PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2009-D37

PROVIDER -
Canonsburg General Hospital
Skilled Nursing Facility

Provider No.: 39-0160/39-5580

vs.

INTERMEDIARY -
Blue Cross of Western Pennsylvania/
Highmark Medicare Services (d/b/a
Veritus Medicare Services)

DATE OF HEARING -
April 15, 2009

Cost Reporting Period Ended –
June 30, 1996

CASE NO.: 98-3491

INDEX

ISSUE:

Whether the Centers for Medicare and Medicaid Services' methodology for determining the Provider's exception to the hospital-based skilled nursing facility (HB-SNF) routine cost limit was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due providers under Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R §405.l803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.l835.

Section 1819(a) of the Social Security Act (Act) defines a SNF as an institution engaged in providing skilled nursing and related services for residents who require medical and nursing care or rehabilitative services for injured, disabled or sick persons. Section 1861(v)(1)(A) of the Act establishes the method of cost reimbursement for SNFs as well as limitations on reimbursable costs. These limitations are called routine cost limits (RCL) and are addressed in §§1861(v)(7)(D) and l888(a) of the Act. 42 C.F.R. §413.30 implements the cost reimbursement limits for SNFs and also provides an exception to the limits for providers for "Atypical Services." 42 C.F.R. §413.30(f), states, in part:

> *Exceptions*. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) of this section. An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.
>
> (1) *Atypical services*. The provider can show that the---
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> (i) Actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature

and scope, compared to the items or services generally furnished by providers similarly classified; and

(ii) 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 intent of Congress in providing an exception to the cost limits was to ensure that providers would be reimbursed their reasonable 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 U.S.C. §1395yy(c); 42 U.S.C. § 1395x(v)(1)(A).

The issue in dispute in this appeal is whether the Intermediary improperly limited the exception amount to which the Provider was entitled under 42 C.F.R. §413.30(f) of the Medicare regulations.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Provider and Intermediary have stipulated to the following pertinent facts:

- For the entirety of FY 1996, Canonsburg operated an urban hospital-based SNF, which was to be reimbursed on a reasonable cost basis, subject to the routine cost limits promulgated by CMS.[1]

- As a new provider, Canonsburg's SNF received an exemption from the RCLs for the fiscal years ending June 30, 1984, 1985 and 1986.

- For every fiscal year thereafter, through and including FY 1996, Canonsburg's costs exceeded the SNF-RCLs. Accordingly, Canonsburg has sought SNF-RCL exception relief for every fiscal year from FY 1987 through FY 1996, the fiscal year at issue here.

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

- In addition, throughout FY 1996, Canonsburg's more acutely ill Medicare SNF patient population required more registered nurses than were then reflected in the RCL; the competitive nature of hiring and retaining skilled nurses in the Pittsburgh, Pennsylvania standard metropolitan statistical area generated atypical nursing labor costs, and Canonsburg's atypical nursing hours led to atypical indirect costs that exceeded the indirect costs reflected in the RCLs.

[1] *See* 42 U.S.C. § 1395x(v)(1)(A), 1395yy and 42 C.F.R. § 413.30.

- Although Canonsburg timely filed its FY 1996 cost report, noting its self-disallowance, under protest, of $470,528, that being the amount of its reasonable and necessary atypical costs which exceeded its Reasonable Cost Limits but were less than 112% of the of the mean *per diem* routine service costs for its peer group of hospital-based SNFs (hereinafter the so-called "Gap Costs"), the Intermediary (by desk review) disallowed all such Gap Costs per its FY 1996 NPR issued on May 4, 1998.[2]

- In addition to disallowing Canonsburg's Gap Costs, the Intermediary also disallowed $46,765 worth of the amount of Canonsburg's reasonable and necessary atypical costs which were above 112% of the of the mean *per diem* routine service costs for its peer group of hospital-based SNFs, by off-setting them against three categories of the SNF's indirect costs (*i.e.*, laundry, dietary and nursing administration) which the Intermediary calculated as falling below 112% of the of the mean *per diem* routine service costs for its peer group of hospital-based SNFs.[3]

- In total, of the $529,943 disallowed by the Intermediary, Canonsburg has appealed $526,293 worth of Canonsburg's reasonable and necessary atypical costs.[4]

- The Intermediary's denial of $526,293 worth of reasonable and necessary atypical costs was based (directly for the amount of $470,528, and indirectly for the amount of $46,765) solely on CMS's then PRM § 2534.5, which directs intermediaries to approve routine cost limit exceptions for the atypical costs of hospital-based SNFs only for those amounts exceeding 112 percent of the mean *per diem* routine service costs for hospital-based SNFs.

Pursuant to 42 C.F.R. §§405.l835-405.1841 the Provider timely appealed the methodology used by the Intermediary to determine the amount of its cost limit exception and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $526,293.[5]

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

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

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

[5] Stipulation as to Facts.

The Provider was represented by Stephen M. Nash, Esq. and Sven C. Collins, Esq. of Holme Roberts & Owen, LLP. The Intermediary was represented by Bernard M Talbert, Esq., Senior Medicare Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider claims that by refusing to grant an exception for the portion of its SNF's atypical per diem costs which do not exceed 112 percent of the total peer group mean cost, CMS has created a reimbursement "gap" that is arbitrary, capricious, not in accordance with Medicare law, and denies reimbursement of costs that qualify for an exception for atypical services.

In addition, the Provider contends that the "gap" methodology set forth in CMS Pub. 15-1 §2534.5 directly contradicts the regulation controlling atypical service exceptions. The Provider believes that CMS should be given no deference in interpreting this regulation because it has not applied its interpretation consistently over time, and its interpretation is not the result of thorough and reasoned consideration. The "gap" methodology in CMS Pub. 15-1 §2534.5 is also inconsistent with the statute prohibiting cross-subsidization between Medicare and other payors.

The Provider also believes that 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 (APA).

Additionally, the Provider contends that the language of 42 C.F.R. §413.30(f)(1) could not have been intended to support the reimbursement "gap" of CMS Pub. 15- 1 §2534.5 because the original interpretation of the regulation that measured exceptions from the cost limits had been consistently maintained by CMS for fifteen years prior to the issuance of CMS Pub. 15-1 §2534. CMS' current interpretation of the regulation was not developed contemporaneously with the regulation's original promulgation and is inconsistent with CMS' earlier interpretations; therefore, it is due no deference. The Provider cites St. Luke's Methodist Hospital v. Thompson, 182 F. Supp. 2d 765 (N. D. Iowa 2001), aff'd. Eighth Circuit (St. Luke's), finding HCFA Pub. 15-1 §2534.5 "invalid as an unreasonable interpretation of 42 C.F.R. §413.30 in light of the language of that regulation and the principles underlying the Medicare statute," Mercy Medical Skilled Nursing Facility v. Thompson, C.A. 99-2765 (D.D.C. May 14, 2004) striking down CMS' approach of limiting exception relief to costs in excess of 112 percent of the peer group mean; and Montefiore Medical Center v. Leavitt, 578 F. Supp. 2d 129 (D.D.C. 2008) also striking down CMS' approach of limiting exception relief to costs in excess of 112 percent of the peer group mean.

Finally, the Provider contends that CMS Pub. 15- 1 §2534.5 is invalid because it arbitrarily and capriciously discriminates in favor of freestanding SNFs and against hospital-based SNFs.

The Intermediary contends that the Provider's cost limit exception request was properly calculated in accordance with CMS Pub. 15-1 §2534.5 which prescribes the methodology for making that calculation. The Intermediary relies upon the Administrator's decision in Montefiore Medical Center v. Blue cross Blue Shield Association/Empire Medicare Services, PRRB Dec. No. 2006-D29, June 5, 2006, rev'd., CMS Administrator, July 26, 2006, finding that

CMS Pub. 15-1 §2534.5 is consistent with the plain meaning of the pertinent statute and regulations.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds that the methodology applied by CMS in partially denying the Provider's exception request for per diem costs that exceeded the cost limit was not consistent with the statute and regulation relating to this issue.[6]

The regulation, 42 C.F.R. §413.30(f)(1), permits the Provider to request from CMS an exception from the cost limits because it provided atypical services. It is undisputed that for 15 years the Secretary interpreted the regulation as permitting a provider to recover all reasonable costs that exceeded the limits 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 percent of the peer group mean for that hospital-based SNF rather than the SNF's limit. This specific requirement was also established as CMS Pub. 15-1 §2534.5.

In essence, CMS replaced the limit with an entirely new and separate "cost limit" (112 percent of the peer group mean routine services cost). It is also undisputed that 112 percent of the peer group mean of hospital-based SNFs is significantly higher than the hospital's cost limit. As a result, under CMS Pub. 15-1 §2534.5, a reimbursement "gap" is created between the limit and 112 percent of the peer group mean that represents costs incurred by a hospital-based SNF which it is not allowed to recover.

CMS reached a conclusion regarding the intent of Congress toward reimbursing the routine costs of hospital-based SNFs which provide only typical services and illogically applied that same rationale to hospital-based SNFs that 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 CMS' prior interpretation and application of 42 C.F.R. §413.30(f), which states:

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[6] This decision is also consistent with the Board's decisions in Quality 89-92 Hospital Based SNF v. BlueCross BlueShield Association/ National Government Services LLC-CA, PRRB Dec. No. 2009-D8, January 26, 2009, rev'd, CMS Administrator, March 10, 2009; Memorial Health Care v. Blue Cross Blue Shield Association/National Government Services LLC-WI, PRRB Dec. No. 2007-D66, August 30, 2007, rev'd, CMS Administrator, October 29, 2007; Hi-Desert Medical Center v. United Government Services/Blue Cross Blue Shield Association, PRRB Dec. No. 2007-D 17, February 2, 2007, rev'd., CMS Administrator, April 2, 2007; Montefiore Medical Center v. BlueCross BlueShield Association/National Gov't Services, PRRB Dec. No. 2007-D61, August 14, 2007, rev'd, CMS Administrator, (July 21, 2006) Glenwood Regional Medical Center v. Mutual of Omaha Insurance Company, PRRB Dec. No. 2004-D23, January 7, 2004, rev'd, CMS Administrator, August 9, 2004, and Montefiore Medical Center v. Blue cross Blue Shield Association/Empire Medicare Services, PRRB Dec. No. 2006-D29, June 5, 2006, rev' d, CMS Administrator, July 26, 2006.

> Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) of this section. An adjustment is made only to the extent the costs are reasonable, attributable to circumstances specified, separately identified by the provider, and verified by the intermediary.

The only reimbursement limit intended by Congress and imposed by the plain language of the applicable statute and regulation is the cost limit. To qualify for an atypical services exception a provider must show that the actual cost of items and services furnished by a provider *exceeds the applicable limit because such items are atypical* in nature and scope, compared to the items or services generally furnished by providers similarly classified.

The controlling regulation specifically states that a provider must show only that its cost "exceeds the applicable limit," not that its cost exceeds 112 percent 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" (emphasis added), 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. CMS has no statutory or regulatory authority to establish a *new* "peer group" for hospital-based SNFs (112 percent of the peer group mean routine service cost) and determine atypical service exceptions from an entirely *new* cost limit rather than from the limit intended by Congress.

The Board finds CMS' methodology a departure from its earlier method of determining the amount for 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 CMS with any legal authorization to adjust its pre-existing policies or regulations. Because CMS Pub. 15-1 §2534.5 defines an exception methodology contrary to that contained in the applicable regulation and in the unwritten policy of CMS for 15 years prior to adoption of this manual section, it "effected a change in existing law or policy" that is substantive in nature. Linoz v. Heckler, 800 F.2d 871, 877 (9th Cir. 1986).

Even if CMS Pub. 15-1 §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 invalid because it was not issued pursuant to notice and comment rulemaking as required by the Administrative Procedure Act (APA). "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 rulemaking." Paralyzed Veterans of America v. D.C. Arena L.P., 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, 1034 (D.C. Cir. 1999), the Court held: "[w]hen an agency has given its regulation a definitive interpretation, and later significantly revises that

interpretation, the agency has in effect amended its rule, something it may not accomplish without notice and comment." Without question, that is precisely what CMS did when it changed its methodology of determining atypical services exceptions for hospital-based 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 at 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 U.S.C. §1395 x(v)(l)(A). Had the "gap" methodology been subjected to the rulemaking process under the APA, 5 U.S.C. §553, it would have been a legitimate exercise of that power.[7] The Board's decision is supported by the decision in St. Luke's supra, which found that CMS Pub. 15-1 §2534.5 does not reasonably interpret 42 C.F.R. §413.30.

The District Court in St. Luke's found CMS Pub. 15-1 §2534.5 "invalid as an unreasonable interpretation of 42 C.F.R. §413.30 in light of the language of that regulation and the principles underlying the Medicare statute." The Court reasoned that CMS Pub. 15-1 §2534.5 created an irrefutable 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 42 C.F.R. §413.30(f) or subsequently enacted statutes." 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 U.S.C. §1395x(v)(1)(A).

The St. Luke's Court stated 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 [HCFA] Pub. 15-1 §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 [reasonable cost limit] 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.

St. Luke's, at 787.

The Court also determined that CMS Pub. 15-1 §2534.5 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

[7] The Board also notes the consistent finding in the district court's decision in Montefiore, supra, which found that "[CMS] has reimbursed atypical costs in their entirety for the past 15 years … [t]hus, PRM §2534.5 represents a substantial departure from this interpretation and was subject to the notice and comment rulemaking requirements of the APA."

> persuade this Court that despite its incongruous and inconsistent procedural history, the interpretation is the product of "thorough and reasoned consideration."

St. Luke's, at 781.

The findings and decision of the St. Luke's Court are equally applicable to the present case and support the Board's conclusion that the partial denial of the Provider's request for an exception to the SNF routine cost limit should be revised to permit the Provider to recover its costs.

DECISION AND ORDER:

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

Board Members Participating:

Suzanne Cochran, Esq.
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: August 20, 2009