CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Mercy General Hospital **Provider** **vs.** **Cahaba Safeguard Administrators, LLC** **Medicare Administrative Contractor**	**Determination for Cost Year Ending: March 31, 1995** **Review of:** **PRRB Dec. No. 2016-D13** **Dated: June 6, 2016**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f). The parties were notified of the Administrator's intention to review the Board's decision. The Medicare Administrative Contractor (MAC) submitted comments, requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue was whether the Medicare Contractor properly calculated the amount of the Provider's exception to the routine cost limitations (RCLs) for hospital-based skilled nursing facilities (or HB-SNFs) by excluding from the calculation those costs that were above the HB-SNF RCL but below 112 percent of the peer group mean cost for hospital-based skilled nursing facilities (HB-SNFs).

The Board found 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 regulations. The Board stated that the regulation at 42

CFR §413.30(f)(1) permits a provider to request from CMS an exception to the cost limit because it provided atypical services. The Board claimed that it is undisputed that for fifteen years, the Secretary interpreted the regulation as permitting a provider to recover its reasonable costs that exceeded the cost limits if the provider demonstrated that it met the exception requirements. The Provider's exception request was processed in accordance with PRM 15-1 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 cost limit. CMS incorporated this transmittal into PRM 15-1 at §2534.5.

Thus, the Board continued, CMS replaced the limit with a new "cost limit," i.e., 112 percent, of the peer group mean routine services cost. The Board stated it is undisputed that 112 percent of the peer group mean of hospital-based SNFs is significantly higher than the applicable routine cost limit. Thus, under §2534.5 of the PRM, a reimbursement "gap" is created between the cost limit and 112 percent of the peer group mean that represents costs incurred by a hospital-based SNF, which are not allowed.

The Board noted that it is not bound by interpretive rules but rather must "afford great weight" to such rules. Notwithstanding the great weight afforded to PRM 15-1 §2534.5, the Board found that §2534.5 is inconsistent with the relevant statutory and regulatory provisions and that the Manual provision is arbitrary and capricious.

The Board also noted that its decision in this matter is consistent with its prior decisions in similar SNF RCL cases[1] and the court cases. In one district court case, the court followed the *Alaska Professional Hunters Association v. FAA*. In the Eighth Circuit Court of Appeals case, the court found that "PRM 15-1 §2534.5 is a 'plainly erroneous' interpretation of the provisions that allow the Secretary to grant an upward adjustment to hospital-based SNFs and thus, in any event, PRM §2534.5. is not entitled to our deference."

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[1] *See, e.g., Toyon 85-98 112% Hospital-Based Peer Group v. BlueCross BlueShieldAss'n*, PRRB Dec. No. 2010-D35 (June 10, 2010), *rev'd*, Administrator Dec. (Aug. 23, 2010); *Canonsburg Gen. Hosp. SNF v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2009-D37 (Aug. 20, 2009), *rev'd*, Administrator Dec. (Oct. 14, 2009); *Quality 89-92 Hospital Based SNF v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2009-DS (Jan. 26, 2009), *rev'd*, Administrator Dec. (Mar. 10, 2009).

SUMMARY OF COMMENTS

The Medicare Administrative Contractor (MAC) commented, requesting that the Administrator reverse the Board's decision. The Medicare Contractor believes that the PRRB erred in relying on the 8th Circuit decision in *St. Luke's Methodist Hospital, Id.* In light of the U.S. Supreme Court ruling in *Perez v. Mortgage Bankers Ass'n*, and consistent with the Administrator's decision in PRRB Decision 2013-D8, the MAC recommended to the Administrator to reverse the PRRB's decision for this case. Under the Perez standard, the CMS interpretation was proper and the MAC adjustment followed the CMS interpretation.

The MAC stated that one of the Provider's major arguments in this appeal was that the validity of PRM-1, §2534.5, is controlled by holdings set forth in *Alaska Professional Hunters Ass'n v. FAA*, 177 F.3d 1030 (D.C. Cir. 1999) and *Paralyzed Veterans of America v. D.C. Arena*, 117 F.3d 579 (D.C. Cir. 1997). Specifically, the *Paralyzed Veterans* doctrine holds that an agency must use the APA notice and comment procedures when it wishes to issue a new interpretation of a regulation that deviates significantly from a previously adopted interpretation. The Providers contend that to the extent that PRM-1, §2534.5, constitutes an interpretative rule, it deviated significantly from a previously adopted interpretation and did not comply with notice and comment procedures when it was issued.

However, the MAC points out that the *Paralyzed Veterans* doctrine was recently overruled by the United States Supreme Court in *Perez v. Mortgage Bankers Ass'n*, No. 13-1041 (March 9, 2015). In this case, the Supreme Court held that "[t]he *Paralyzed Veterans* doctrine is contrary to the clear text of the APA's rulemaking provisions and improperly imposes on agencies an obligation beyond the APA's maximum procedural requirements." *Id.*, at p. 2. The Court further held that Section 4 of the APA specifically exempted interpretative rules from notice and comment requirements and, as a result, was also not required to use those procedures to amend or repeal interpretative rules. *Id.*

Finally, the MAC noted that in PRRB Decision Number 2013-D18, Blumberg Ribner 91-99 SNF 112% Peer Mean Group, FYEs 1991 through 1999, the issue was identical to the case at hand. The Administrator overturned the PRRB in that case, stating that even if Transmittal 378 constituted a new methodology to determine the reasonable cost under the exception process, such a methodology was based upon new facts demonstrating that certain HB-SNF costs above the limit were per se unreasonable.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely submitted have been taken into consideration and included in the record.

The Provider is a hospital-based 111-bed skilled nursing facility (SNF). For cost reporting period for the fiscal year (FY) 1995, the Provider applied for an atypical services exception from its hospital-based skilled nursing facilities (HB-SNF RCL). The Medicare Administrative Contractor (MAC)[2] (formerly referred to as the Intermediary) reviewed the FY 1995 exception request arid agreed that: (1) The Provider provided atypical services; (2) its reasonable costs exceeded the HB-SNF RCL; and (3) the Provider is entitled to an additional payment. However, the Medicare Contractor limited the additional payment for FY 1995 to the Provider's costs that exceeded 112 percent of the peer group mean per diem cost. In this appeal, the Provider 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.

During the cost years at issue, Medicare reimbursed for SNF services largely on the basis of reasonable cost. Prior to 1972, §1861(v)(1) initially set forth that reasonable costs shall be determined, *inter alia*, in accordance with the regulations establishing the method or methods to be used.[3] Generally, providers were able to be reimbursed the cost of services to Medicare patients, unless such costs were found to be substantially out of line with those of similar institutions.

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[2] https://www.ems.gov/medicare/medicare-contracting/medicare-administrative-contractors/medicareadministrativecontractors.html ("Since Medicare's inception in 1966, private health care insurers have processed medical claims for Medicare beneficiaries. Originally these entities were known as Part A Fiscal Intermediaries (Fl) and Part 13 carriers. In 2003 the Centers for Medicare & Medicaid Services (CMS) was directed via Section 911 of the Medicare Prescription Drug Improvement, and Modernization Act (MMA) of 2003 to replace the Part A FIs and Part B carriers with A/B Medicare Administrative Contractors (MACs) in accordance with the Federal Acquisition Regulation (FAR).)

[3] *See* Pub. L. No. 89-97.

However, in 1972, §1861(v)(1) of the Social Security Act, was amended by section 223 of the Social Security Amendments of 1972[4], to limit the amount a provider could be reimbursed to those costs that meet the definition of reasonable cost. Section 1861(v)(1)(A) defines reasonable cost broadly as the cost actually incurred, excluding any cost found to be unnecessary in the efficient delivery of needed health services, and authorizes the Secretary to issue appropriate regulations setting forth the methods to be used in computing such costs.

Section 223 also amended §1861(v)(1) to authorize the establishment of limits on allowable costs that will be reimbursed under Medicare. Section 1861(v)(1)(A) authorized the Secretary to establish limits on the direct and indirect overall incurred costs of specific items or services or groups of items or services. The limits are based on estimates of the costs necessary for the efficient delivery of needed health care services. The limits on inpatient general routine service costs set forth at §1861(v)(1)(A) apply to SNF inpatient routine costs, excluding capital-related costs and are referred to as the routine cost limits or RCLs.

The regulations at 42 C.F.R. §413.9 establish the determination of reasonable costs specifically for Medicare. If a provider's costs include amounts not related to patient care, or costs that are specifically not reimbursable under the program, those costs will not be paid by the Medicare program. Further, 42 C.F.R. §413.9(b) provides that the reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used and the items to be included.

The regulations at 42 C.F.R. §413.30, *et seq*., implement the cost limit provisions of §1861(v)(1)(A) of the Act by setting forth the general rules under which CMS may establish limits on provider costs, including SNF costs recognized as reasonable in determining Medicare program payments. It also sets forth rules governing exemptions and exceptions to limits.

Pursuant to §1861(v)(1)(A) of the Act, CMS has promulgated annual schedules of limits on SNF inpatient routine service costs since 1979 and notified participating providers of the exception process in the *Federal Register*.[5] Initially, separate reimbursement limits were implemented for hospital-based SNFs and freestanding SNFs. Reimbursement limits for hospital-based SNFs were higher than for freestanding SNFs, due to historically higher costs incurred by hospital-based SNFs.

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[4] Pub. L. No. 92-603.

[5] *See, e.g*., 42 Fed. Reg. 36,237 (1976); 44 Fed. Reg. 29,362 (1979); 44 Fed. Reg. 51,542 (1979); 45 Fed. Reg. 58,699 (1980); 46 Fed. Reg. 48,026 (1981); 47 Fed. Reg. 42,894 (1982).

While hospital-based SNFs maintained that they incurred higher costs because of the allocation of overhead costs required by Medicare and higher intensity of care, this was a subject of debate. For cost reporting periods beginning on or after October 1, 1980, the cost limits were changed to 112 percent of the average per diem costs of each comparison group.[6]

However, amid the growing belief that the cost difference between hospital-based and freestanding SNFs was unjustified, Section 102 of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) eliminated the separate limits for hospital-based SNFs and freestanding SNFs, mandating that Medicare pay no more to hospital-based SNFs than would be paid to the presumably more efficient freestanding SNFs. The effective dates of these cost limits were retroactively postponed twice by Congress, and were never actually implemented.

In 1984, the Deficit Reduction Act (DEFRA) rescinded the single TEFRA limit for SNFs, and directed the Secretary to set separate limits on per diem inpatient routine service costs for hospital-based SNFs and freestanding SNFs, revising §1861(v) of the Act and adding a new §1888 to the Act, specifying the methodology for determining the separate cost limits.[7] Section 1888(a) states that the limit for freestanding SNFs is set at 112 percent of the mean per diem routine service costs for freestanding SNFs. The limit for hospital-based SNFs is equal to the limit for freestanding SNFs plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based SNFs exceeds the limit for freestanding SNFs. Thus, DEFRA allowed higher payments for hospital-based SNFs compared to the proposed payment methodology under TEFRA, but recognized that not all of the cost differences between hospital-based and freestanding SNFs were justifiable.

The rationale behind the limits promulgated in DEFRA can be found in a report prepared for Congress by HCFA, which studied the cost differences between

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[6] *See, e.g.*, 45 Fed. Reg. 58,699 (1980); 46 Fed. Reg. 48,026 0981); 47 Fed. Reg. 42,894 (1982). *See also* 51 Fed. Reg. 11,234 (1986) ("Prior to the September 29, 1982 schedule of single limits (required by Pub. L. 97-248), we published separate schedules. Under these schedules, the SNF cost limits for inpatient routine services were calculated at 112 percent of the mean of the routine costs for freestanding and hospital-based SNFs, respectively. Further, the routine costs considered for each comparison group were the routine costs attributable to the particular group…" *Id.*).

[7] Deficit Reduction Act of 1984 (DEFRA), Pub. L. No. 98-369 (Medicare and Medicaid Budget Reconciliation Amendments of 1984), applicable as provided in §2319(c) and (d) of the amendments. See also §2530, *et. seq*. of the PRM.

hospital-based and freestanding SNFs.[8] The results of this Report were communicated to Congress before enactment of DEFRA.[9] The Report found that, while case mix difference accounted for approximately 50 percent of the cost difference, the remaining 50 percent was due to such things as provider inefficiency, facility characteristics, and overhead allocations. This conclusion was further supported by three separate subsequent studies.[10]

In establishing the hospital-based SNF cost limit at the freestanding SNF limit plus 50 percent of the difference between the freestanding limit and the 112 percent of the mean hospital-based SNF routine service costs, Congress accepted the findings of this report. Congress thus mandated that the 50 percent difference in costs related to inefficiency, facility characteristics, and overhead allocations[11] were not reasonable

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[8] *Health Care Financing Administration Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare*, U.S. Government Printing Office, January 1985.

[9] *See St. Luke's Methodist Hospital v. Blue Cross and Blue Shield Association*, PRRB Dec. No. 2000-D11

[10] A study conducted by Abt Associates, Inc., found that hospital-based SNFs have significantly higher per-patient costs than freestanding SNFs after controlling for various factors, but could not explain why. *See* Abt Associates, Inc., *Why Are Hospital-Based Nursing Homes So Expensive? The Relative Importance of Acuity and Treatment Setting*, Health Services and Evaluation (HSRE) Working Paper No. 3 (Cambridge, Massachusetts: February 2001). Available online at *http://www.abtassociates.com/Reports/HSRE-W3-HBDDMC.pdf*. Another study, which compared hospital-based and freestanding SNF costs when controlled for case-mix and staffing patterns, found that less than one-half of the cost differences could be attributed to those factors. *See Cost and case-mix difference between hospital-based and freestanding nursing homes*, by Margaret B. Sulvetta and John Holahan, Health Care Financing Review, Spring 1986, Volume 7, Number 3, p. 83. A study conducted by the General Accounting Office on the Medicare Exception Process in SNFs found no substantive differences between the characteristics of, and services received by Medicare patients residing in SNFs which had been granted exceptions for atypical services and those in SNFs that did not receive exceptions. As others have noted, "If hospital-based facilities do not serve the more disabled patients or provide higher quality care, then the cost differential is not justified and should not be recognized by Medicare." *See Prospective payment for Medicare skilled nursing facilities: Background and issues*, by George Schieber, Joshua Wiener, Korbin Liu, and Pamela Doty, Health Care Financing Review, Fall 1986, Volume 8, Number 1, p. 83.

[11] An add-on for the overhead allocation was mandated by Congress under DEFRA, but was subsequently disallowed in the Omnibus Budget Reconciliation Act of 1993.

costs and should not be reimbursed. This results in the reimbursement gap disputed by the Provider that is comprised of an amount that CMS recognizes as unreasonable and, thus, not allowable.

In addition to establishing dual limits for hospital-based and freestanding SNFs, DEFRA (1984), in subsection (b) of §1888, mandated that an additional amount be added to the hospital-based SNF limit to account for cost differences between hospital-based and freestanding SNFs that are attributable to excess overhead allocations resulting from Medicare reimbursement principles. However, this subsection was subsequently changed, pursuant to §13503(a) of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66) (OBRA '93). Congress instead mandated that the Secretary not recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities limits attributable to excess overhead allocations.[12] This . change further shows that Congress intended that the hospital-based SNF inefficiencies should never be recognized as reasonable and, likewise, should not be paid pursuant to the exception methodology. If CMS were to allow exceptions for hospital-based SNFs for costs that fell within the "gap" between the hospital-based SNF routine cost limit and 112 percent of the peer group mean, it would be paying those very costs which are not recognized as reasonable and which Congress has specifically instructed it not to pay. Notably, Congress has never mandated the recognition of the cost differences between hospital-based and freestanding SNFs that are attributed to inefficiencies and facility characteristics.

The Secretary was also given broad discretion to authorize adjustments to the cost limits under DEFRA provisions. Section 1888(c) provided:

> The 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.

In accordance with this section, the regulation at 42 C.F.R. §413.30(f) provides for exceptions as follows:

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[12] *See* Conference Agreement noting "Additional payments for excess overhead costs allocated to hospital-based facilities are eliminated, effective for cost reporting periods beginning on or after October 1, 1993." 139 Cong Rec H 5792 (Aug. 4, 1993).

> *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. [Emphasis added.][13]

Pertinent to this case, §413.30(f)(1) specificaIIy provides for an exception for atypical services if the provider can show that:

> (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
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> (ii) Atypical items or services are furnished because of the special needs of the patients treated and are necessary on the efficient delivery of needed heath care.

This regulation creates a two-prong test, requiring that any exception request be examined to determine the reasonableness of the amount that a provider's actual costs exceed the applicable cost limits, and determine the atypicality of the costs by using a peer group comparison, i.e., the 112 percent threshold. A hospital-based SNF's costs are thus compared to the costs of a typical facility (112 percent of the peer group mean) in order to determine if its costs are actually atypical.

Although this peer group comparison exceeds the RCLs established for hospital-based SNFs, it is a practical standard for measuring the atypical nature of a provider's services. It is also the same test used to determine the amount of an exception for a freestanding SNF, and is a standard based entirely upon data from similarly-situated hospitals.

Consistent with the statute and regulations, CMS set forth the general provisions concerning payment rates for certain SNFs in Chapter 25 of the PRM. However, Chapter 25 of the PRM did not address the methodology used to determine exception requests. In July 1994, in order to provide the public with current information on the

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[13] *See also* 44 Fed. Reg. 31804 (June 1, 1979), adopting language at 42 C.F.R. §405.460(f) stating that: "An adjustment will be made only to the extent the costs are *reasonable*, attributable to circumstances specified, separately identified by the Provider, and verified by the Intermediary." [Emphasis added].

SNF cost limits under §1888 of the Act, CMS issued Transmittal No. 375.[14] Transmittal No. 378 explained that new manual sections, at §2530, *et seq*., were being issued to "provide detailed instructions for skilled nursing facilities (SNFs) to help them prepare and submit requests for exceptions to the inpatient routine service cost limits."

Section 2534.5, as adopted in Transmittal No. 378, "Determination of Reasonable Costs in Excess of Cost Limit or 112 Percent of Mean Cost," explains the process and methodology for determining an exception request based on atypical services. In determining reasonable costs, a provider's costs are first subject to a test for low occupancy and then are compared to per diem costs of a peer group of similarly classified providers. Section 2534.5B of the PRM explains the methodology CMS developed to quantify the peer group comparison that is part of the test for reasonableness:

> *Uniform National Peer Group Comparison*. — The uniform national peer group data are based on data from SNFs whose costs are used to compute the cost limits. The peer group data are divided into four groups: Urban Hospital-based, Urban Freestanding, Rural Hospital-based, and Rural Freestanding. For each group, an average per diem cost (less capital-related costs) is computed for each routine service cost center (direct and indirect) that the provider reported on its Medicare cost report. For each cost center, a ratio is computed as the average per diem cost to total per diem cost. Those cost centers not utilized on the Medicare cost report must be eliminated and all ratios are revised based on the revised total per diem cost…
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> With cost reporting periods beginning prior to July 1, 1984, for each freestanding group and each hospital-based group, each cost center's ratio is applied to the cost limit applicable to the cost reporting period for which the exception is requested. For each hospital-based group with cost reporting periods beginning on or after July 1, 1984, the ratio is applied at 112 percent of the group's mean per diem cost (not the cost limit), adjusted by the wage index and cost reporting year adjustment factor applicable to the cost reporting period for which the exception is requested. The result is the Provider's per diem cost is disaggregated into the same proportion of its peer group mean per diem cost for each cost center.

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[14] Transmittal No. 378 also rendered §§2520-2527.4 of the PRM, adopted in July 1975, under Transmittal No. 129, as obsolete.

> The SNF's annual per diem cost or, if applicable, the cost as adjusted for low occupancy for each applicable routine cost center (less capital-related costs) is compared to the appropriate component of the disaggregated cost limit or 112 percent of the hospital-based mean per diem cost. If the SNF's per diem cost exceeds the peer group per diem cost for any cost center, the higher cost must be explained. Excess per diem costs which are not attributable to the circumstances upon which the exception is requested and cannot be justified may result in either a reduction to the amount of the exception or a denial of the exception.

The Administrator finds that the exception guidelines in Chapter 25 of the PRM are reasonable and appropriate, as they closely adhere to the requirements of §1888(a) of the Act and are within the scope of the Secretary's discretionary authority under §1888(c) of the Act to make adjustments in the SNF RCLs, and under the implementing regulations at §413.30(f)(1)(i). The Administrator rejects the view that §1888(a) of the Act and the implementing regulation at 42 C.F.R. §413.30 entitle all SNFs to be paid the full amount by which their costs exceed the applicable RCL.[15] The Administrator finds that the policy interpretation in §2543.5B, requiring the hospital-based 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 requirements that have existed in the regulation since at least 1979.

Furthermore, the Administrator finds use of the methodology set forth in §2534.5 of the PRM in no way alters, or revises, Medicare policy as set forth in the regulations at §413.30(f)(1)(i) but is one method of applying that policy. Indeed, §2534.5 did not affect a change in CMS policy. Although Congress changed the RCLs for hospital-based SNFs in 1984, the published cost limits since 1980[16] reflect that CMS had

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[15] The Board had previously reached the opposite conclusion in several other cases on this issue. *See Mercy Medical Skilled Nursing Facility*, PRRB Dec. No. 1999-D61; *Riverview Medical Center Skilled Nursing Facility*, PRRB Dec. No. 1999-D67; *St. Luke's Methodist Hospital-SNF*, PRRB Dec. No. 2000-DI1; *New England Rehabilitation Hospital*, PRRB Dec. No. 2000-D53; *Fort Bend Community Hospital-SNF*, PRRB Dec. No. 2000-D86; *San Joaquin Community Hospital-SNF*, PRRB Dec. No. 2001-D17; *Centennial Medical Center-SNF*, PRRB Dec. No. 2001-D54; *Colleton Regional Hospital-SNF*, PRRB Dec. No. 2002-D8; *Alameda Hospital SNF*, PRRB Dec. No. 2002-D46; *Providence Hospital-Central SNF*, PRRB Dec. No. 2002-D50.

[16] 45 Fed. Reg. 41,292 (1980) ("We are proposing that the limits be set at 112 percent of each group's mean cost. We believe that the 12 percent allowance above mean cost is a reasonable margin factor in view of the refinements made in the method used to establish the limits."); 45 Fed. Reg. 58,699 (1980) ("[l]imits set at

previously used a methodology under which the SNFs' per diem costs were compared to a percentage of the peer group mean diem cost.[17]

Notably, §2534.5 refers to the "cost limit", rather that)! to 112 percent of a SNF's peer group mean per diem cost, only where the terms are interchangeable, i.e., where the cost limit is equal to 112 percent of the SNF's peer group mean cost. For periods prior to the effective date of the hospital-based SNF RCL under DEFRA, July 1, 1984, the term, "112 percent of the peer group mean per diem cost" was synonymous with the term, "cost limit," for both freestanding SNFs and hospital-based SNFs. After June 1984, the freestanding SNF RCL remained at 112 percent of the peer group mean per diem cost. However, as explained above, Congress changed the amount of the hospital-based SNF RCL. Thus, §2534.5 uses the term of cost limit to refer to 112 percent of the freestanding SNF mean per diem cost, but cannot use the same term for the hospital-based SNFs. Section 2534.5 simply recognizes that, after July 1, 1984, the term of cost limit can no longer be used interchangeably with the term of 112 percent of the peer group mean per diem cost for hospital-based SNFs. In short, although the statutory cost limit for hospital-based SNFs was changed under DEFRA, that change did not impact CMS' peer group methodology.

The Administrator also disagrees with the Board's finding that the methodology for determining an exception for atypical services of a hospital-based SNF using the uniform peer group comparison, as set forth in §2534.5 of the PRM, constituted a change in policy requiring notice and comment rule-making under 5 U.S.C. §552. CMS has consistently compared SNF costs to their comparison group in applying the cost limits. The Administrator finds that the methodology at issue does not involve application of a "substantive" rule requiring publication of notice and comment under the APA. The Secretary has broad authority to promulgate regulations under §§1861(v)(1)(A) and 1888 of the Act. 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

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112 percent of the average per diem labor-related and non-labor costs of each comparison group." *Id.*) 46 Fed. Reg. 48,026 (1981); 51 Fed. Reg. 11,234 (1986).

[17] *See, e.g.*, 44 Fed. Reg. 51,542, 51,544 (Aug. 31, 1979) ("We believe the use of a limit based on the average to be superior to a percentile limit. The average is a good measure of the cost incurred in the efficient delivery of services by peer providers…. Since these are the first limits we have established for SNFs, the methodology used does not account for any conceivable variable which could affect SNF costs. As we gain information and experience, the methodology will be refined.")

process of determining reasonable costs.[18] Rather, the MAC is required to make a determination on the exception request, applying the existing reasonable cost statute, controlling regulations, and any further guidance that CMS has issued. Notably, the regulation instructing the payment of reasonable cost only where an exception is granted has been in place since 1979. The methodology set forth in §2534.5 of the PRM 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. A regulatory step in the exception process is that the amounts allowed above the routine cost limitation when an exception is processed must first be determined to be "reasonable" on order to be allowed. That is regulatory requirement was not addressed by the *St Luke*'s court's analysis, relied upon by the Board, that not all costs are allowed carte blanche above the routine cost limits when an exception is granted.[19] The methodology set forth at §2534.5 of the PRM does not constitute a substantive rule, and is consistent with the reasonable cost rules in effect for the cost years at issue. Moreover, the nature of reasonable cost reimbursement requires the determination of allowable costs after the close of the cost reporting period and by their nature are "retroactive" in that they are determined after the close of the cost reporting period. The statute gives the Secretary broad authority to determine reasonable costs, which is typically done through interpretative rules that act within the scope of that authority. The methodology also is specifically consistent with the instruction of Congress in OBRA '93 to not recognize as reasonable certain specified cost differences in hospital-based and freestanding SNFs caused by inefficiencies.[20] This latter provision was evidence that Congress also recognized the presumed unreasonableness of certain HB SNF excess overhead costs.

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[18] *See Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87, 96(1995) (The Supreme Court also explained that, "[t]he APA does not require that all the specific applications of a rule evolve by furthermore, precise rules rather than by adjudication,"); *Chrysler Corp. v. Brown*, 441 U.S. 281, 302, n. 31 (1979) ("An interpretive rule is issued by the agency to advise the public of the agency's construction of the statutes and the rules which it administers," quoting the Attorney General's Manual on the Administrative Procedure Act," 30 at n.3 (1947).).

[19] Regarding the status of the policy in the courts, the court in *Canonsburg General Hospital v. Sebelius*. 989 F. Supp. 2nd $ (D.C.D.C. 2013) observed that: 'Here. the question at issue, regarding the validity of PRM §2534.5, has not been the subject of a ruling by any authority binding on this Court….[A] consensus appears elusive regarding the validity of PRM §2534.5, in view of at least three cases, including one circuit court, finding the regulation to be invalid[ ] and at least four other cases, including a different circuit court, finding the opposite.[ ] Thus, continued application of the challenged rule does not work a substantial unfairness."

[20] *See* §1888(b) of the Act.

Furthermore, while it is maintained CMS never used this methodology before the period at issue, other cases show that CMS used this method before it was set forth in the PRNI in July 1994. On November 16, 1992, HCFA responded to a provider's exception request for its August 31, 1989 cost reporting period by comparing its cost to its peer group mean costs, and granting only a partial exception. This same provider, a hospital-based SNF, had been granted similar partial exceptions for its 1985, 1986, 1987, and 1998 cost reporting periods.[21] On February 23, 1993, HCFA denied another provider's 1985 cost year exception request because the costs did not exceed the peer group per diem cost. HCFA explained[22]:

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

Further, the Board decision seems to rely in part upon the doctrine set forth in *Alaska Professional Hunters Ass'n* and *Paralyzed Veterans.*[23] However, that doctrine was recently overruled by the United States Supreme Court in *Perez v. Mortgage Bankers Ass'n*, No. 13-1041 (March 9, 2015). The Supreme Court held that "[t]he *Paralyzed Veterans* doctrine is contrary to the clear text of the Administrative Procedure Act rulemaking provisions and improperly imposes on agencies an obligation beyond the APA's maximum procedural requirements." *Id*., at p. 2. The Court further held that the APA specifically exempted interpretative rules from notice and comment requirements and, as a result, was also not required to use those procedures to amend or repeal interpretative rules.[24]

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[21] *North Coast Rehabilitation Center*, PRRB. Dec. No. 1999-D22 (June 23, 1998), p. 2-3.

[22] *New England Rehabilitation Hospital*, PRRB Dec. No. 2000-D53 (April 13, 2000). p.4.

[23] *Alaska Prof'l Hunters Ass'n v. FAA*, 177 F.3d 1030 (D.C. Cir. 1999); *Paralyzed Veterans of Am. v. D.C. Arena L.P*., 117 F.3d 579 (D.C. Cir. 1997)

[24] Prior to the overruling of the *Alaska Professional Hunters Ass'n,/Paralyzed Veterans* rationale the Administrator had pointed out that the Court of Appeals in the District of Columbia in *Hudson v. FAA*, 192 F.3d 1031 (D.C. Cir. 1999), rejected the argument that an agency had impermissibly changed its interpretation of the regulation. In that case, the court found the agency was entitled to apply the

Accordingly, after review of the record and applicable law, the Administrator finds that the methodology set forth in §2534.5 of the PRM is consistent with the plain meaning of §§1861(v) and 1888(a)-(c) of the Act,[25] the legislative intent, and the regulations at 42 C.F.R. §413.30. The MAC properly applied the methodology at §2534.5 of the PRM in partially denying the Provider's request for an exception to the RCL.

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regulation to a new understanding of the facts without violating the principles set forth in *Alaska Professional Hunters Ass'n* or *Paralyzed Veterans of America*.

[25] In addition, the exceptions for the routine cost limits have been in place since 1979 (*See, e.g.*, 44 Fed. Reg. 31, 802 (1979)) and initially covered a broad spectrum of providers and were not specific to SNFs. Thus, the wide prescription in the regulation that all costs allowed pursuant to the granting of an exception must be reasonable is consistent with the various types of providers to which the cost limits were applied.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 8/03/2016

/s/
Patrick H. Conway, M.D., MSc
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services