which result when fixed costs must be spread over a smaller population than that which typically occupies a peer group SNF. CMS has explained the purpose as follows:

> Basically, the biggest part that concerns us in terms of when a provider's occupancy level is below 75 percent is the fixed costs. The fixed costs are being spread over a lower number of days, which means your per diem costs are going to be higher in relationship to your occupancy level. So we would look for the provider to identify what cost in each

cost center is fixed and which costs are variable.[1]

This rationale has also been articulated in CMS Administrator decisions. "Since the inception of the skilled nursing facility cost limit exceptions process, [CMS] has interpreted 42 C.F.R. § 413.30(f)(l) to provide for the evaluation of all applications to ensure that excess costs are not due to excessive staffing or idle capacity (low occupancy), resulting in fixed expenses being spread over fewer inpatient days, creating unnecessarily high costs per patient day." Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, CMS Administrator Decision, October 20, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,722 ("Southfield"), at 46,858.

The Provider notes that CMS Pub. 15-1§ 2534.5.A creates only a rebuttable presumption that all of the provider's costs are fixed. A provider is expressly permitted to demonstrate that its costs are in fact variable, and not fixed, and that no low occupancy adjustment is appropriate:

> [b]oth the Board and the Administrator have recognized in similar cases that the occupancy adjustment applied to skilled nursing facility exception requests operates as a rebuttable presumption, and not as an inflexible rule. That is, a provider may rebut application of the adjustment by identifying costs subject to the limitation that, in fact, vary with occupancy and/or by furnishing a sufficient explanation of why, in its particular case, the lower occupancy level was reasonable.

Southfield, CCH ¶ 43,722, at 46,858.

The Intermediary expressly stated that Southfield represented its position on the low occupancy issue.[2]

The dispute regarding direct costs focuses solely on Registered Nurse ("RN") and Licensed Vocational Nurse ("LVN") costs. CMS deemed 63 percent of the Provider's RN costs and 58 percent of the Provider's LVN costs to be fixed.[3] The Provider contends that 100 percent of both RN and LVN costs were variable in the fiscal year at issue. Both CMS and the Provider agree that all of the Nursing Management and Clerical direct costs were fixed, and that all of the Aides and Registry costs were variable.

CMS Pub. 15-1 § 2534.5.A defines fixed costs as those that are both defined as fixed costs by standard accounting principles and required by the Medicare conditions of participation. By simplistically deeming as fixed the cost of meeting the condition of participation requiring the

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1 Testimony of Robert Kul, May 15, 1997, Provider Exhibit 20 at 80, lines 9-17.

2 Tr. at 12, lines 11-15.

3 Provider Exhibit 50.

provision of 24 hours of licensed nursing care, CMS failed to follow the requirement of its rule that fixed costs are defined by standard accounting practices.

The Provider contends that simply deeming any cost to be fixed in the abstract is inconsistent with any standard accounting practice or principle. Accounting practices typically apply accounting principles or rules to particular facts. There is no accounting practice of simply declaring some cost as fixed or variable.

The Provider introduced excerpts from the leading textbook on cost accounting, Cost Accounting: A Managerial Emphasis by Charles T. Horngren.[4] A fixed cost is defined by standard accounting practices as one which "remains unchanged in total for a given time period despite wide changes in the related level of total activity or volume."[5] A variable cost is defined by standard accounting practices as one which "changes in total in proportion to changes in the related level of total activity or volume."[6]

The Provider contends that standard accounting practices identify four principles as significant to the definition of a cost as fixed or variable:

Cost Object: This is the item of expense which is being evaluated as to whether it is fixed or variable. Nursing salaries is an example of a Cost Object.

Cost Driver: This is the level of activity or volume that causally affects cost over a given span of time. Patient days is an example of a Cost Driver.

Time: This is the period of time relevant to the evaluation of the fixed or variable nature of the cost object. A fiscal year is an example of a Time Horizon.

Relevant Range: This is the range of activity in which the Cost Object may vary in reaction to the causal affects of the Cost Driver. The range over which nursing hours vary in reaction to the rise and fall of patient census is the relevant range for nursing hours.[7]

During the fiscal year at issue, the Provider's occupancy ranged from one day in which there were only 5 patients in the unit to four days when there were 23 patients in the unit.[8] This demonstrates that the relevant range of evaluating fixed and variable nursing salaries for the

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4 Provider Exhibit 27.
5 Tr. at 67-68.
6 Tr. at 68.
7 Tr. at 68-70.
8 Provider Exhibits 51, 52 and 53 and Tr. at 70-72.

fiscal year at issue is from 5 to 23 patients per day.[9] The Provider also introduced evidence as to how it staffed nurses in its skilled nursing facility using its nursing protocol for making staffing decisions in the skilled nursing facility,[10] and its "Optimum Matrix for a Skilled Nursing Facility" which was used by the department of nursing to make day-to-day decisions on nurse staffing in the skilled nursing facility.[11] The Provider had a minimum staffing policy of 48 hours, which is double the minimum required by the Medicare conditions of participation.[12]

The Provider illustrated that when the census dropped below six patients, there were some nursing hours which now became excess hours because the provider no longer reduced staffing below the 48 hours per day level due to its own safety policy. However, the Provider had only one day when its census fell in this inefficient zone, and this day resulted in only five excess nursing hours. This illustrated the concept that when the Provider's census dipped below a census of six, its nursing hours were now a "fixed" cost because the provider no longer made adjustments to correspond to the lower census. However, within the relevant range of a census between 6 and 23, nursing hours, and thus their costs, were wholly variable.

The Provider contends that CMS' notion that 24 hours of nursing care must always be deemed "fixed" defies standard accounting practices because it always makes the first, latest, and most variable nursing hours of every day "fixed" when they are in fact the essence of what defines a "variable" cost.[13] No matter how efficient this provider is, or how variable its nursing hours are in reality, CMS will always deem the first 24 hours of nursing care each day to be a fixed cost.

The Provider points out that CMS' conclusion that this provider had fixed costs of 24 hours of nursing care each day is a misapplication of CMS Pub. 15-1 § 2534.5.A. If there were occasions where the census fell so low that compliance with the conditions of participation required higher nurse staffing than otherwise indicated by the needs of the patients, then at this range there would be fixed costs under both standard accounting practices and the conditions of participation.[14] If the Provider was a very small hospital-based skilled nursing facility with only five beds, it might frequently have fixed nursing hour costs because its small sized combined with low occupancy caused the 24 hour requirement of the conditions of participation to actually operate as a fixed cost.[15] However, that was simply never the case at this Provider in this fiscal year.

The Provider also points out that the Intermediary introduced no evidence to rebut the evidence introduced by the Provider of the staffing of nursing hours during the fiscal year. The

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9 Tr. at 72.
10 Provider Exhibit 29 and Tr. at 72.
11 Tr. at 72-74 and Provider Exhibit 30.
12 Tr. at 75-76 and Provider Exhibit 54.
13 Tr. at 78-79.
14 Tr. at 81-83.
15 Tr. at 56

Intermediary also did not introduce any evidence to rebut the Provider's evidence of the application of standard accounting practices to the nursing hours issue.

The Provider argues that CMS also improperly applied its low occupancy instruction in Section 2534.5.A to the Provider's indirect costs in every indirect cost center except Operation of Plant. Section 2534.5.A specifies that the low occupancy adjustment is made "to the provider's per diem cost." As explained above, the premise of the whole adjustment is that when fixed costs must be spread over a lower than typical census, the per diem cost is unreasonably raised.

The Provider argues that this premise works well when applied to a free standing skilled nursing facility. For example, the free standing facility is required to have the services of a dietician, with some portion of those costs being fixed, and the logic of a per diem cost adjustment to instances of low occupancy applies.[16]

However, this premise does not apply to hospital-based SNFs because the costs of the general service cost centers of a hospital-based SNF are statistically allocated by the cost-reporting instructions.[17] Thus they are by their very nature variable. Because they are completely variable on a statistical basis, rises and falls in occupancy do not result in any changes in "per diem" expenses. Thus the "provider's per diem cost" is self-adjusting under the cost reporting instructions on the basis of occupancy, and no further "low occupancy" adjustment is logical or appropriate.[18] The costs that are allocated to the hospital-based skilled nursing facility already reflect the SNF's lower occupancy and are therefore a variable cost; they require no further occupancy adjustment.[19] The Provider contends that recognizing the indirect costs of a hospital-based SNF as variable is also consistent with standard accounting practices. Because of the statistical allocation of costs to the SNF's indirect cost centers required by the cost reporting instructions, the traditional analysis of attempting to identify fixed and variable costs within these cost centers did not apply. As far as the "cost object" of the indirect costs of the SNF was concerned, they were all variable because of the method by which they were allocated.[20] Indeed, in light of the cost reporting methodology by which these indirect costs are required to be assigned, it would be a misapplication of standard accounting practices to attempt to identify fixed and variable costs within each indirect cost center which are statistically assigned to routine cost centers.

INTERMEDIARY'S CONTENTIONS:

The Intermediary notes that the Provider objects to the low occupancy adjustment required by CMS Pub. 15-1 § 2534.5.A which reads:

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16 Tr. at 55-56.
17 Tr. at 20-21.
18 Tr. at 83-85.
19 Tr. at 27-28 and 50.
20 Tr. at 83-85.

> [i]f a provider's occupancy rate is lower than the average occupancy rate of the providers used to develop the cost limits, an adjustment to the provider's per diem cost may be made. The average occupancy rate for all SNFs is approximately 92 percent with a standard deviation of approximately 9 percentage points. Accordingly, the threshold occupancy rate of 75 percent . . . is used to determine if an adjustment is necessary. If a provider's occupancy rate is below 75 percent, all fixed per diem costs by cost center, are adjusted to reflect its per diem equivalent at the 75 percent occupancy rate . . ."[21]

CMS' Administrator has found in Southfield, supra, that "the occupancy standard represents [CMS'] longstanding interpretation of the governing reasonable cost statutes and regulations, and has been used to evaluate skilled nursing facility cost limit exceptions since the beginning of the exception process."[22] As recited above, the statute establishes that in determining reasonable costs, Medicare shall not pay for excess costs generated by inefficiencies in provider operations, including idle capacity. Pursuant to the Congressional mandate, 42 C.F.R. § 413.30(f) of the regulations, governing all exceptions to the routine cost limits, provides that the limits may be adjusted upwards, and that adjustments shall be permitted "only to the extent the costs are reasonable, attributable to the circumstances specified, and separately identified by the Provider." Further, 42 C.F.R. § 413.30(f)(1) states that in obtaining an exception for atypical services, a provider must show, among other things, that the atypical items and services that it furnishes are "necessary in the efficient delivery of needed health care." Accordingly, responding to Congressional concern that the Medicare program not pay for excess costs incurred as the result of low occupancy, reflected in section 1861(v)(1)(A) of the Social Security Act and the legislative history of the 1972 amendments, the Secretary provided in the governing regulation for evaluation of exception requests under efficiency standards, including guidelines limiting Medicare payment for idle capacity. The SNF occupancy adjustment is just such a valid, interpretive guideline.[23]

Issue 1(B) - 112 Percent Gap:

Issue 1(B) was heard on the record. The Provider's exception request was governed by CMS Transmittal No. 378 which was issued in July 1994. This issue relates to the instruction in CMS Transmittal No. 378 that the atypical services exception of every hospital-based SNF must be measured from 112 percent of the peer group mean for that hospital-based SNF. This specific requirement is found in CMS Pub. 15-1 § 2534.5. The figure of 112 percent of the peer group mean of every hospital-based SNF is always significantly higher than its RCL. Thus under CMS Transmittal No. 378 there is a reimbursement "gap" between the RCL and 112 percent of the

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21 Intermediary Exhibit 11.

22 Intermediary Exhibit 14.

23 Id.

peer group mean which represents costs incurred by the hospital-based SNF which it can never recover.

PROVIDER'S CONTENTIONS:

The Provider's contentions concerning the reimbursement gap fall within three broad categories. First, the Provider contends the "gap" methodology in CMS Pub. 15-1 § 2534.5 is directly inconsistent with the regulation controlling atypical services exceptions and with the statute prohibiting cross subsidization between Medicare and other payers. Second, the, Provider contends the "gap" methodology in CMS Pub. 15-1 § 2534.5 is invalid because it was not adopted pursuant to the notice and comment rule making provisions of the Administrative Procedure Act or as a regulation as required by statute. Third, the Provider contends that CMS' action in adopting the "gap" methodology in CMS Pub. 15-1 § 2534.5 was arbitrary, capricious, an abuse of discretion and not in accordance with law, and should therefore be overturned under other provisions of the Administrative Procedure Act.

Inconsistency With Law:

The Provider contends that the "gap" methodology in CMS Pub. 15-1 § 2534.5 violates the clear and unambiguous language of 42 C.F.R. § 413.30(f)(l) which controls atypical services exception requests. The Provider contends that according to the language of § 413.30(f)(1) the Provider must establish only three facts: 1) that the Provider's costs exceeded its RCL, 2) that these costs exceeded the RCL because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified, and 3) that the atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care. The Provider contends that under the "gap" methodology in CMS Pub 15-1 § 2534.5, CMS has substituted a new cost threshold for the RCL in item number one which violates the regulation.

The Provider points out that 42 C.F.R. § 413.30 focuses its language on the adjustment of limits, and not on an add-on based on exceeding a threshold higher than the limits. 42 C.F.R. § 413.30 "sets forth rules governing exemptions, exceptions, and adjustments to limits established under this section that [CMS] may make as appropriate in consideration of special needs or situations of particular providers." (Emphasis added). 42 C.F.R. § 413.30(f) also expressly states that an atypical services exception is an adjustment to a RCL, and not an adjustment to some higher threshold set by CMS:

> (f) Exceptions. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(l) through (f)(8) of this section.... An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

(Emphasis added)

Most importantly, 42 C.F.R. § 413.30(f)(l) expressly states that a provider' costs must only exceed its RCL in order for it to qualify for an exception. 42 C.F.R. § 413.30(f)(1) states that the "limits" may be adjusted upwards if "[t]he provider can show that the (i) Actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope . . . ." (Emphasis added). The controlling regulation specifically states that the provider must only show that its cost "exceeds the applicable limit," and not that its cost exceeds 112 percent of the peer group mean.

The Provider also contends that in devising the "gap" methodology of CMS Pub. 15-1 § 2534.5 CMS has confused the concept of a peer group comparison of atypical services with the concept of a peer group comparison of atypical costs. 42 C.F.R. § 413.30 requires the peer group comparison to be made in terms of the atypical nature and scope of services, and not in terms of the atypical cost of services.

Under the language of 42 C.F.R. § 413.30 a provider must show that the actual cost of the items and services it furnished exceeded the applicable limit "because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified." The comparison to a peer group of "providers similarly classified" required by the regulation is of the "nature and scope" of the items and services actually furnished, not their cost.

The Provider points out that CMS Transmittal No. 378 does contain a peer group comparison that is consistent with the controlling regulation. Transmittal No. 378 has benchmarks that measure whether the provider has a lower than average length of stay, higher than average ancillary costs per day, and higher than average Medicare utilization. According to the testimony of the CMS witness at the hearing, once a provider has established that it exceeds these benchmarks, "they have, as far as we are concerned, they have established that they are providing atypical services."[24]

The Provider contends that CMS plainly goes beyond the language of § 413.30(f)(l) when it states that the regulation requires a comparison of cost to a peer group. That may be an appropriate comparison for establishment of limits. But it directly contradicts the language of 42 C.F.R. § 413.30(f)(l) when applied to the atypical services exception process. The only peer group costs to which CMS can compare under 42 C.F.R. § 413.30(f)(1) is the RCL.

The Provider also contends that the "gap" methodology in CMS Pub 15-1 § 2534.5 violates the prohibition against cross subsidization between Medicare and other payers found in 42 U.S.C. § 1395x(v)(1)(A)(i) because it makes it impossible for any hospital-based SNF which provided atypical services and whose costs exceeded it RCL from ever obtaining reimbursement up to all

[24] Provider Exhibit 39, St. Luke's Transcript 92.

of its costs.

The Provider points out that Medicare is required to reimburse providers for their reasonable costs incurred in treating Medicare beneficiaries. "Reasonable cost" is defined as only those costs "actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(l)(A)(i). The reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services." Id. (emphasis added). The Secretary is authorized to establish appropriate cost limits as part of her method of determining reasonable costs. Id. See Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993).

42 U.S.C. § 1395x(v)(1)(A)(i) prohibits Medicare and other payers from "cross-subsidizing" each other. It states that "[s]uch regulations shall (i) take into account both direct and indirect costs of providers of services.., in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs." 42 U.S.C. § l395x(v)(1)(A)(i) (emphasis added). The "no cross-subsidization" principle is further required by 42 C.F.R. §§ 413.5(a) and (b)(3) and 42 C.F.R. § 413.50.

42 U.S.C. § 1395yy(A) establishes the definition of the RCL applicable to the Provider in this appeal. This section establishes different RCLs, sometimes referred to as "dual limits," for freestanding SNFs and for hospital-based SNFs. The RCL for freestanding SNFs is set at "112% of the mean per diem routine service cost for freestanding skilled nursing facilities" while the RCL for hospital-based SNFs is set at "the limit for freestanding skilled nursing facilities. . . , plus 50% of the amount by which 112% of the mean per diem routine service cost for hospital-based skilled nursing facilities . . . exceeds the limit for freestanding skilled nursing facilities." 42 U.S.C. § 1395yy. The Provider points out that although there is no dispute that Congress established dual cost limits, § 1395yy does not qualify the clear prohibition against cross-subsidization contained in Section 1395x(v)(1)(A)(i) nor does it prohibit hospital-based SNFs from obtaining full reimbursement of reasonable costs.

The Provider points out that the RCL sets only a presumptive, and not a conclusive, limitation on the reimbursement that a provider may receive for its reasonable costs.

Indeed CMS has acknowledged and confirmed the presumptive nature of the RCL for SNFs in CMS Transmittal No. 378,[25] which is at issue in this case:

> Section 1861(v)(1)(A) of the Social Security Act (the Act), as implemented in 42 C.F.R. Section 413.30, authorizes the Secretary to establish limits on

[25] Provider Exhibit 34.

> provider costs recognized as reasonable in determining Medicare program payment. The limits are a presumptive estimate of reasonable costs . . .

The Provider emphasizes a Senate Print which is the only evidence of legislative intent which specifically addresses the issue before the Board. In discussing the Senate Bill that became Section 1395yy, Title 42, United States Code, the Senate Finance Committee print, S. Rpt. 98-169, Vol. 1, March 21, 1984, states that providers, where justified, should be able to receive "up to all of their reasonable costs" through the exception process. It states that:

> [u]nder this provision, both hospital-based and freestanding facilities could continue to apply for and receive exceptions from the cost limits in circumstances where high costs result from more severe than average case mix or circumstances beyond the control of the facility. Indicators of more severe case mix include a comparatively high proportion of Medicare days to total patient days, comparatively high ancillary costs, or relatively low average length of stay for all patients (an indicator of the rehabilitative orientation of the facility). Facilities eligible for exceptions could receive, where justified, up to all of their reasonable costs.[26]

Failure To Follow Notice And Comment Rulemaking:

The Provider also contends that because the "gap" methodology in CMS Pub 15-1 § 2534.5 establishes or changes a substantive legal standard governing the payment for services it must be published as a regulation under the provisions of 42 U.S.C. § 1395hh(a)(2).

CMS' conduct is arbitrary, capricious and an abuse of discretion and not in accordance with law. The Provider contends that the "gap" methodology in CMS Pub. 15-1 § 2534.5 also violates the Administrative Procedure Act because it was not adopted pursuant the notice and comment rulemaking requirement of 5 U.S.C. § 533. Because the "gap" methodology effects a change in the existing law contained in 42 C.F.R. § 413.30(f)(1) by requiring a provider to show that its costs exceed 112 percent of the peer group mean instead of the applicable RCL, such a change in the regulation must be made pursuant to the notice and comment provisions of 5 U.S.C. § 533.

Accordance With Law:

The Provider contends that CMS' action in adopting the "gap" methodology in CMS Pub 15-1 § 2534.5 was arbitrary, capricious, an abuse of discretion and not in accordance with law, and should therefore be overturned under the Administrative Procedure Act.

The Provider points out that in this case CMS' methodology is a departure from its earlier method of determining hospital-based SNF exception requests and requires an explanation for its

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[26] Provider Exhibit 11 at 21

change of direction. The Provider identifies case law which states that it is "a clear tenet of administrative law that if the agency wishes to depart from its consistent precedent it must provide a principled explanation for its change of direction." National Black Media Coalition v. FCC, 775 F.2d 342, 355 (D.C. Cir. 1985). The Provider points to the case of Motor Veh. Mfrs. Assn. v. State Farm Mut., 463 U.S. 29, 43 (1983) as identifying the standard of review.

> [T]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.' Burlington Truck Lines. Inc. v. United States, 371 U.S. 156, 168, 9 L. Ed. 2d 207, 83 S. Ct. 239 (1962). In reviewing that explanation, we must 'consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.' Bowman Transportation, Inc. v. Arkansas-Best Freight System, Inc. [419 U.S. 281] at 285, 42 L. Ed. 2d 447, 95 5. Ct. 438; Citizens to Preserve Overton Park v. Volpe, [401 U.S. 402] at 416, 28 L. Ed. 2d 136, 91 S. Ct. 814. Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

463 U.S. at 43.

The Provider points out that it is undisputed that CMS' stated reason for adopting the "gap" methodology is that CMS believed that it was the intent of Congress that in implementing its exception process CMS should not recognize the costs of hospital-based SNFs which fell within the "gap." The Provider points to written discovery responses which state this as the reason for the "gap" methodology.[27] The same explanation was given by the testimony of CMS' witness at the hearing.[28] This explanation was also stated in a CMS Administrator Decision on the same issue. St. Francis Health Care Centre v. Community Mutual Insurance Company, PRRB Case No. 97-D38, March 24, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,159, rev'd, CMS Administrator, May 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,545, aff'd, 10 F. Supp. 2d 887 (NDWD Ohio 1988), aff'd, 205 F. 3d 937 (6th Cir 2000).

The Provider contends that CMS' stated reason for its adoption of the "gap" methodology failed to consider the only direct evidence of the intent of Congress on this issue. The Provider again

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27 Provider Exhibits 9 and 10.

28 Provider Exhibit 39, St. Luke's Transcript 100.

points to the aforementioned Senate Print 98-169. This document unequivocally shows that it was the intent of Congress to permit hospital-based SNFs which provide atypical services to obtain up to all of their reasonable costs.

The Provider also contends that CMS offered an explanation for its decision that runs counter to the evidence before the agency when it illogically chose to penalize those hospital-based SNFs which treat the sickest of patients after Congress took great care to compensate the costs of hospital-based SNFs providing only typical services to sicker patients.

Logically, the fact that Congress set a higher RCL for hospital-based SNFs providing only typical services in order to compensate them for the additional cost of treating sicker patients-(which is precisely the conclusion that CMS has drawn for the DEFRA 1984 dual limits) would lead to the similar and parallel conclusion that those hospital-based SNFs which provide atypical services (because they treat even sicker patients than the hospital-based SNF which provides only typical services) should also receive compensation for the cost of treating these sickest of patients.

Instead of following this logic, however, CMS illogically created a reimbursement "gap" which penalizes all hospital-based SNFs which treat the sickest patients by making it impossible for them to receive compensation for all or some significant portion of the cost of providing atypical services.

The Provider also contends that CMS relied on factors which Congress clearly had not intended it to consider. CMS states that it came up with its methodology "[i]n order to give meaning to Congress's explicit intention that 50 percent of the cost differences between hospital-based and freestanding SNFs not be reimbursed."[29] However, Senate Print 98-169, shows that this intent of Congress applied only to hospital-based SNFs providing only typical services, and not to that minority of hospital-based SNFs which provide atypical services. CMS could point to no statement by Congress that hospital-based SNFs which provided atypical services should uniformly be denied as a class from obtaining up to all of their reasonable costs.[30] The Provider contends that CMS took factors relied upon by Congress for one purpose (to set discriminatory cost limits taking into account presumed additional costs in furnishing typical services for sicker patients), and used them for a second and unintended purpose - to create a discriminatory exception process for those minority hospital-based SNFs which provide atypical services.

The Provider also contends that CMS' "gap" methodology is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. First, the Provider points out that the "gap" methodology of quantifying the amount of an atypical services exception from 112 percent of the peer group mean leads to the absurd result of treating the costs of atypical

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29 Provider Exhibit 9 at 3 and Provider Exhibit 10 at 3-4.

30 Provider Exhibit 23, St. Luke's Tr. at 102-103.

services more severely than the costs of typical services. The RCL discounts the last dollars of the cost to

a hospital-based SNF of providing typical services; hospital-based SNFs providing only typical services are presumed to have reasonable costs "up to" the RCL. In contrast, the cost of the atypical services provided by a hospital-based SNF are treated much more severely in that the discount is applied to the first dollars of such cost. For example, a hospital-based SNF providing typical services at the RCL and atypical services at below 112 percent of the peer group mean receives no compensation for its cost of providing atypical services. In another example, a hospital-based SNF providing typical services at the RCL and atypical services at an amount above 112 percent of the peer group mean equal to the amount of the "gap" suffers a 50 percent discount for its cost of providing atypical services.

Second, the Provider points out that the "gap" methodology of quantifying the amount of an atypical services exception from 112 percent of the peer group mean leads to the absurd result of assuming that a hospital-based SNF's costs above the RCL are unreasonable, but then become reasonable again above the higher level of 112 percent of the peer group mean.

Third, the Provider points out that the "gap" methodology plays no role in screening out unreasonable costs. Unreasonable costs are screened out by other provisions of CMS Transmittal No. 378 to which the Provider does not object.

The Provider also contends that the "gap" methodology impermissibly discriminates between freestanding and hospital-based SNFs in that freestanding SNFs which provide atypical services do have an opportunity to obtain reimbursement of up to all of their reasonable costs, while no hospital-based SNF will ever be able to do so. The Provider points out that 42 U.S.C.A. § 1395yy(c), which gives CMS the authority to develop and apply an exception procedure, does not articulate any express intent of Congress to discriminate between freestanding SNFs and hospital-based-SNFs in the exception process. Although the statute does grant the Secretary broad discretion as to whether or not to make adjustments to the limits, and as to the appropriate extent of the adjustments made, it nowhere permits the Secretary to discriminate against hospital-based SNFs. The Provider cites Addison v. Holly Hill Fruit Products, 322 U.S. 607 (1944) in support of its conclusion that such discrimination is arbitrary, capricious, an abuse of discretion and not in accordance with law.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that 42 C.F.R. § 413.30 requires a reasonableness determination in granting an exception and discusses the situations under which an upward adjustment may be made to the limits for atypical services. This section states that the provider must show:

(i) The actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly

classified; and

(ii) The atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

42 C.F.R. § 413.30(c) discusses how requests are handled. An exception request must be filed within 180 days of the notice of program reimbursement. The Intermediary makes a recommendation to CMS which renders a decision. Interim exceptions are explained in a CMS memo dated August 11, 1994 and CMS Pub 15-1 § 2534.2.[31] According to CMS Pub 15-1 § 2534.2.A(c), interim exceptions are granted to "lessen cash flow problems for providers with substantial Medicare utilization. While a final approval or denial of an exception is made by HCFA, interim exceptions may be tentatively approved and payments may be adjusted by an intermediary without prior approval from HCFA."

CMS Pub. 15-1 § 2530ff, Transmittal 378 is effective for all exception requests submitted to intermediaries on or after July 20, 1994. Section 2534 refers to exception requests. Section 2534.5 states, "[i]n determining reasonable cost, the provider's per diem costs in excess of the cost limit are subject to a test for low occupancy and are compared to per diem costs of a peer group of similarly classified providers." The Intermediary has followed these instructions.

The Provider objects to the reclassification of certain costs from direct cost to indirect costs. CMS Pub. 15-1 § 2534.5 requires that certain directly assigned costs be removed from direct cost for purposes of comparison to the peer group. That section states at B, "[i]f indirect costs are directly assigned (e.g. nursing administration (indirect cost) assigned to the direct cost center), the indirect cost elements must be identified and reassigned for the purpose of constructing the peer group, to the indirect cost center identified with the type of cost incurred . . . ." The Intermediary has applied these instructions.

The following are the Intermediary reclassifications with which the Provider disagrees:[32]

1. Direct Expense ($77,868); Nursing Administration $9,995: To reclassify Nursing Supervisors salary to Nursing Administration and step back down the applicable amount to the SNF. It shows that 12.8 percent of nursing administration cost is allocated to the SNF. That percentage was applied to the Nursing Administration cost directly assigned to the SNF for the amount that would have been stepped-down to the SNF if the entire amount had been recorded in Nursing Administration.

2. Direct Expense ($1,649); Central Services $1,649: To reclassify medical supplies to the Central Service cost center.

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31 Intermediary Exhibits 10 and 11.

32 Intermediary Exhibit 3.

3. Central Services $7,805: To reverse transfer of Central Services expense.

4. Administrative and General $23,523: To reverse transfer of Storeroom expense.

The Provider has not shown that the Intermediary failed to make its determination in accordance with the referenced program instructions.

The Provider also objects to CMS 15-1 § 2534.5 in regard to the peer group comparison, stating that such comparison results in a "reimbursement gap." The Intermediary contends that it has followed Program regulation, policy and instructions. CMS requires that hospital-based SNFs have a routine cost per day exceeding 112 percent of the peer group mean cost per day for hospital-based SNFs rather than the routine cost limits to receive an exception to the RCL. The regulation at 42 C.F.R. § 413.30(f)(1)(I) requires that "actual cost of items or services furnished by the provider exceeds the applicable limit because such items or services are atypical in nature and scope compared to the items or services generally furnished by providers similarly classified . . . . ." That regulation is interpreted by CMS Pub. 15-1 § 2534.5.

The hospital-based SNF cost limits are based on the freestanding SNFs limit plus certain adjustments. In order to evaluate the request for exception due to atypical costs, the Provider's cost must be compared to similar providers according to the regulations. Therefore, the comparison is made to the peer group costs rather than the cost limits. A letter from the Director, Office of Payment and Policy, Bureau of Policy Development to another provider on the same issue is cited by the Intermediary.[33] It explains,

> [s]ection 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 cost limits for routine services for hospital-based SNFs must be 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 the 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.
>
> The regulations at 42 C.F.R. § 413.30 provide for an exception to the routine cost limits if the SNF has provided atypical services as compared to similarly classified providers. Accordingly, 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 SNFs costs to those of the typical facility to determine the amount of its

[33] Intermediary Exhibit 12.

costs that are typical. As a result, a hospital-based SNF is only eligible for an exception for atypical services for the amount that its actual costs exceed 112 percent of the mean

costs of hospital-based SNFs and not by the amount that its actual costs exceeds the limit.

The CMS' Administrator decision in St. Francis, supra, has upheld an intermediary's application of CMS Pub 15-1 § 2534.5, which he noted explains the method CMS developed to quantify the peer group comparison that is part of the test for reasonableness. The Administrator found:

1. the exception guidelines in Chapter 25 of the PRM are reasonable and appropriate, as they closely adhere to the requirements of section 1888(a) of the Act; are within the scope of the Secretary's discretionary authority under Section 1888(C) of the Act to make adjustments in the SNF RCLs; and adhere to the regulations at 413.30(f)(1)(i).

2. the policy interpretation in PRM Section 2534.5B, requiring the hospital-based SNFs costs to be compared to 112 percent of the group's mean per diem costs, is an appropriate method of applying the reasonable cost requirements and is not inequitable.

3. CMS properly determined that 50 percent of the difference between the free standing - SNF and the hospital-based SNFs cost limits, i.e., the "gap,", was due to hospital-based SNFs inefficiencies. Since those costs are not reasonable, CMS properly determined that these costs would not be reimbursement pursuant to the exception process.

4. the plain language of 42 CFR 413.30(f)(1)(i) supports the use of a peer group comparison such as that made under the method set forth in CMS Section 2534.5.B to determine reasonableness and atypicality.

The Intermediary contends that it has properly applied CMS Pub. 15-1 § 2534.5

The Provider also maintains that CMS Pub. 15-1 § 2534.5 is invalid because it was not adopted pursuant to Notice and Comment Rulemaking and required by the Administrative Procedure Act. CMS' Administrator has ruled on this issue also in his review of St. Francis. He states, "[t]he Administrator finds that the methodology at issue does not involve application of a 'substantive' rule requiring publication of notice and comment under section 553 of the APA."

Relevant to this case, the Secretary has promulgated a regulation at 42 C.F.R. § 413.30(f)(1) establishing a specific exception from the RCLs based on atypical services. The Secretary does not have an obligation to promulgate regulations that specifically address every conceivable situation in the process of determining reasonable costs. Rather, the Intermediary is required to make a determination of the reasonableness of the exception request, applying the existing reasonable cost statute, controlling regulations, and any further guidance that CMS has issued. The methodology set forth in CMS Pub. 15-1 § 2534.5 is a proper interpretation of the statute and the Secretary's rules allowing an exception to the limits on reasonable costs based on atypical services." Id., n. 35.

CMS' requirement that hospital-based skilled nursing facilities have a routine cost per day exceeding 112 percent of the peer group mean cost per day for hospital-based SNFs rather than the routine cost limits to receive an exception to the RCLs is a proper interpretation of 42 C.F.R. § 413.30(f)(1). The Intermediary has properly applied CMS Pub 15-1 § 2534.5 which interprets these regulations.

Issue 2 - Community Education Director's Salary

The Provider operates a Prospective Payment System-excluded Geropsychiatric Unit which is managed by Cornerstone Health Management ("Cornerstone"). Payments to Cornerstone include services of a Community Education Director. The Director's salary and benefit amounts in the management contract total $50,979. This amount was eliminated from cost report line 39, Subprovider I, as a non-allowable cost. The Intermediary claimed that the function of this position is to increase patient utilization which is a non-allowable expense. The Intermediary based this determination on the job description as well as an interview with the current Community Education Director and noted that the functions included informing the public and health care professional staff about the unit at the Provider.

PROVIDER'S CONTENTIONS:

The Provider contends that the functions of the Community Education Director fall into the definition of allowable advertising costs per CMS Pub. 15-1 § 2136.1. This section of the manual states that "costs of activities involving professional contacts with physicians, . . . to apprise them of the availability of the provider's covered services are allowable." The provider agrees that not all of the functions of the Community Education Director relate to allowable marketing activities. Provider Exhibit 15 contains a time study prepared by Gloria Delucchi, Community Education Director, which illustrates the percent of time spent on allowable versus non-allowable activities. This time study was prepared from the Community Education Director's appointment book from a current period. The time allocation demonstrates that only 15 percent of the Community Education Director's time is spent on non-allowable functions. The Provider argues that the audit adjustment should be modified to eliminate only $7,712 of the total Community Education Director cost.

INTERMEDIARY'S CONTENTIONS:

The Intermediary notes that the management fee expenses were reviewed for reasonableness. As part of this review, it analyzed payments to Cornerstone for the services of a Community Education Director . Adjustment 24 resulted from the review.

Adjustment 24 in the amount of $50,979, reads, "[t]o disallow the community education director's salaries and benefits expenses due to the function of this position is to increase patient

utilization, which is non-allowable per Medicare regulations."[34] Supporting regulations and instructions given were 42 C.F.R. § 413.9 and CMS Pub. 15-1 §§ 2135 and 2126.2. The adjustment disallowed salary of $38,600 and benefits of $12,379 of the Community Education Director.

Audit workpapers state, "[e]arly on, we have problem (sic) with the Community Education Director, based on the job description. It stated that the CED is basically performing marketing duties. An interview with the current CED, Gloria Delucchi, on July 14, 1997, noted the functions of the CED is to inform the public and health care professional staff about the Transition unit in Alameda Hospital. We requested Ms Delucchi to recap her contacts in the past year, and later on due to the volume (sic), auditor agreed that Ms Delucchi can recap only a quarter of the year, as long as it is representable of the entire year's contacts. Auditor also asked Ms Delucchi if it was her duty to inform the patient or potential patient's family regarding the Transition unit. According to Ms Delucchi, such contact is done by the Social worker at the hospital. Her function is more geared to the outside contacts. A review of the CED recap confirmed that the function of this position is to inform and educate the public at large, therefore, it appears that this function is to increase patient utilization and is therefore not allowable for cost reimbursement per CMS Pub. 15-1 §§ 2135 and 2136.2."[35]

The Intermediary contends that these costs are not related to the care of this Provider's patients. The Provider maintains that only 15 percent of the Community Education Director's time is spent in non-allowable functions. This percentage is based on a study prepared from the Community Education Director's appointment book from a two-week period in September of 1996 and a two-week period in November of 1997.

To qualify for reimbursement under 42 C.F.R. § 413.9(a), expenses must related to the Provider's cost of furnishing services to Medicare beneficiaries.

Medicare may not share in the cost of services to those members of the community who are not the Provider's patients.

CMS Pub 15-1 §§ 2136, 2136.1 and 2136.2 give the Program instructions for determining allowable advertising costs and non-allowable advertising costs. CMS § 2136.1 states that the costs of advertising done in connection with the provider's public relations activities are allowable under these two conditions: 1) The advertising must be primarily concerned with the presentation of a good public image, 2) The advertising must be directly or indirectly related to patient care.

CMS Pub 15-1 § 2136.2 gives examples of unallowable advertising costs. Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities as independent practitioners are not allowable. Costs of advertising to the general public which seeks to

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34 Intermediary Exhibit 15.

35 Id.

increase

patient utilization of the provider's facilities are not allowable.

In considering how to differentiate between advertising to present a good public image and advertising to sell services, the Intermediary considers whether the advertising is used to influence public opinion of the provider's facilities and services (public relations) or advertising to influence public opinion with regard to a buying decision (marketing).

CMS Pub. 10, Section 80-1 describes educational activities, "[h]owever, where the educational activities are not closely related to the care and treatment of the patient, such as programs directed toward instructing patients or the public generally in preventive health care activities, reimbursement cannot be made since the law limits Medicare payment to covered care which is reasonable and necessary for the treatment of an illness or injury. For example, programs designed to prevent illness by instructing the general public in the importance of good nutritional habits, exercise regimens, and good hygiene are not reimbursable under the program."

The Provider has not shown that the claimed costs are allowable. Also, the proposed revision to the adjustment in dispute was not supported by evidence that the activities were related to the care of the Provider's patients. The study presented by the Provider does not comply with CMS Pub. 15-1 § 2313.2.E and is not auditable. 42 C.F.R. § 413.24.[36]

Advertising costs designed to affect the Provider's market share or to influence the general public's purchasing decision in the use of the Provider's services or facilities are not allowable. Advertising to promote an increase in the patient utilization of the Provider's services is not properly related to the care of patients.

The Provider has not met its burden to maintain adequate documentation to assure proper program payment in its claim for reimbursement.

CITATIONS OF LA W, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law:

5 U.S.C. §§ 500-575, 701, 706	-	Administrative Procedure Act
42 U.S.C. § 1395x(v)(1)(A)(i)	-	Reasonable Costs
42 U.S.C. § 1395yy et seq.	-	Payment to SNFs for Routine Service Costs
42 U.S.C. § 1395hh et seq.	-	Regulations

[36] Intermediary Exhibit 17.

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

§ 413.5 et seq.	-	Cost Reimbursement; General
§ 413.9 et seq.	-	Costs Related to Patient Care
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Finding
§ 413.30 et seq.	-	Limitations on Reasonable Costs
§ 413.50	-	Apportionment of Allowable Costs

3. Cases:

Addison v. Holly Hill Fruit Products, 322 U.S. 607 (1944)

Colleton Regional Hospital – Skilled Nursing Facility v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of South Carolina, PRRB Case No. 2002-D8, February 21, 2002, Medicare and Medicaid Guide (CCH) ¶ 80,795, CMS Administrator declined rev. April 4, 2002.

Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993)

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.

Mercy Medical Center SNF-Daphne v. Mutual of Omaha Insurance Company, PRRB Dec. No. 01-D38, July 27, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,727.

Motor Veh. Mfrs. Assn. v. State Farm Mut., 463 U.S. 29 (1983)

National Black Media Coalition v. FCC, 775 F.2d 342 (D.C. Cir. 1985)

New England Rehabilitation Hospital v. C&S Administrative Services for Medicare, PRRB Case No. 2000-D53, May 24, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,443.

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.

Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-

D67, September 2, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,311.

St. Francis Health Care Centre v. Community Mutual Insurance Company, PRRB Case No. 97-38, March 24, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,159, rev'd, CMS Administrator, May 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,545.

Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, CMS Administrator Decision, October 20, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,722, aff'd, 10 F. Supp. 2d (NDWD Ohio 1988), aff'd, 205 F.3d 937 (6th Cir. 2000).

4. Program Instructions – CMS Pub. 15-1:

§ 2530 et seq.	-	Inpatient Routine Service Cost Limits for SNFs
§ 2135	-	Purchased Management and Administrative Support Services
§ 2136 et seq.	-	Advertising Costs; General
§ 2162.2	-	Insurance Purchased from a Limited Purpose Insurance Company
§ 2313.2.E	-	Special Appilications

5. Other Sources:

CMS Pub. 10-1 § 80	-	Patient Education Programs

64 Fed Reg. 42610 (August 5, 1999)

Charles F. Horngren, Cost Accounting: A Managerial Emphasis, (10th ed. 1999)

Senate Finance Committee Print 98-169, Vol. 1, March 21, 1984.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

Issue 1(A) – Application of Low Occupancy Adjustment

The Board notes that HCFA Pub. 15-1 § 2534.5.A applies to this case. That section established an appropriate level of occupancy (75 percent) and requires an adjustment to "fixed" cost where a provider's occupancy falls below that level. The Board notes that a provider may rebut the presumption that all costs are fixed. However, the Board notes that the manual section indicates

that costs are considered fixed by standard accounting principles and those costs that must be met by all SNFs in order to meet the standards of participation. Id. In the instant case, the Intermediary used minimum nurse staffing levels as fixed costs for the Provider. Although the Provider contends that nurse staffing costs are 100 percent variable, the Board continues to find that use of minimum staffing requirements as a fixed costs is appropriate. See Colleton Regional Hospital – Skilled Nursing Facility v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of South Carolina, PRRB Case No. 2002-D8, February 21, 2002, Medicare and Medicaid Guide (CCH) ¶ 80,795, CMS Administrator declined rev. April 4, 2002.
The Board also notes that the Provider argued that certain indirect costs such as dietary and laundry were completely variable and should not be treated as fixed costs under the low cost adjustment. The Board notes that even though the costs of these services are allocated to the SNF based on a patient meals or pounds of laundry that varies with patient census, this does not mean that a portion of the cost for each meal or pound of laundry do not contain a portion of fixed costs. To the extent that there is low occupancy and low use of these services, the proportion of fixed costs in each unit will increase. The Board finds the Intermediary application of the low occupancy adjustment to these costs to be reasonable.

Issue 1(B) – 112 Percent Reimbursement Gap

The Board majority finds 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 the Deficit Reduction Act of 1984, the Secretary was given broad discretion in authorizing 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)(i), 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 hospital-based SNFs is set at 112 percent of the mean hospital-based inpatient routine service costs, and not at the hospital-based SNF's 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. Under this methodology, if a hospital-based 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 hospital-based 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 hospital-based SNF data as opposed to the hospital-based 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 majority further notes that HCFA's methodology of using the standard of 112 percent of the hospital-based 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 hospital-based SNFs.

Finally, the Board majority acknowledges the Provider's reliance upon the previous Board's decision in St. Francis, supra, to help support its position and arguments. The Board notes that its findings are consistent with the circuit court ruling which upheld the HCFA Administrator's reversal of the Board's decision in St. Francis, and 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.

- New England Rehabilitation Hospital v. C&S Administrative Services for Medicare, PRRB Case No. 2000-D53, May 24, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,443.

- Mercy Medical Center SNF-Daphne v. Mutual of Omaha Insurance Company, PRRB Dec. No. 01-D38, July 27, 2001, Medicare and Medicaid Guide (CCH) ¶ 80,727.

Issue 2 – Community Education Director's Salary

The Board finds that the Provider did not submit sufficient documentation to support its contention that the Community educators costs were allowable in whole or in part. The Board notes that the Provider acknowledged that some portion of the costs were unallowable. See Provider's Post Hearing Brief at 30. It is incumbent on the Provider to clearly demonstrate with auditable records what the allocation should be. The Board notes that the Intermediary was concerned with the job description and evaluation and asked for further information. The Board notes that the job descriptions or evaluations were not part of the record making any assessment for the Provider impossible. Further, the Board must agree with the Intermediary that the time study for four weeks from a subsequent time period was insufficient. Finally, the list of places that the employee visited was not detailed enough to determine what occurred and many of the places on the list appeared to be places where referral of patients could be expected versus other allowable functions related to patient care such as coordination or education of Providers. See Intermediary Exhibit 15.

The Board finds that the Provider failed to submit adequate auditable documentation to support its claim for the costs of the Community Education Director. 42 C.F.R. §§ 413.20 and 413.24.

DECISION AND ORDER:

Issue 1(A) – Low Occupancy Adjustment

The Board finds that the Intermediary's application of the low occupancy adjustment was proper.

The Intermediary's adjustment is affirmed.

Issue 1(B) - 112 Percent Reimbursement Gap

The Board majority finds that the Intermediary's application of the 112 percent gap was proper and CMS' partial denial of the Provider's exception request was proper. CMS' determination in this area is affirmed.

Issue 2 – Community Education Director's Salary

The Board finds that the Provider did not submit adequate documentation to support its claim for a portion of the Community Education Director's salary. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Skolove
Dr. Gary Blodgett (dissenting in part)
Suzanne Cochran, Esquire (dissenting in part)

Date of Decision: September 27, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman

We respectfully dissent with the majority opinion in the Alameda Hospital SNF case wherein HCFA[37] refused to grant an atypical services exception for that portion of the provider's per diem costs which did not exceed 112% of the peer group mean routine services cost.

> HCFA's refusal to approve additional costs for providing atypical services that were in excess of Provider's Routine Cost Limit (RCL) but not by more than 112% of the peer group mean cost limit was not consistent with the statutes and regulations relating to this issue.

The intent of Congress in providing an exception to the routine cost limit to compensate providers for the additional costs associated with the provision of atypical services was to ensure providers that they would be reimbursed their full costs for providing those additional services and that patients not covered by Medicare would not be unfairly burdened with subsidizing the cost of the care of Medicare patients. 42 USC §1395yy(a); 42 USC § 1395x(v)(1)(A).

The regulation, 42 CFR Section 413.30(f)(1), permits the Provider to request from HCFA an exception from its Routine Cost Limit because it provided atypical services. It is undisputed that for 15 years the Secretary interpreted the regulation as permitting a provider to recover its reasonable costs that exceeded the RCL if it demonstrated that it met the exception requirements. The Provider's exception request was processed in accordance with HCFA Transmittal No. 378, which was issued in July, 1994 and decreed that the atypical services exception of every hospital-based SNF must be measured from 112 % of the peer group mean for that hospital-based SNF rather than the SNF's Routine Cost Limit. This specific requirement was also published as Section 2534.5 of the Provider Reimbursement Manual (PRM).

In essence, for the purpose of determining atypical services exceptions for HB-SNFs, HCFA replaced the Routine Cost Limit with an entirely new and separate "cost limit" (112% of the peer group mean routine services cost). It is undisputed that 112% of the peer group mean of every hospital-based SNF is always significantly higher than the hospital's RCL. As a result, under section 2534.5 of the Provider Reimbursement Manual, a reimbursement "gap" is created between the RCL and 112% of the peer group mean which represents costs incurred by a hospital-based SNF which it is not allowed to recover.

HCFA has taken a conclusion regarding the intent of Congress toward reimbursing the routine costs of HB-SNFs which provide only typical services and illogically applied that same rationale to HB-SNFs which provide atypical services. This is contrary to what Congress intended when it implemented the exception process to address the additional costs associated solely with the provision of atypical services, and it clearly represents a substantive change in HCFA's prior

[37] Now the Centers for Medicare and Medicaid Services (CMS)

interpretation and application of 42 CFR § 413.30(f)(1) and PRM § 2534.5.

> 42 CFR Section 413.30(f)(1) states that
>
> "limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section…..an adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary." (emphasis added)

The only limit intended by Congress and imposed by the applicable statute and regulation is the Routine Cost Limit. To qualify for an atypical services exception a provider must show that the "actual cost of items or services furnished by the provider exceeds the applicable limit (Routine Cost Limit) because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified." (emphasis added) That Alameda Hospital was providing atypical services and, but for the methodology described, would have been entitled to an exception, was not contested by HCFA.

The controlling regulation specifically states that the provider must only show that its cost "exceeds the applicable limit;" not that its cost exceeds 112% of the peer group mean. The comparison to a peer group of "providers similarly classified," required by the regulation, is of the "nature and scope of the items and services actually furnished," not of their cost. Also, it must be noted that Congress itself established the four "peer groups" that are to be considered in determining Medicare reimbursement of skilled nursing facilities: free-standing urban, free-standing rural, hospital-based urban and hospital-based rural. HCFA had no statutory or regulatory authority to establish a new "peer group" for hospital-based SNFs (112% of the peer group mean routine service cost) and determine atypical services exceptions from an entirely new cost limit rather than from the Routine Cost Limit as intended by Congress.

In addition, the provisions of PRM § 2534.5 that require an exception for a HB-SNF to be measured from "112% of the peer group mean" rather than from the routine cost limit are invalid because they have not been adopted pursuant to notice and comment rulemaking as required by the Administrative Procedure Act.

In this case, HCFA's methodology is a departure from its earlier method of determining hospital-based SNF exception requests and requires an explanation for its change of direction. It is a "clear tenet of administrative law that if the agency wishes to depart from its consistent precedent it must provide a principled explanation for its change of direction." National Black Media Coalition v. FCC, 775 F.2d 342, 355 (D.C. Cir. 1985).

42 U.S.C. § 1395yy only set the formula for determining the cost limit; it did not change the method to be used to determine exceptions to the cost limit nor provide HCFA with any legal authorization

to adjust its pre-existing policies or regulations. Congressional imposition of a rate that is out of line with economic reality (in a case concerning the composite rate for end-stage renal disease services) "does not give HCFA the right to justify using out-of-line-with-reality component numbers to make exception determinations." University of Cincinnati, d/b/a University Hospital v. Shalala, No. C-1-93-841, (S.D. Ohio, Nov. 8, 1994), ¶42,976, at footnote 6, CCH Medicare and Medicaid Guide.

Because PRM § 2534.5 carves out a per se exception to the exception methodology contained in the applicable regulation and in the unwritten policy of HCFA for 15 years prior to adoption of this manual section, it "effect[ed] a change in existing law or policy" and is substantive in nature. Linoz v. Heckler, 800 F.2d 871,877 (9th Cir. 1986).

Even if PRM § 2534.5 should be considered an "interpretive" rule, it nevertheless constitutes a significant revision of the Secretary's definitive interpretation of 42 C.F.R. § 413.30 and is, therefore, invalid because it was not issued pursuant to notice and comment rulemaking. "Once an agency gives its regulation an interpretation, it can only change that interpretation as it would formally modify the regulation itself: through the process of notice and comment rulemaking." Paralyzed Veterans of America v. D.C. Area,117 F.3d 579, 586 (D.C. Cir. 1997).

In a District of Columbia Circuit Court decision, Alaska Professional Hunters Ass'n., Inc. v. Federal Aviation Admin., 177 F.3d.1030 (D.C. Cir. 1999), the Court held that even though a rule is "interpretive" and not "substantive," it must nevertheless be adopted through notice and comment rulemaking if it significantly revises the definitive interpretation by an agency of its regulation. Without question, that is precisely what HCFA did when it changed its methodology of determining atypical services exceptions for HB-SNFs after having consistently applied it in a much different manner for 15 years prior to making the change.

There is nothing in the statute or regulation that requires the gap methodology interpretation in issue here. Congress gave the Secretary broad authority to establish "by regulation" the methods to be used and items to be included in determining reimbursement. 42 USC §1395x(v)(1)(A). Had the gap methodology been subjected to the rulemaking process under the APA, 5 USC § 553, we do not contest that it would have been a legitimate exercise of that power. However, it was not, and, in addition to the arguments we have previously presented, we are further persuaded by the District Court's decision in St. Luke's Methodist Hospital v. Thompson, 182 F. Supp. 2d 765 (N.D. Iowa, 2001), that PRM §2534.5 does not reasonably interpret 42 CFR § 413.30. Id at 784.

The St. Luke's Court recognized that its holding was contrary to that of the Sixth Circuit in St. Francis Health Care Centre v. Shalala, 205 F.3d 937 (6th Cir. 2000). It explained that, shortly after the St. Francis Court issued its opinion applying the deference standard established by the Supreme Court in Chevron v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), the Supreme Court issued its decision in Christensen v. Harris County, 529 U.S. 576 (2000). The Christensen Court held that a lower level of deference is to be accorded to an agency interpretation where the interpretation is not contained in the statute or regulation itself but rather is articulated through less

formal means such as "policy statements, agency manuals, and enforcement guidelines."

Christensen at 777.[38] The St. Luke's Court concluded that the Christensen standard was applicable to the issue. It cited the gap methodology as an "abrupt and significant alteration of a longstanding, consistently followed policy…developed years after the regulation it interprets and the statute it purports to incorporate" as a "weighty" factor in the deference analysis under Christensen. Id. at 780.

The sole issue on summary judgment in the St. Luke's case was "whether HCFA's methodology of determining the amount of an atypical service exception under HCFA Transmittal Number 378, as found in PRM section 2534.5, is arbitrary and capricious or not in accordance with law." The court noted that when the issue is whether the agency has erred in interpreting its own regulations, the plain meaning of a statute or regulation, if there is one, controls, regardless of an agency's interpretation. Id. at 775. The St. Luke's Court found "PRM § 2534.5 invalid as an unreasonable interpretation of 42 CFR 413.30 in light of the language of that regulation and the principles underlying the Medicare statute." The Court reasoned that PRM § 2534.5 created an irrebuttable exclusion of gap costs that, if permitted to stand, would allow the Secretary to "substantively rewrite the regulation to impose an additional hurdle for exceptions eligibility not clearly contemplated by the language of the regulation or subsequently enacted statutes."39 Id. The Court also found that application of the gap methodology would result in non-Medicare payors subsidizing the care of Medicare patients in violation of 42 USC §1395x(v)(1)(A). Id. at 787. Clearly, that cannot be disputed.

The St. Luke's Court further concluded that "[t]here is no explicit language in either 42 C.F.R. § 413.30 or 42 U.S.C. § 1395yy which mandates the Secretary's interpretation. The regulation refers only to discretionary adjustments to the 'applicable limit,' and the statute is silent as to its effect on the pre-existing exceptions process." Id. at 781.

The St. Luke's Court goes on to state that "[t]he Court does not agree that 42 U.S.C. § 1395yy, read in conjunction with 42 C.F.R. § 413.30 reasonably results in the interpretation promulgated by the Secretary in PRM § 2534.5. There is no inherent conflict between the Secretary's original, longstanding interpretation of 42 C.F.R. § 413.30 and Congress' subsequent imposition of a two-tiered RCL measure through 42 U.S.C. § 1395yy. Absent persuasive evidence to the contrary, there is no reason to believe that Congress, in enacting 42 U.S.C. § 1395yy, meant to override the distinction between typical and atypical service reimbursement eligibility explicitly recognized in 42 C.F.R. § 413.30." Id. at 787.

The Court also determined that, "PRM § 2534 represents an abrupt and significant alteration of a longstanding, consistently followed policy and was developed years after the regulation it interprets and the statute it purports to incorporate. The Secretary has failed to persuade this Court that despite

its incongruous and inconsistent procedural history, the interpretation is the product of 'thorough and

[38] St. Luke's Methodist Hospital v. Thompson, supra at 787, fn 19.

[39] The Secretary argued that his rationale for the "gap methodology" was based on legislative changes to the statute in 1984 in which 112% of the mean was used to calculate new Routine Cost Limits. There were no changes to the statute or regulations concerning the exemption process, however.

reasoned consideration.' " Id. at 781.

The findings and decision of the St. Luke's Court are equally applicable to the present case and support the dissenters' contention that the denial of Alameda Hospital's request for an atypical services exception should be reversed.

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