PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2016-D13

PROVIDER –
Mercy General Hospital

Provider No.: 05-0017

vs.

MEDICARE CONTRACTOR –
Cahaba Safeguard Administrators, LLC

DATE OF RECORD HEARING -
February 9, 2015

Cost Reporting Period Ended –
March 31, 1995

CASE NO.: 07-0631

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the amount of the Provider's exception to the routine cost limits ("RCL") for hospital-based skilled nursing facilities ("HB-SNF") by excluding from that calculation those costs that were above the RCL but below 112 percent of the peer group mean cost?[1]

DECISION

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds that Medicare Contactor improperly calculated the amount of the exception to the HB-SNF RCL for Mercy General Hospital ("Mercy General" or "Provider") for its fiscal year ending March 31, 1995 ("FY 1995"). Mercy General is entitled to be reimbursed for all of its costs above the cost limit, rather than only for those costs that exceeded 112 percent of the peer group mean per diem cost.

INTRODUCTION

Mercy General operates a hospital located in Sacramento, California. Within the hospital, Mercy General operates a 111-bed skilled nursing facility ("SNF"). The Medicare contractor[2] assigned to Mercy General during the time at issue was United Government Services, LLC and currently is First Coast Options, Inc. (collectively referred to as the "Medicare Contractor").

For FY 1995, Mercy General applied for an atypical services exception from its HB-SNF RCL. The Medicare Contractor reviewed the FY 1995 exception request and agreed that: (1) Mercy General provided atypical services; (2) its reasonable costs exceeded the HB-SNF RCL; and (3) Mercy General is entitled to an additional payment. However, the Medicare Contractor limited the additional payment for FY 1995 to Mercy General's costs that exceeded 112 percent of the peer group mean per diem cost. In this appeal, Mercy General disagrees with the method for calculating the additional payment and maintains that the additional payment should be the amount that its FY 1995 reasonable costs exceeded the HB-SNF RCL.[3]

STATEMENT OF THE FACTS

During FY 1995, the Medicare program paid Mercy General's SNF based on the reasonable cost it incurred to provide skilled nursing care services to Medicare beneficiaries. 42 U.S.C. § 1395x(v)(1)(A) establishes the method of cost reimbursement for SNFs as well as limitations on reimbursable costs. One of these limitations is the limit on routine service costs which is known as the RCL and is addressed at 42 U.S.C. §§ 1395x(v)(7)(D) and 1395yy(a). Further, § 1395yy(a) sets the formula for calculating the HB-SNF RCL at issue[4] and § 1395yy(c)

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[1] *See* Stipulation of Facts ¶¶ 5, 7, 8 (Apr. 9, 2014).

[2] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to as Medicare contractors.

[3] *See* Stipulation of Facts at ¶¶ 4-8.

[4] Per 42 U.S.C. § 1395yy(a)(3) the RCH for HB-SNFs located in urban areas is equal to the sum of the limit for freestanding urban SNFs plus 50 percent of the amount by which 112 percent of the mean per diem routing service

specifies that the Secretary has the discretion to establish exceptions to RCLs applicable to SNFs.

Consistent with this discretionary authority, the Secretary promulgated regulations 42 C.F.R. § 413.30 to establish a process for setting RCLs for providers such as SNFs and to create a process under which providers could request exceptions to those limits. The exception process is delineated at § 413.30(f) (1995) and includes an exception for atypical services.

Mercy General timely requested that the Medicare Contractor grant it an exception to the HB-SNF RCL for FY 1995 due to atypical services. The Medicare Contractor granted the exception request and calculated an amount of the exception to the HB-SNF RCL for FY 1995. Consistent with 42 C.F.R. §§ 405.l835-405.1841 (2007), Mercy General timely appealed the methodology used by the Medicare Contractor to determine the amount of its HB-SNF RCL exception for FY 1995 and met the applicable jurisdictional requirements for that appeal.[5]

The Provider Reimbursement Review Board ("Board") held a hearing on the record. Mercy General was represented by Frank P. Fedor, Esq. of Murphy Austin Adams & Schoenfeld LLP. The Medicare Contractor was represented by Brendan G. Stuhan, Esq. of the Blue Cross and Blue Shield Association.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor contends that Mercy General should not be reimbursed for all of its costs in excess of the HB-SNF RCL because that would result in Mercy General being reimbursed for costs that were "unnecessary in the efficient delivery of needed health services."[6] Specifically, the Medicare Contractor contends that it properly excluded unreasonable costs for which Mercy General is not entitled when it denied Mercy General's reimbursement of costs that were above the HB-SNF RCL but below the 112 percent of the peer group mean per diem.[7]

The Medicare Contractor explains that Program Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2534.5, authorizes the use of the 112 percent threshold for calculating payment and that this Manual provision is a reasonable interpretation of 42 C.F.R. § 413.30 (1995). The Medicare Contractor maintains that the regulation does not require the Secretary to grant an exception to any given provider and does not describe the appropriate amount payment for an exception. Rather, it describes the general conditions under which an exception may be granted. The Medicare Contractor concludes that PRM § 2534.5 is a reasonable approach to implementing the policies underlying Congress' decision to lower the cost limit for HB-SNFs.[8]

The Board notes that 42 C.F.R. § 413.30(f) (1995) permits HB-SNFs to request an exception from the HB-SNF RCL if they provided atypical services. Pursuant to 42 U.S.C. § 1395yy(c)

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costs for urban HB-SNFs exceeds the limit for freestanding urban SNFs. Thus, the HB-SNF RCL will always be below 112 percent of the peer group mean per diem costs.

[5] *See* Provider Exhibit P-22 (providing full explanation of the Medicare Contractor's calculation of the exception payment).

[6] 42 U.S.C. § 1395x(v)(1)(A).

[7] *See* Medicare Contractor's Supplemental Final Position Paper at 10.

[8] *See id.* at 13-14.

and 42 C.F.R. § 413.30(b)(3), the Secretary annually *publishes* in the Federal Register the RCL applicable to providers, such as the HB-SNF RCL at issue in this case. The record demonstrates that, for at least ten years prior to 1994, CMS (then known under its former name, the Health Care Financing Administration) interpreted § 413.30(f) to allow payment of all reasonable costs up to and exceeding the HB-SNF RCL to any HB-SNF who qualified for an exception to the HB-RCL for atypical services.[9]

In July 1994, CMS issued PRM 15-1 Transmittal No. 378, incorporating § 2534.5 into the PRM.[10] This policy substantively changed the method of calculating the amount of an atypical services exception for HB-SNFs from simply payment of the reasonable costs that exceed the RCL published in Federal Register to payment of those costs that exceed 112 percent of the SNF peer group mean. This new method created a cost "gap" between the HB-SNF RCL and 112 percent above the SNF peer group mean and precluded HB-SNFs from recovering the full amount of their reasonable cost of providing atypical services during the relevant fiscal year. In essence, CMS replaced the original cost limit (*i.e.*, HB-SNF RCL) with an entirely new and higher "cost limit" (*i.e.*, 112 percent of the peer group mean routine services cost).

Notwithstanding the great weight that 42 C.F.R. § 405.1867 requires the Board to afford to PRM 15-1 § 2534.5, the Board finds that § 2534.5 is inconsistent with the relevant statutory and regulatory provisions and that the Manual provision is arbitrary and capricious. The controlling regulation specifies that "*[l]imits* established under this section [*i.e.*, the published RCLs] *may be adjusted upward* for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section."[11] To qualify for an exception for atypical services and, thereby, receive this upward adjustment of the RCL, § 413.30(f)(1) specifies that a provider must show *only* that its cost "exceeds the applicable limit [*i.e.*, the published RCL]," *not* that its cost exceeds 112 percent of the peer group mean.

When CMS promulgated § 413.30(f) in the final rule issued on June 1, 1979, CMS provided the following guidance in the preamble to explain how it would calculate the amount for an exception to the RCL: "If a provider receives an exception, it ***is*** *reimbursed* on the basis of the cost limit [*i.e.*, the published RCL], *plus an incremental sum* for the reasonable costs warranted by the circumstances that justified its exception."[12] Thus, the "incremental sum" is reflected by the upward adjustment of the published RCL. Consistent with this preamble discussion and § 413.30(f), the record demonstrates that CMS itself established the amount for an approved exception to an RCL for atypical services as the reasonable cost of atypical services that exceed

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[9] *See, e.g.*, Provider Exhibit P-14 at 24-25, 27-29, 129-130, 133-35, 159, 176-180, (testimony of CMS employee who processed SNF exception requests); Provider Exhibit P-21 at 7 (testimony of consultant who supervised over 600 atypical exception requests of which over 150 were approved prior to July 1994). *See also St. Luke's Methodist Hosp. v. Thompson*, 315 F.3d 984, 986-987 (8th Cir. 2003); *Montefiore Med. Ctr. v. Leavitt*, 578 F. Supp. 2d 129, 131, 133 (D.D.C. 2008); *Mercy Med. Skilled Nursing Facility v. Thompson*, Cas No. C.A.99-2765, 2004 WL 3541332, at *1, *3.

[10] *See* Provider Exhibit P-12 (copy of Transmittal No. 378).

[11] (Emphasis added.)

[12] 44 Fed. Reg. 31802 (June 1, 1979) (emphasis added) (promulgating 42 C.F.R. § 405.460 and discussing the difference between an exemption in § 405.460(e) and an exception in § 405.460(f)) (excerpts included at Provider Exhibit P-2). This final rule promulgated 42 C.F.R. § 405.460 which was later redesignated as 42 C.F.R § 413.30 effective October 1, 1986. 51 Fed. Reg. 34790 (Sept. 30, 1986).

that RCL (rather than only those costs that exceed 112 percent of the peer group mean) and that CMS applied this policy until 1994.[13]

In July 1994, CMS changed its exception policy through its issuance of Transmittal 374 promulgating PRM 15-1 § 2534.5. Pursuant to § 2534.5, when a HB-SNF's costs exceed the RCL and such excess costs are found to be reasonable under the exception review process, the HB-SNF will receive an additional payment *only* for that fraction (if any) of the excess costs that surpass another specified threshold – 112 percent of the mean per diem costs for a peer group of similarly classified providers. The Board finds that PRM 15-1 § 2534.5 does not comply with the regulation because the Manual provision does not adjust the RCL upward, *i.e.*, add "an incremental sum" onto the RCL.

Further, the Board notes that Congress itself specified in 42 U.S.C. § 1395yy(a) the formula to calculate the RCL for the four distinct and separate "peer groups" that are to be considered in determining different Medicare reimbursement for SNFs: free-standing urban, free-standing rural, hospital-based urban, and hospital-based rural. Based on this statutory framework, the Board finds that 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.[14]

The Board finds that PRM 15-1 § 2534.5 is procedurally invalid based on a lack of notice and comment as mandated by § 553 of the Administrative Procedure Act ("APA")[15] for changes to substantive rules that effect change in existing law or policy. As previously discussed, CMS' revised methodology was a marked departure from its earlier method of determining the amount for HB-SNF exception requests and hence the revised methodology requires an explanation. "[I]t 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."[16] 42 U.S.C. § 1395yy only set the formula for determining the cost limits for the four different types of skilled nursing facilities; it did not change the method to be used to determine exceptions to these cost limits nor provide CMS with any legal authorization to adjust its pre-existing policies or regulations. Because PRM 15-1 § 2534.5 defines an exception methodology contrary to that contained in the applicable regulation and in the longstanding unwritten CMS policy, it effected a change in existing law or policy that is substantive in nature and required notice and opportunity to comment before any change can be made to this policy.

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[13] *See supra* note 9 and accompanying text.

[14] *See Blumberg Ribner 91-99 112% Peer Mean Group v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2013-D18 (May 16, 2013), *rev'd*, CMS Adm'r Dec. (July 9, 2013). CMS in its rejection of the Board decision maintains that CMS is simply reflecting Congress' directive in OBRA '93 not to recognize as reasonable certain differences in hospital-based and free-standing SNFs caused by inefficiencies and that these presumably unreasonable costs are reflected in the 50 percent difference between the hospital-based SNF cost limit and the 112 percent peer group mean per diem cost for hospital-based SNFs. *See* CMS Adm'r Dec. at 9. The Board finds this logic another, and perhaps more compelling, reason to find that its change in policy was arbitrary and capricious, or required, at the very least, a notice and an opportunity for SNFs to comment on whether this manner of imposing a cost limit is an accurate reflection of the additional costs for providing atypical services.

[15] 5 U.S.C. § 553.

[16] *National Black Media Coalition v. FCC*, 775 F.2d 342, 355 (D.C. Cir. 1985).

The Board's position is consistent with its decisions in other similar cases. [17] Further, the Board's decision have been upheld by federal courts including: (1) a 2008 decision by the District Court in *Montefiore Medical Center v. Leavitt* ("*Montifiore*");[18] and (2) a 2003 decision by the Eighth Circuit Court of Appeals ("Eighth Circuit") in *St. Luke's Methodist Hospital v. Thompson* ("*St. Luke's*").[19]

In *Montefiore*, the District Court found that PRM 15-1 § 2534.5 was a "significant departure" from CMS' earlier longstanding interpretation and that CMS violated the Administrative Procedures Act by failing to comply with notice and comment rulemaking. The District Court analogized the CMS' position to that of the Federal Aviation Administration in *Alaska Prof'l Hunters Ass'n., Inc. v. Federal Aviation Admin.* in which the U.S. Court of Appeals for the District of Columbia Circuit declared the following principle: "[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."[20] The D.C. District Court concluded that "PRM § 2534 may assist the [Secretary] in determining reasonableness, but because it significantly alters an established agency interpretation, notice and comment procedures must be followed."[21]

Similarly, the Eighth Circuit in *St. Luke's* stated that federal statute, 42 U.S.C. § 1395yy(c), allowed upward adjustments to the RCL based on case mix or circumstances beyond the SNF's control, not to some point above the RCL. If the SNF can show that its "[a]ctual cost…exceeds *the applicable limit,"* federal regulation requires payment—it does not have to show that its costs exceed 112 percent of the mean per diem cost for all hospital-based SNFs.[22] The Court further stated that PRM 15-1 § 2534.5 is contrary to the intent of the Medicare statute by discouraging efficient HB- SNFs that have typical costs below the HB-RCL from providing atypical services to those who need them because the HB-SNFs will not be reimbursed for the reasonable cost of those services.[23]

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[17] This decision is also consistent with the Board's decisions in similar SNF RCL cases. *See, e.g., Blumberg Ribner 91-99 112% Peer Mean Grp. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2013-D18 (May 16, 2013), *rev'd*, CMS Adm'r Dec. (July 9, 2013); *Toyon 85-98 112% Hospital-Based Peer Grp. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2010-D35 (June 10, 2010), *rev'd*, CMS Adm'r Dec. (Aug. 2, 2010); *Canonsburg Gen. Hosp. SNF v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2009-D37 (Aug. 20, 2009), *rev'd*, CMS Adm'r Dec. (Oct. 14, 2009); *Quality 89-92 Hosp. Based SNF v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2009-D8 (Jan. 26, 2009), *rev'd*, CMS Adm'r Dec. (Mar. 10, 2009).

[18] 578 F. Supp. 2d 129 (D.D.C. 2008). *See also Mercy Medical Skilled Nursing Facility v. Thompson*, Case No. C.A.99-2765, 2004 WL 3541332 (D.D.C. 2004) (earlier decision that mirrors *Montefiore*).

[19] 315 F.3d 984 (8th Cir. 2003).

[20] 177 F 3d 1030, 1030 (D.C. Cir. 1999). *See* 578 F. Supp. 2d at 133-134.

[21] 578 F. Supp. 2d at 134.

[22] 315 F.3d 984, 988-89.

[23] *Id.* at 989; *see also* 42 C.F.R. § 413.30(f)(1) (1996).

DECISION

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds that the Medicare Contractor improperly calculated the amount of the exception to the HB-SNF RCL for Mercy General for FY 1995. Mercy General is entitled to be reimbursed for all of its costs above the cost limit, rather than only for those costs that exceeded 112 percent of the peer group mean per diem cost.

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/s/
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DATE: June 6, 2016