PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2010-D35

PROVIDERS –
Toyon 85-98 112% Hospital-Based Peer Group Mean; Catholic Healthcare West 96-98 112% Hospital-Based Peer Group Mean; Sutter Health 91-99 112% Hospital-Based Peer Group Mean; St. Joseph Health System 92-98 112% Hospital-Based Peer Group Mean; Toyon 1999 112% Hospital-Based Peer Group Mean; Toyon 2000 112% Hospital-Based Peer Group Mean; and Toyon 2001 112% Hospital-Based Peer Group Mean

Provider Nos.: See Appendices I-VII

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
First Coast Service Options, Inc.

DATE OF HEARING –
March 17, 2010

Cost Reporting Periods Ended –
See Appendices I -VII

CASE NOs.: 98-0850G, 09-1633GC, 09-1634GC, 09-1635GC, 07-2034G, 07-2032G, and 07-2033G

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ISSUE:

Whether the Centers for Medicare and Medicaid Services' methodology for determining the exception from the routine cost limits (RCL) for hospital-based skilled nursing facilities (HB-SNF) was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs 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. §405.1803. 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. §405.1835.

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.
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> (1) *Atypical services*. The 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, 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 amounts to which the Providers were entitled under 42 C.F.R. §413.30(f) of the Medicare regulations.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This appeal is the consolidation of seven (7) cases before the PRRB and the Providers in these cases are twenty (20) acute care hospitals with HB-SNFs. The Providers collectively have disputed 74 cost reporting periods spanning from fiscal year 1985 through 2001.[1]

Pursuant to 42 C.F.R. §§405.l835-405.1841 the Providers timely appealed the methodology used by the Intermediary to determine the amount of their HB-SNF cost limit exceptions and met the jurisdictional requirements of those regulations.

The Providers were represented by Frank P. Fedor, Esq. of Murphy Austin Adams Schoenfeld, LLP, and Thomas P. Knight of Toyon Associates, Inc. The Intermediary was represented by Bernard M Talbert, Esq., Senior Medicare Counsel, of the BlueCross BlueShield Association.

STIPULATION OF FACTS:

The Providers and Intermediary stipulated to the following pertinent facts:[2]

- The HB-SNF Providers each operated a hospital-based skilled nursing facility during each of the years at issue, each were reimbursed based upon the reasonable costs it incurred to provide health care services to Medicare beneficiaries as provided by 42 U.S.C. § 1395x(v), each were subject to the cost limits placed upon SNF costs as provided by 42 U.S.C. § 1395yy, and

[1] *See* Appendices I-VII.

[2] *See* Stipulations dated August 28, 2009 for Case Nos. 98-0850G, 09-1633GC, 09-1637GC and 09-1635GC.

each requested that it be granted an exception to the cost limits in accordance with 42 C.F.R. § 413.30(f).[3] In addition, each met the requirements of 42 C.F.R § 413.30(f), and any successor regulation, for the granting of payment of an exception amount for atypical services, namely that the actual cost of services furnished by each of the HB-SNF Providers exceeds the applicable cost limit because the services were atypical in nature and scope, compared to the services generally furnished by other HB-SNFs similarly classified, and that the atypical services were furnished because of the special needs of the patients treated and were necessary in the efficient delivery of needed healthcare.

- The only issue in dispute is the enforceability of the rule stated in HCFA Transmittal No. 378 dated July 1994, at CMS Pub. 15-1 § 2534.5(B) Uniform National Peer Group Comparison, that "[f]or each hospital-based group with cost reporting period beginning on or after July 1, 1984, the ratio is applied to 112 percent of the group's mean per diem cost (not the cost limit)." (Emphasis in the original). Stated differently, the HB-SNF Providers maintain that the amount of their per diem atypical services exception payment should be measured from the routine cost limit instead of 112 percent of the peer group mean, and the Fiscal Intermediary maintains the opposite.

- Under HCFA Transmittal No. 378, this rule was made effective for an exception request submitted to intermediaries on or after July 20, 1994. For exception requests for an atypical services exception made by the HB-SNF Providers before the effective date of HCFA Transmittal No. 378, the amount of the exception payment was calculated from the HB-SNF Providers' routine cost limit, and not from 112 percent of the peer group mean.

The parties also stipulated to the following facts specific to the "transition period" from cost-based to prospective payment reimbursement for SNFs:[4]

- As described in 42 C.F.R. § 413.340, beginning with a SNF's first cost reporting period on or after July 1, 1998, there is a transition period covering three cost reporting periods during which the SNF is paid based on a blend of the facility-specific rate and the Federal adjusted rate.

- In the first transition year the payment is based on 75 percent of the facility-specific rate and 25 percent of the Federal rate.

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[3] 42 C.F.R 413.30(f) was renumbered 413.30(e) effective September 7, 1999, in Fed. Reg. 42610 (August 5, 1999).

[4] See Stipulations dated August 28, 2009 for Case Nos. 07-2034G, 07-2032G, and 07-2033G.

- In the second transition year the payment is based on 50 percent of the facility-specific rate and 50 percent of the Federal rate.

- In the third and final transition year the payment is based on 25 percent of the facility-specific rate and 75 percent of the Federal rate.

- The Fiscal Intermediary has calculated the additional exception amounts that would be awarded if the HB-SNF Providers prevail. The additional exception amounts are reflected in Column E of the Schedules of Providers.[5]

PROVIDERS' CONTENTIONS:

The Providers claim 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.

The Providers claim that CMS Pub. 15-1 § 2534.5 and the "gap" methodology are invalid because they were not adopted pursuant to the notice and comment rulemaking provisions of the Administrative Procedure Act (APA). The Providers argue that the manual provision changed a binding interpretation of a "legislative" rule and changed long-established practices under the controlling statutes and regulation 42 C.F.R. 413.30(f), which did not include any such "gap."

The Providers also argue that CMS Pub. 15-1 §2534.5 is substantively invalid because the statutory directive in 42 U.S.C. §1395yy(a) to reduce the RCL by the amount of the "gap" cannot be read directly into the regulation providing an exception to the cost limit for atypical services, when the same statute preserved the right to pursue an exception or adjustment to the new, lowered limits due to higher intensity of care. The "gap" methodology in CMS Pub. 15-1 §2534.5 is also inconsistent with the statute prohibiting cross-subsidization between Medicare and other payors.

In addition, the Providers believe that the "gap" is only entitled to deference to the extent of its power to persuade. The original interpretation of the regulation that measured exceptions from the cost limits had been consistently maintained by CMS for over ten 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, is inconsistent with prior longstanding interpretation and regulatory notice, and is not supported by the statutory and regulatory provisions; therefore, it is due no deference.

The Providers cite St. Luke's Methodist Hospital v. Thompson, 182 F. Supp. 2d 765 (N. D. Iowa 2001), aff'd. Eighth Circuit (St. Luke's), finding CMS Pub. 15-1 §2534.5

[5] *See* Appendices I-VII.

"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."

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Providers' cost limit exception requests were properly calculated in accordance with CMS instructions at CMS Pub. 15-1 §2534.5, which prescribes the methodology for making that calculation. The Intermediary relies upon the Administrator's decision in St. Francis Health Care Center v. Community Mutual Insurance Company, PRRB Dec. No. 97-D38, March 24, 1997, rev'd., CMS Administrator, May 30, 1997, finding that the methodology in CMS Pub. 15-1 §2534.5 is consistent with the Medicare policy set forth in 42 C.F.R. § 413.30(f)(1). The Intermediary argues that the policy interpretation requiring HB-SNF costs to be compared to 112 percent of the group's mean per diem costs is an appropriate method of applying the reasonable cost requirement and is not inequitable.

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 Providers' exception requests 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 Providers 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 Providers' exception requests were processed in accordance with HCFA Transmittal No. 378, which was issued in July 1994, and decreed that the atypical

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[6] This decision is also consistent with the Board's decisions in Canonsburg General Hospital SNF v. Blue Cross Blue Shield Association/Veritus Medicare Services, PRRB Dec. No. 2009-D37, August 20, 2009, rev'd, CMS Administrator, October 14, 2009; Quality 89-92 Hospital Based SNF v. Blue Cross Blue Shield 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; Montefiore Medical Center v. Blue Cross Blue Shield Association/National Government Services-NY, PRRB Dec. No. 2007-D61, August 14, 2007, rev'd, CMS Administrator, October 12, 2007; Hi-Desert Medical Center v. Blue Cross Blue Shield Association/United Government Services LLC, PRRB Dec. No. 2007-D17, February 2, 2007, rev'd, CMS Administrator, April 2, 2007; 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; and Glenwood Regional Medical Center v. Mutual of Omaha Insurance Company, PRRB Dec. No. 2004-D23, June 7, 2004, rev'd, CMS Administrator, August 9, 2004.

services exception of every HB-SNF must be measured from 112 percent of the peer group mean for that HB-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 HB-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 HB-SNF that it is not allowed to recover.

CMS reached 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 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).

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 HB-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 HB-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 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 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:

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[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."

> [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 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 denial of the Providers' requests for exceptions to the SNF routine cost limit should be revised to permit the Providers to recover their costs.

DECISION AND ORDER:

CMS' methodology for determining the amount of the Providers' exceptions to the HB-SNF routine cost limit was improper. The Providers are entitled to be reimbursed for all of those costs above the cost limit as opposed to being reimbursed only for their costs that exceeded 112 percent of the peer group's mean per diem cost.

Board Members Participating:

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

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: June 10, 2010