PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2000-D10

PROVIDER -
Canonsburg General Hospital Skilled
Nursing Facility
Canonsburg, PA

Provider No. 39-5580

vs.

INTERMEDIARY -
Blue Cross and Blue Shield
Association/Veritus Medicare Services, Inc.

DATE OF HEARING-
October 20, 1999

Cost Reporting Periods Ended -
June 30, 1987 through June 30, 1993

CASE Nos. 94-3018, 94-3019,
94-3020, 94-3021 &
95-2194

INDEX

ISSUE:

1. Was HCFA's decision limiting SNF routine cost limit exception relief for fiscal years 1987 through 1990 and 1993 proper?

2. Was HCFA's denial of the Provider's request for an exception to its routine cost limits for fiscal years ended June 30, 1991 and 1992 due to untimely filing proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Canonsburg General Hospital Skilled Nursing Facility ("Provider") is a hospital based ("HB") skilled nursing facility ("SNF") located in Canonsburg, Pennsylvania. For each of its cost reporting periods ended June 30, 1987, 1988, 1989, 1990, and 1993, the Provider requested an exception to Medicare's routine service cost limits ("RCL") based upon the provision of furnishing "atypical services." 42 C.F.R. § 413.30(f)(1). The Health Care Financing Administration ("HCFA") approved the Provider's requests and determined the amount of each exception. HCFA's determinations limited the amount of each exception to the amount by which the Provider's costs exceeded 112 percent of the peer group mean per diem used to determine each applicable limit rather than the limit itself. Because the 112 percent level is greater than the limits, the Provider appealed HCFA's determinations to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations.[1]

The Provider also requested an exception to the RCLs for its cost reporting periods ended June 30, 1991 and June 30, 1992. Veritus Medicare Service, Inc. ("Intermediary") reviewed the Provider's request and determined that it was submitted on December 15, 1994, which is more than 180 days after the date of each year's Notice of Program Reimbursement ("NPR"). Since providers are required to submit such requests no later than 180 days from the date of an NPR, the Intermediary recommended that the Provider's request be denied. On March 24, 1995, HCFA concurred with the Intermediary's recommendation and denied the Provider's request. On July 7, 1995, the Provider appealed HCFA's denial to the Board pursuant to the aforementioned regulations and jurisdictional requirements.[2] The amount of program funds in controversy exceeds $10,000 for each fiscal year ended June 30, 1987 through June 30, 1990.[3] The amount of program funds in controversy for fiscal years ended June 30, 1991 and June 30, 1992, is approximately $235,733 and $232,000, respectively.[4]

---

[1] Intermediary Position Paper dated August 27, 1999 at 1-4. Provider Position Paper, CN: 95-2194 at 2-4.

[2] Intermediary Position Paper, CN:95-2194 at 3.

[3] Provider Position Paper, CN:95-2194 at 1.

[4] Provider Position Paper, CN:95-2194 at 11.

On August 27, 1999, the Provider and Intermediary submitted a Stipulation For A Hearing On The Record. In part, the parties agree that the Board may limit its review of the Provider's case to its position paper filed for CN: 95-2194, as opposed to the position papers filed for each individual case included herein. Accordingly, all further references to the Provider's position paper will pertain to that individual case.

The Provider was represented by M. Theresa Creagh, Esq. of Nash and Company. The Intermediary was represented by Eileen Bradley, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

Issue No. 1- Fiscal Years Ended 1987-1990 and 1993:

PROVIDER'S CONTENTIONS:

The Provider contends that the methodology used by HCFA to limit the amount of its RCL exceptions is invalid.[5] Pursuant to the enabling statute and pertinent regulation, HB-SNFs are entitled to the full amount that their atypical service costs exceed the applicable limit. The methodology used by HCFA, however, limits exception amounts for HB-SNFs to the amount that a provider's costs exceed 112 percent of the hospital-based peer group mean per diem rather than the limit. Since the 112 percent level is the greater number, the methodology creates a "gap" which is not reimbursed, i.e., the difference between the limit and the 112 percent level.[6]
In sum, the Provider maintains that a plain reading of the statute and regulation shows that exceptions are based upon the amount by which atypical costs exceed the cost limit not the higher 112 percent level, as follows:

Provisions at 42 U.S.C. § 1395yy(a)(3), which pertain to HB-SNFs in urban areas such as the Provider, state:

> [w]ith respect to hospital-based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in urban areas exceeds the limit for freestanding skilled nursing facilities located in urban areas.

42 U.S.C. § 1395yy(a)(3).

---

[5] Provider Position Paper at 23.

[6] See Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2534.5 ("Transmittal No. 378").

The pertinent regulation at 42 C. F. R. 413.30(f)(1) states:

> 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:
> (i) The actual costs of items 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.

42 C. F. R. 413.30(f)(1) (emphasis added).

The Provider also contends that the methodology used by HCFA to determine the amount of HB-SNF exceptions is invalid based upon 42 U.S.C. § 1395x(v)(1)(A), which requires providers to be reimbursed for the reasonable costs of necessary health care, and 42 U.S.C. § 1395yy(c), which mandates that the Secretary of Health and Human Services ("Secretary") provide exceptions to the cost limits.[7] Where evidence establishes the provision of atypical services, 42 U.S. C. § 1395x(v)(1)(A) mandates that the costs of atypical services "be reimbursed in full over and above the routine cost limits." Sacramento Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 80-D56, August 1, 1980, Medicare & Medicaid Guide (CCH) ¶ 30,826, rev'd. HCFA Admin., September 29, 1980, Medicare & Medicaid Guide (CCH) ¶ 30,859 ("Sacramento Medical Center"). Notably, prior to the publication of Transmittal No. 378, HCFA recognized that providers were entitled to full reimbursement of the costs of atypical services.

The Provider also explains that the Board, relying in part on Sacramento Medical Center, has already held that HCFA's RCL methodology for HB-SNFs as set forth in Transmittal No. 378 violates both the SNF-RCL statute and the exception regulation. In St. Francis Health Care Centre v. Community Mutual Ins. Co., PRRB Dec. No. 97-D38, March 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,159, rev'd. HCFA Admin., May 30, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,545, affirm'd. USDC, Northern District of Ohio, Western Div., July 13, 1998, ("St Francis") the Board states:

---

[7] Provider Position Paper at 25.

> [c]ontrary to HCFA's exception methodology, which fails to reimburse HB-SNFs for routine service costs that exceed the limit but are less than the 112 percent level (the gap), the Board finds that 42 U.S.C. § 1395yy entitles SNFs, either freestanding or hospital-based, to be paid the full amount by which their costs exceed the applicable limit.
>
> Clearly, the cost limits established by Congress and implemented at 42 C.F.R. § 413.30 are the gauge for evaluating the routine service costs of a SNF, and represent the upper mist [sic] per diem amount a SNF can be reimbursed absent an exception. If an exception is granted the provider is to be paid each and every dollar that its costs exceed the limit.
>
> The Board also finds there is no authoritative basis supporting HCFA's reliance upon the 112 percent per group per diem to determine the amount of a HB-SNF exception. As discussed above, reliance upon the 112 percent level effectively increases the amount or level a provider's cost must exceed before it may be granted an exception. The Board finds it inappropriate for HCFA to establish and rely upon an amount greater than the limit established by Congress as it would find it inappropriate for HCFA to introduce a methodology that would effectively reduce the limits set by Congress.

St Francis, Medicare & Medicaid Guide (CCH) ¶ 45,159 at 53,321 (emphasis added).

The Board concluded:

> HCFA's methodology does not produce sound results. In the case where a HB-SNF qualifies for an exception, it is reimbursed only for the amount that its costs exceed the 112 percent level. The provider is not reimbursed for the amount that its costs exceed the cost limit up to the 112 percent level because this portion of costs, the gap, is considered unreasonable. The Board disagrees with the concept that costs are considered unreasonable once they exceed the cost limit but become reasonable again once they exceed the even greater 112 percent level.
>
> The Board does not believe that Congress intended each and every HB-SNF that furnishes atypical services to bear a financial loss up to the difference between the cost limit and the 112 percent level.

Id. at 53,323.

The Provider contends that HCFA's defense of the HB-SNF exception methodology is self-serving and unavailing on several grounds.[8] First, in St. Frances the Intermediary testified that the HB-SNF exception methodology stems from HCFA's interpretation of the 1984 RCL statute, i.e., 42 U.S.C. § 1395yy. See Transcript of July 18, 1996 Hearing at 124-25.[9] The Intermediary explained that in January 1985, the Secretary issued a report to Congress in which HCFA concluded that 50 percent of the difference between the costs incurred by HB-SNFs and the costs incurred by freestanding ("FS") SNFs was due to case-mix differences, and the remaining 50 percent was due to inefficiencies in HB-SNF operations. HCFA then concluded that, when Congress set the HB-SNF limit at 50 percent of the difference between 112 percent of the FS-SNF peer group's average cost per diem and 112 percent of the HB-SNF peer group's average cost per diem, Congress was deeming the remaining 50 percent of the cost differential to represent unreasonable costs. The flaw in this testimony, which was adopted by HCFA's Administrator in reversing the Board's decision, is that Congress enacted the SNF RCLs in 1984, the year before HCFA issued its report.

Next, in St. Francis, the Intermediary explains HCFA belief that gap costs are always deemed unreasonable. And, had Congress intended reimbursement of gap costs for HB-SNFs that were providing atypical services, Congress would have so directed. However, this interpretation ignores the structure of the statute which, by its own terms, imposes limits upon payments which may be made under this title with respect to routine service costs of extended care services. Once a SNF establishes that it is providing atypical services, the costs of providing those services are not routine service costs covered by the RCLs. Moreover, the Intermediary testified that HCFA interprets the statutory limits as presumptive tests, established by Congress, of reasonable costs for both typical (or routine) and atypical services. However, if this were true there could be no atypical service exception to the RCLs. Yet, HCFA's regulations expressly provide for such exceptions for both FS and HB- SNFs.

In addition, HCFA's HB-SNF exception methodology or interpretation of the statute contradicts the plain language of the RCL regulation. In order to be entitled to an atypical service exception the regulation requires a provider to demonstrate that its "actual cost of items or services furnished . . . exceeds the applicable limit because such items or services are atypical in nature and scope compared to the items and services generally furnished by providers similarly classified. 42 C.F.R. § 413.30(f)(1)(i)(emphasis added). Therefore, by establishing that its costs exceed the RCL because of the atypical nature of services provided, a provider refutes any generalized supposition that its costs in excess of the limit are the result of HCFA's presumed HB-SNF inefficiency. Simply stated, once it has been established that costs in excess of the limit are the result of atypical services, those same costs, including the gap costs, cannot be the result of provider inefficiency. Thus, HCFA Pub. 15-1 § 2534.1 - 2534.11, which denies reimbursement of gap costs even when a provider receives an atypical service exception, violates the statute and regulation which mandate the reimbursement of atypical service costs for all SNFs.

---

[8] Provider Position Paper at 27.

[9] Exhibit P-121.

The Provider contends that HCFA's HB-SNF exception methodology is also improper since it impermissibly offsets amounts in certain cost categories that are below the 112 percent level against amounts in cost categories that exceed the 112 percent level.[10] The Board explained the operation of this methodology in St. Francis, as follows:

> [t]he Provider also notes that the instructions for determining the amount of an exception, as implemented by Transmittal No. 378, requires an analysis of the individual categories of cost shown on a provider's Medicare cost report. Any category of costs in which the provider is found to exceed the 112 percent level is offset to the extent that total costs in other categories are less than the 112 percent level. Accordingly, the Provider argues that the methodology contained in Transmittal No. 378 confuses the concept of "atypical total costs" with the concept of "costs of atypical services." The Provider asserts that even assuming for purpose of argument that services cannot be considered "atypical" unless the total cost of such services (both typical and atypical) exceeds the 112 percent level, it makes no sense to reduce the exception to the extent that an other service area had costs under that level when the provider was never reimbursed up to that level in the first place.

St Francis, Medicare & Medicaid Guide (CCH) ¶ 45,159.

Clearly, this offset mechanism violates the SNF-RCL statute and regulation. If atypical services cause certain constituent categories of cost to exceed the RCL and thereby justify an exception, the provider is entitled to the full amount of that exception for those atypical service costs regardless of the level of the provider's costs in other categories. A hypothetical situation demonstrates that HCFA's methodology unfairly penalizes the efficient provider. Assume for example that a provider's nursing administration costs exceed the 112 percent level by $6 per day due to the provision of atypical services. Further, assume that the provider was operated so efficiently that its costs in all other categories were more than $7 per day below the 112 percent level. Under HCFA's offset methodology, this provider does not qualify for any exception relief. Thus, because of its efficiency, this provider is denied an exception to account for its excess nursing administration costs that are undisputedly generated by the provision of atypical services.
Notably, in St. Francis, the Board again agreed with the provider and held that the offset methodology violated the RCL statute and regulation by confusing atypical total costs with the costs of atypical services. St. Francis Medicare & Medicaid Guide (CCH) ¶ 45,159 at 53,322.

---

[10] Provider Position Paper at 32.

Finally, the Provider contends that HCFA's SNF-RCL exception methodology is invalid because it was not implemented in accordance with required standards and procedures.[11] The Provider asserts that both the Medicare Act and the Administrative Procedure Act ("APA") require agencies to adopt substantive standards by promulgating regulations subject to notice and comment. 42 U.S.C. § 1395hh(a)(2) and 5 U.S.C. §§ 551-553. The Provider explains that the HCFA Administrator, in reversing the Board's decision in St. Francis, noted that not all Medicare reimbursement methodologies require notice and comment. The Provider argues, however, that in reaching this conclusion the HCFA Administrator misinterpreted Shalala v. Guernsey Memorial Hospital, 115 S.Ct. 1232, 1237 (1995) ("Guernsey"), and misconstrues an agency's obligation under the Medicare Act and the APA.

The Supreme Court in Guernsey allowed the Secretary to select between two established and acceptable accounting methods by publishing a manual provision. Here, rather than selecting between two pre-existing methods, HCFA has established the standard by which all SNF-RCL exception requests are measured. The statute, however, expressly requires such standards to be established by regulation. 42 U.S.C. § 1395hh(a)(2). And, as a general matter, whenever any agency, including HCFA, establishes a new standard, it must act subject to notice and comment. See American Ambulance Services of PA, Inc. v. Sullivan, 911 F.2d 901, 907 (3d Cir. 1990); American Hospital Association v. Bowen, 834 F.2d 1037, 1046-47 (D.C. Cir. 1987). Accordingly, HCFA was obligated to establish the SNF-RCL exception standards through notice and comment, but it failed to do so. Therefore, the SNF-RCL exception methodology is illegal and cannot be applied to limit a provider's exception relief.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA's decision limiting the amount of the Provider's exceptions to the SNF cost limits is proper.

The Intermediary contends that, contrary to the Provider's assertions, HCFA's methodology for determining the amount of HB-SNF exceptions as put fourth in Transmittal No. 378 (HCFA Pub. 15-1 § 2534.5) is a reasonable interpretation of the RCL statute and regulation.[12] The Provider's primary challenge is that the exception methodology is inconsistent with the statute and regulation because HB-SNFs that qualify for an exception under 42 U.S.C. § 1395yy(a) are entitled to be reimbursed for the full difference between their allowable costs and the statutory limit. In response, however, it is important to note that both the statute and regulation are silent with respect to the exact methodology that should be employed in recognizing exceptions to the cost limits for HB-SNFs. Therefore, the Secretary enacted HCFA Pub. 15-1 § 2534.5, which reasonably implements both the statute and regulation as well as Congress' concerns in establishing a two-tiered system of cost limits. 42 U.S.C. § 1395yy(a).

---

[11] Provider Position Paper at 34.

[12] Intermediary Position Paper dated August 27, 1999 at 22.

Clearly, the instructions contained in HCFA Pub. 15-1 § 2534.5 do not conflict with the Medicare Act as the statute does not prescribe or even require any particular exceptions methodology. Instead, the statute simply states that the Secretary "may" make adjustments, and "to the extent the Secretary deems appropriate[.]" 42 U.S.C. § 1395yy(c). This language constitutes an explicit mandate to the Secretary to administratively define what reimbursement is due under the Medicare program. Moreover, given the breadth and generality of that mandate, the Secretary must be accorded the broadest possible discretion in implementing the statute, and her interpretation may be set aside only if arbitrary, capricious or manifestly contrary to the law. Heckler v. Campbell, 461 U.S. 458, 466 (1983); Chevron USA. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 843-844 (1984). Also, deference is all the more warranted where, as here, the question of interpretation arises under "a complex and highly technical regulatory program," in which the identification and classification of relevant criteria require significant expertise, and entail the exercise of judgment grounded in policy concerns." Pauley v. BethEngery Mines, Inc., 501 U.S. 680, 697 (1991); accord. , University of Cincinnati v. Heckler, 731 F.2d 1171, 1173-1174 (6th. Cir. 1984)(deference appropriate "especially in areas like Medicare reimbursements").

The RCL regulation is also plainly ambiguous with respect to the calculation of an exception to the statutory limits. Provisions at 42 C.F.R. § 413.30(f)(1) explain that a provider "may" qualify for an exception if it can show that its costs exceed the applicable limit "because" it provides "items or services" that are atypical in nature and scope "compared to the items or services generally furnished by providers similarly classified." Id. This language simply establishes a means of qualifying for an upward exception, but it does not address the amount of the exception that should be recognized.

Also, and most fundamentally, the Provider ignores the issues posed by Congress' creation of a unique two-tiered system of SNF cost limits in recognition of the fact that the prevailing higher costs of HB-SNFs in comparison to FS-SNFs cannot be fully justified.[13] How the exceptions process should be implemented in light of that two-tiered system is not addressed by the regulation. HCFA's exception methodology, as applied to the current appeals and the issuance of HCFA Pub. 15-1 § 2534.5 is, however, a reasonable response to the foregoing issues left unanswered by the statute and regulation and, most importantly, to the unique manner in which the cost limit for HB-SNFs was constructed.

The Intermediary also contends, contrary to the Provider's arguments, that Congress determined the so called "gap costs" to be unreasonable.[14] Cost limits implemented by the Secretary have traditionally been constructed by reference to a peer group. They are based on the assumption that costs generally incurred by the group are reasonable and are at least a roughly accurate measure of the costs that must be incurred by even efficient providers in furnishing services. In this vein, Congress set the cost limits for FS-SNFs at 112 percent of the peer group mean per diem costs, and all of the costs of a FS-SNF that are within this range are reimbursable. For this reason, in evaluating exception requests for FS-SNFs, there is no reason to make any downward adjustment for costs that are within 112 percent of

---

[13] Intermediary Position Paper dated August 27, 1999 at 24.

[14] Intermediary Position Paper dated August 27, 1999 at 25.

the peer group mean because all of such costs are presumed to be reasonable. The same, however, is not true for HB-SNFs. That is, for this group Congress explicitly determined that the normal peer group costs, 112 percent of the peer group mean, were not reasonable but included unjustified costs presumed to be due to inefficiencies on the part of HB-SNFs as compared to FS-SNFs. Congress also quantified the amount of costs that could not be justified. Such costs were equal to 50 percent of the difference between the cost limit for FS-SNFs and 112 percent of the peer group mean for HB--SNFs. Therefore, this 50 percent of the difference between costs for the two groups of SNFs, the gap, measures the costs generally occurring within the peer group of HB-SNFs which Congress thought were unreasonable and required the creation of a two-tiered system of cost limits. 42 U.S.C. § 1395yy(a). For this reason, HCFA's exception methodology bases the threshold availability and the amount of an exception for HB-SNFs at 112 percent of the peer group mean.

The Intermediary maintains that the reasonableness of HCFA's exception methodology and its operational effect can also be seen from another perspective.[15] In general, the Medicare program presumes that costs generally borne by a peer group of providers reasonably measures the cost of efficiently providing services. Therefore, it makes sense to treat as presumptively reasonable those costs that are true for most providers, i.e., costs within the 112 percent level of the peer group mean. However, Congress recognized that this generalization simply did not hold for HB-SNFs and for that reason subjected the 112 percent of the peer group mean to a discount factor equal to 50 percent of the difference in costs between HB and FS-SNFs. Because the normally prevailing reimbursement amount, i.e., the 112 level, is discounted by this factor to arrive at costs that are considered reasonable, it is reasonable to similarly adjust downward the requests for even higher reimbursement requested by some providers. It is unreasonable for an individual HB-SNF to compare all of its costs against this lowered line for purposes of receiving additional reimbursement through the exception process.

Similarly, the Intermediary rejects the Provider's argument that HCFA's exception methodology confuses the concepts of atypical costs and that of atypical services.[16] The Intermediary asserts that there is nothing in the RCL statute or regulation which prohibits HCFA from using total costs and a peer group comparison as a measure or proxy for both the reasonableness of a provider's costs and the atypical nature of its items or services. If a HB-SNF can establish that its costs are reasonable and atypical in relation to its peer group, the provider then has the opportunity to demonstrate that its atypical costs are related to the special needs of its patients. Therefore, if a provider is furnishing items or services that are truly atypical "in nature and scope" as compared to its peers, thereby adding to that provider's costs, one would expect to see that provider's costs exceeding those of its peers. Conversely, if a provider's costs are in fact not unusual compared to its peers, there is little reason to find that the provider has furnished items or services that are atypical in "nature and scope" calling for additional reimbursement. Clearly, such an approach does not fatally blur the concept of atypical costs and the concept of atypical services. What the Provider ignores is that a strict separation between these two concepts is neither desirable nor required. That is, because the cost data available to HCFA,

---

[15] Intermediary Position Paper dated August 27, 1999 at 30.

[16] Intermediary Position Paper dated August 27, 1999 at 31.

and from which both the cost limits and peer group costs were constructed, include both atypical and typical services and their attendant costs. Thus, in constructing the 112 percent of the peer group mean, HCFA used an average of all HB-SNFs' costs based upon their as-filed cost reports, which included all costs regardless of whether or not they might be deemed typical or atypical. For this reason, both the cost limit and the 112 percent of the peer group mean already include and reflect the cost of atypical services furnished by providers, and thus may be used to measure the degree by which an individual provider furnishes atypical services relative to its peers.

The Intermediary believes its position regarding this matter is supported by the fact that Congress has revisited SNF reimbursement since the enactment of HCFA's exception methodology and has not expressed disagreement with the Secretary's administration of the statute.[17] Rather, Congress enacted further amendments designed to contain costs and to further reduce systemic and categorical differences in reimbursement between FS and HB-SNFs.[18]

The Intermediary also rejects the Provider's assertions that HCFA's exception methodology leads to unsound results.[19] The Provider relies on the Board's decision in St. Francis, as follows:

> HCFA's methodology does not produce sound results. In the case where a HB-SNF qualifies for an exception, it is reimbursed only for the amount that its costs exceed the 112 percent level. The provider is not reimbursed for the amount that its costs exceed the cost limit up to the 112 percent level because this portion of costs, the gap, is considered unreasonable. The Board disagrees with the concept that costs are considered unreasonable once they exceed the cost limit but become reasonable again once they exceed the even greater 112 percent level.
>
> The Board does not believe that Congress intended each and every HB-SNF that furnishes atypical services to bear a financial loss up to the difference between the cost limit and the 112 percent level.

St. Francis. Medicare & Medicaid Guide (CCH) ¶ 45,159.

The Intermediary asserts, however, that the Board's reasoning as stated in these passages is misleading. Specifically, Congress concluded that HB-SNFs have higher costs than FS-SNFs, which are not justified. Therefore, Congress subjected the cost limit for HB-SNFs to a discount factor equal to 50 percent of the difference between the cost limit for FS-SNFs and 112 percent of the peer group mean for HB-SNFs. Rather than allowing HB-SNFs to compare their unadjusted actual costs to this

---

[17] Intermediary Position Paper dated August 27, 1999 at 33.

[18] Intermediary Position Paper dated August 27, 1999 at 33.

[19] Intermediary Position Paper dated August 27, 1999 at 34.

discounted cost limit and to recapture the entirety of the difference, HCFA's exception methodology simply requires an individual HB-SNF's costs to be first discounted by the same discount factor to eliminate unreasonable costs before recognizing any exception amount. Accordingly, it is not the case that costs above the 112 level somehow become reasonable. Rather, the rule simply holds that a HB-SNF which has costs in excess of the cost limit after application of the discount factor has costs that are potentially reimbursable under the exceptions process because the cost limits have been exceeded even after unreasonable costs have been eliminated.

Moreover, all HB-SNFs, including those with costs above the 112 percent level and those under the 112 percent level are treated similarly by the discount factor. It is true that providers with costs under the 112 percent level are not entitled to additional reimbursement. However, it is similarly true that providers with costs above the 112 percent level receive only the amounts above that line, rather than the full difference between their costs and the statutory cost limit. In all cases, potential reimbursement is reduced by the same amount, i.e., the discount factor equal to 50 percent of the difference between FS and HB-SNFs costs.

The Intermediary notes that the majority of the Board in North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,158, modif'd. HCFA Admin., April 20, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,195 ("North Coast"), reversed the position held by the Board in St. Francis. In part, the majority of the Board stated :

> [t]he Board majority also finds that the regulation affords HCFA a two prong test in which it can compare costs and types of services. 42 C.F.R. § 413.30(f)(1). The Board majority also notes that HCFA's methodology of using of (sic) 112 percent of the hospital based peer mean group when reviewing exception requests is supported in the Program instructions. HCFA Pub. 15-1 § 2534.5B. Therefore, based on the above analysis of the statute, regulation and program instruction, the Board majority concludes it was not unreasonable for HCFA to use the 112 percent of the hospital based peer mean group when reviewing exception requests.

North Coast.

The Intermediary also rejects the Provider's argument that it is impermissible for HCFA's exception methodology to offsets amounts by which costs in certain cost categories exceed 112 percent of the peer group's mean per diem by the amount by which a provider's costs in other categories fall below the 112 percent level.[20] The Intermediary's argues that the Provider believes it should be free to keep as a profit any savings made with respect to some cost centers while receiving additional reimbursement for costs that exceed the peer group mean with respect to other cost centers. However, to the extent

---

[20] Intermediary Position Paper dated August 27, 1999 at 37.

that a provider's efficiencies reduce its total cost, the cost savings should be passed to the government since Medicare is intended only to cover a provider's reasonable costs, and not to afford any profit. 42 U.S.C. § 1395x(v)(1)(A). The Board has already affirmed the validity of an exception methodology in which unjustified excess costs in a cost center are used to reduce the amount of an atypical services exception otherwise substantiated. University of California Medical Center (San Francisco) v. Blue Cross and Blue Shield Association, PRRB Dec. No. 97-D36, March 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,151, decl'd rev. HCFA Admin., May 5, 1997.

The Intermediary also argues that there is no merit to the Provider's complaint that HB-SNFs are treated differently than FS-SNFs. Clearly, it was Congress itself which mandated such differential treatment. 42 U.S.C. §§ 1395yy(a)(1), (a)(2). A FS-SNF may receive reimbursement for all of its costs above its cost limit since Congress determined that FS-SNFs were efficiently run and were entitled to full reimbursement up to 112 percent of their peer group mean. Therefore, it is entirely rational to afford differing treatment for the two groups of SNF providers.

Finally, the Intermediary contends that HCFA's exception methodology does not violate the requirements of the APA as argued by the Provider.[21] The APA generally requires an agency to provide the public with notice of, and an opportunity to comment on, a proposed rule. 5 U.S.C. § 553(b) and (c). However, while these procedures are generally mandated for "substantive rules," they are not required for "interpretive rules." 5 U.S.C. § 553(b)(3)(A). Notably, the APA does not define either term but the Attorney General's Manual on the Administrative Procedure Act (1947) ("Attorney General's Manual") provides the following working definitions:

> Substantive rules -- rules, other than organizational or procedural under section 3(a)(1) and (2), issued by an agency pursuant to statutory authority and which implement the statute, as, for example, the proxy rules issued by the Securities and Exchange Commission pursuant to section 14 of the Securities Exchange Act of 1934 (15 U.S.C. 78n). Such rules have the force and effect of law.
>
> Interpretative rules -- rules or statements issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers.

Attorney General's Manual at 30 n.3 (1947).

The example of a substantive rule provided by the Attorney General's Manual, i.e., the proxy rules issued under the Securities Exchange Act of 1934 is an instructive rule. The cited statute forbade certain persons from giving or refraining from giving a proxy "in contravention of such rules and regulations as the Commission may prescribe." 15 U.S.C. § 78n(b). Thus, as demonstrated by the Attorney General's Manual, an agency issues substantive rules when it imposes new legal requirements

---

[21] Intermediary Position Paper dated August 27, 1999 at 39.

or restrictions pursuant to a general grant of lawmaking authority, but not when it simply interprets or clarifies ambiguities in existing statutory or regulatory terms. See American Mining Congress v. Mine Safety and Health Admin., 995 F.2d 1106, 1109 (D.C. Cir. 1993).

The Supreme Court considered the scope of the interpretive rule exception in Guernsey. At issue in Guernsey was the validity of a provision in HCFA Pub. 15-1 which identified the manner in which advance refunding losses should be treated for Part A Medicare reimbursement purposes. Like HCFA Pub. 15-1 § 2534.5, the manual provision in Guernsey "[did] not purport to be a regulation and [had] not been adopted pursuant to the notice-and-comment procedures of the [APA]" Id., at 1234.

In reviewing the challenged provision, the Court in Guernsey first determined that the Medicare statute and regulations do not dictate the precise manner in which advance refunding losses should be treated. The Court noted that while the Secretary's regulations set forth "the basic principles and methods of reimbursement," they cannot "address every conceivable question in the process of determining equitable reimbursement even though the regulations already fill some 620 pages of the Code of Federal Regulations." Id. 115 S.Ct. at 1237-1240. For that reason, the Secretary has issued interpretive rules in the manual "that advise providers how she will apply the Medicare statutes and regulations in adjudicating particular reimbursement claims." Id.115 S.Ct. at 1240. Quoting the definition of interpretive rule contained in the Attorney General's Manual, the Court went on to characterize the manual provision as a "prototypical example of an interpretive rule" issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers." Guernsey, 115 S.Ct. at 1239." The Court held that, because the manual provision did not "effect a substantive change in the regulations," Id., it was exempt from the APA requirements as an "interpretive rule". Id. In sum, like the manual provision at issue in Guernsey, HCFA Pub. 15-1 § 2534.5, which is at issue in this case, does not establish new substantive reimbursement standards. Rather, the instruction merely advises the public of the agency's position on issues which the Medicare statute and regulations do not expressly address. Specifically, while the statute and regulations authorize additional reimbursement for atypical services, they do not specify the precise method of determining whether and in what amount such additional reimbursement should be.

Issue No. 2 Fiscal Years Ended 1991 and 1992:

PROVIDER'S CONTENTIONS:

The Provider contends that HCFA's denial of its request for exceptions to the RCLs is improper. Contrary to the Intermediary's arguments, the Provider asserts that its requests were filed timely.

With respect to its 1992 cost reporting period, the Provider explains that program instructions in effect at that time allowed SNFs to submit exception requests any time up to 180 days from the date of an NPR.[22] See Exhibit P-88. And, in accordance with those instructions, the Provider argues that it submitted a timely request as part of its cost report submission to the Intermediary. As shown in Exhibit

[22] Provider Position Paper at 12.

P-9, the Provider submitted the subject cost report on September 30, 1992 and, at that time, informed the Intermediary that it sought an exception to the RCLs on the same basis and facts asserted in its then pending exception requests for its 1987 through 1990 cost reporting periods. Specifically, the Provider stated:

> Canonsburg General Hospital's Skilled Nursing Facility has applied for an exception to the 223 Routine Limits. If the exception receives a favorable decision from HCFA, it is our understanding that the exemption (sic: exception) will also be applicable to the fiscal year 92 filed cost report. The impact of a favorable decision concerning the limits is approximately $500,000.

Provider Letter dated September 30, 1992.[23]

The Provider contends that even if the above correspondence did not provide all of the information needed by the program to grant an exception to the RCLs, it could have corrected any defects had the Intermediary and/or HCFA complied with the timeliness provisions of the exception process.[24]

Specifically, the program's instructions require intermediaries to forward a provider's exception request (along with its recommendation) to HCFA within 90 days of receipt. Exhibit P-88 at 00589. HCFA is required to advise the intermediary of its decision within 180 days thereafter. This means that HCFA should have issued its decision regarding the subject request no later than July 1993, which is more than 8 months prior to the March 31, 1994 date of the Intermediary's initial NPR.

The Provider rejects the Intermediary's argument that its September 30, 1992 correspondence does not constitute an RCL exception request, i.e., because it does not provide sufficient information to support an intermediary recommendation.[25] Notably, in this type of situation the Intermediary should have requested whatever information it needed. Indeed, when confronted with a similar defect in the original exception request filed for 1989-1990, the Intermediary requested that the Provider supply additional data. Exhibit P-3 at 00034. Moreover, a HCFA employee testifying before the Board in St. Francis stated that it was HCFA's established practice to seek additional information because the prior exception process, i.e., prior to the issuance of Transmittal No. 378, did not provide sufficient guidance regarding the requisite data needed by the program. Exhibit P-121 at 00904.

The Provider contends that it has been prejudiced by HCFA's and the Intermediary's violation of the timeliness requirements in another manner.[26] Notably, the decision issued by HCFA regarding the

---

[23] See Exhibit P-9 at 00142.

[24] Provider Position Paper at 13.

[25] Provider Position Paper at 14.

[26] Provider Position Paper at 15.

Provider's exception requests for 1987 through 1990, Exhibit P-15 at 00166, clearly explains the proper methodology a provider was to follow to obtain an exception for subsequent cost reporting periods. And, had the Intermediary and HCFA acted timely with respect to its prior period requests, the Provider would have received notice of that methodology well in advance of its original NPRs for both its 1991 and 1992 cost reporting periods.

The Provider explains, for example, that it submitted its request for an exception to the RCLs for its 1987 and 1988 cost reporting periods on March 2, 1992. Therefore, based upon the timeliness requirements of the exception instructions (90 days for the Intermediary to make its recommendation and 180 days for HCFA's review), HCFA's decision would have been issued around November 27, 1992, informing the Provider of the correct exception methodology well in advance of the original NPR issued for its 1991 cost reporting period, which is dated April 22, 1993.

However, on January 3, 1994, HCFA rendered a consolidated decision addressing each of the four prior periods for which the Provider had requested an exception to the RCLs. Rather than the 270-day maximum period permitted by HCFA's exception instructions, the Intermediary and HCFA took 916 days to decide the Provider's exception request for its fiscal years ended in 1989 and 1990 that was submitted on July 1, 1991, and 672 days (more than twice the permissible period) to decide the fiscal year 1987 and 1988 request.

The Provider maintains that where a government agency's improper actions prejudice a claimant's rights, all applicable limitation periods are tolled. See Bowen v. City of New York, 106 S. Ct. 2022, 2030 (1986) (tolling limitation period because government conduct prevented plaintiffs from knowing their rights). And, where HCFA's conduct prevents timely action by a provider, the "task for the agency is conscientiously to remold the situation to approximate what it should have been initially, and thereby to avoid positions 'hardly worthy of our great government.'" Beverly Hospital v. Bowen, 872 F.2d 483, 487 (D.C. Cir. 1989).

Finally, the Provider contends that the consequences of the administrative delays in this case should not be avoided.[27] The Intermediary asserts that the Provider was aware of the 180-day regulatory limit for submitting exception requests, and was therefore obligated to continually file SNF-RCL exception requests regardless of the Intermediary's and/or HCFA's delay in processing such requests for prior years. The Provider argues, however, that HCFA often ignores statutorily mandated deadlines for processing provider requests. See C. J. Fletcher, Finding Relief From TEFRA Cost Limits, Healthcare Financial Management, March 1996 at 24 (HCFA often exceeds 180-day time period for ruling on TEFRA adjustment requests). Moreover, HCFA's witness in St. Francis admitted that HCFA often delayed ruling on SNF-RCL exception requests. See Exhibit P-121 at 00904.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider's request for an exception to the RCLs for its 1991 and

---

[27] Provider Position Paper at 18.

1992 cost reporting periods was properly denied as untimely. The initial NPR for the 1991 cost reporting period was issued on April 23, 1993, and the initial NPR for the 1992 cost reporting period was issued on March 31, 1994. The Provider's request for an exception to the RCLs for these periods was made on December 15, 1994, which is not within 180 days of the initial NPR's as required by the pertinent regulation.[28] Specifically, 42 C.F.R. § 413.30(c) states, in part:

> Provider requests regarding applicability of cost limits. A provider may request a reclassification, exception, or exemption from the cost limits imposed under this section. . . . The provider's request must be made to its fiscal intermediary within 180 days of the date on the intermediary's notice of program reimbursement. . . .

42 C.F.R. § 413.30(c)(emphasis added).

The 180-day period for timely filing cost limit requests is also set forth in HCFA Pub. 15-1 § 2531.lA, which states in part:

> SNFs must adhere to the following requirements when filing a request regarding applicability of the cost limits. Failure to follow the requirements is grounds to deny a request.
>
> 1. A written request must be filed with the Intermediary;
>
> 2. The request may be filed prior to the beginning of, during, or after the close of the affected cost reporting period. However, the request must be filed with the intermediary no later than 180 days from the date of the intermediary's notice of program reimbursement (NPR);
>
> 3. The type of request must be specified, i.e., exemption, or exception; and
>
> 4. The request must include all supporting documentation for each type of request as described in subsequent subsections.

HCFA Pub. 15-1 § 2531.1A.

---

[28] Intermediary Position Paper, CN:95-2194 at 7. See Exhibits I-4, I-5, and I-6.

The Intermediary contends that, contrary to the Provider's arguments, the Provider did not file an exception request for its 1992 cost reporting period along with the submission of that cost report.[29] Specifically, the Provider believes that language it included in a letter dated September 30, 1992, which accompanied the submission of its 1992 cost report, constitutes an RCL exception request. That language states:

> Canonsburg General Hospital's Skilled Nursing Facility has applied for an exception to the 223 Routine Limits. If the exception receives a favorable decision from HCFA, it is our understanding that the exemption (sic: exception) will also be applicable to the fiscal year 92 filed cost report. The impact of a favorable decision concerning the limits is approximately $500,000.

Provider Letter dated September 30, 1992.

The Intermediary asserts, however, that this language is not an exception request at all but merely a statement of understanding. Implicit in the Provider's statement is the unspoken caveat "provided that the Provider requested an exception for the 1992 cost reporting period and submitted all necessary supporting documentation."

Medicare regulation 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)(8) of this section, and may be adjusted upward or downward under the circumstances specified in paragraph (f)(9) 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.

42 C.F.R § 413.30(f).

Clearly, the regulation requires a provider to submit documentation in connection with each of its exception requests in order to demonstrate that costs in excess of the routine cost limits for each cost reporting period are due to facts and circumstances for which exception relief may be obtained. This regulatory requirement is also set forth in HCFA Pub. 15-1 § 2534.1. Therefore, the Provider's argument that it was effectively seeking a rollover of prior period exceptions to its 1991 and 1992 cost reporting periods is unfounded. Also, the Provider's September 30, 1992 letter should not be interpreted as a request for an interim exception. The Provider did not request anything. See HCFA Pub. 15-1 § 2534.2(c).

---

[29] Intermediary Position Paper, CN:95-2194 at 8.

Finally, the Intermediary rejects the Provider's argument that HCFA is responsible for its failure to file timely exception requests for its 1991 and 1992 cost reporting periods.[30] With respect to this argument, the Provider explains that if HCFA had issued its decisions regarding the Provider's exception requests for 1987 through 1990, timely, the Provider would have been aware of the need to submit exception requests for the subject cost reporting periods. However, HCFA's decision was not issued until January 3, 1994, which is beyond 180 days from the dates of the applicable NPRs.

However, the Provider's argument is unavailing because it was well aware of the need to file timely exception requests as prescribed by 42 C.F.R. § 413.30(c). The initial NPR's for the Provider's 1987 and 1988 cost reporting periods were issued on March 13, 1989 and January 29, 1990, respectively. The Provider did not request exceptions to the RCLs for these periods until March 2, 1992. Based upon this information, HCFA initially denied the Provider's requests due to untimely filing. This HCFA decision was issued on February 23, 1993, well before the NPRs for the Provider's 1991 and 1992 cost reporting periods were issued.[31]

Moreover, in response to HCFA's denial, on March 23, 1993, the Provider wrote to HCFA pointing out that its March 2, 1992 exception request was submitted within 180 days of revised NPR's for its 1987 and 1988 cost years.[32] Those NPR's were both dated September 5, 1991, and both decreased the otherwise applicable SNF routine cost limits. Accordingly, the Provider's 1987 and 1988 exception requests of March 2, 1992, were subsequently adjudged timely, i.e., as being submitted within 180 days of the relevant NPR and allowed in accordance with HCFA's January 3, 1994 determination. Notably, it was the Provider that alerted HCFA to the timeliness of its exception requests.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395hh et seq.	-	Regulations
§ 1395yy et seq.	-	Payment to Skilled Nursing Facilities for Routine Service Costs

[30] Intermediary's Position Paper, CN:95-2194 at 10.

[31] Exhibit I-25.

[32] Exhibit I-26.

2. Law - 5 U.S.C.:

§§ 551-553 et seq.	-	Administrative Procedure-Definitions; Public Information; Records on Individuals; Open Meetings; Rule Making

3. Law - 15 U.S.C.:

§ 78n et seq.	-	Securities Exchange-Proxies.

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.30 et seq.	-	Limitations on Reimbursable Costs

5. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2534 et seq.	-	Request for Exception to SNF Cost Limits
§2531.1A	-	Provider Requests Regarding Applicability of Cost Limits - General Requirements - SNF

6. Case Law:

Sacramento Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 80-D56, August 1, 1980, Medicare & Medicaid Guide (CCH) ¶ 30,826, rev'd. HCFA Admin., September 29, 1980, Medicare & Medicaid Guide (CCH) ¶ 30,859.

St. Francis Health Care Centre v. Community Mutual Ins. Co., PRRB Dec. No. 97-D38, March 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,159, rev'd. HCFA Admin., May 30, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,545, affirm'd. USDC, Northern District of Ohio, Western Div., July 13, 1998.

Shalala v. Guernsey Memorial Hospital, 115 S.Ct. 1232 (1995).

American Ambulance Services of PA, Inc. v. Sullivan, 911 F.2d 901 (3d Cir. 1990).

American Hospital Association v. Bowen, 834 F.2d 1037 (D.C. Cir. 1987).

Heckler V. Campbell, 461 U.S. 458 (1983).

Chevron USA. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).

Pauley v. BethEngery Mines, Inc., 501 U.S. 680 (1991).

University of Cincinnati v. Heckler, 731 F.2d 1171 (6th. Cir. 1984).

North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,158, modif'd. HCFA Admin., April 20, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,195.

University of California Medical Center (San Francisco) v. Blue Cross and Blue Shield Association, PRRB Dec. No. 97-D36, March 24, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,151, decl'd rev. HCFA Admin., May 5, 1997.

American Mining Congress v. Mine Safety and Health Admin., 995 F.2d 1106 (D.C. Cir. 1993).

Bowen v. City of New York, 106 S. Ct. 2022 (1986).

Beverly Hospital v. Bowen, 872 F.2d 483 (D.C. Cir. 1989).

Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D61, August 20, 1999.

Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D67, September 2, 1999.

7. Other:

Stipulation For A Hearing On The Record.

HCFA Transmittal No. 378.

Attorney General's Manual on the Administrative Procedure Act.

Healthcare Financial Management, March 1996.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Issue No. 1- Fiscal Years Ended 1987-1990 and 1993:

HCFA used the methodology contained in Transmittal No. 378 to determine the amount of the Provider's exception to the SNF-RCLs for each of the subject cost reporting periods. The Provider challenged the validity of this methodology based upon statutory and regulatory provisions. In general, the Provider argues that 42 U.S.C. § 1395yy(a) sets the cost limits for SNFs and, if an exception to these limits is granted, a provider is entitled to each and every dollar that its allowable costs exceed the applicable limit. The Provider concludes, therefore, that the methodology contained in Transmittal No. 378 is invalid since it does not reimburse a HB-SNF's costs between the applicable cost limit and 112 percent of the peer group mean cost. In effect, the Provider maintains that HCFA inappropriately changed the cost limits set by Congress.

The Board majority, however, finds that the methodology contained in Transmittal No. 378 is a proper interpretation of the governing laws and regulations. The Board majority agrees that 42 U.S.C. § 1395yy(a) establishes the cost limits applicable to FS and HB-SNFs. However, the Board majority notes that 42 U.S.C. § 1395yy(c) gives the Secretary broad discretion to adjust the limits. In part, the statute states:

> [t]he Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate. . . . The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

42 U.S.C. § 1395yy(c).

The Board majority finds that following the intent of 42 U.S.C. § 1395yy(c), HCFA promulgated regulations at 42 C.F.R. § 413.30 which, in part, provide for an adjustment to the cost limits where a provider furnishes atypical services as in the instant case. Provisions at 42 C.F.R. § 413.30(f)(1)(i) provide the basic rules for determining the amount of such an adjustment by explaining that the costs incurred by a provider to furnish atypical items or services are compared to the costs of items or services furnished by similarly classified providers. In this regard, the Board majority finds that Transmittal No. 378 provides the instructions for performing the required comparison.

In addition, the Board majority finds that the comparison contained in Transmittal No. 378 is a sound approach for determining the amount of HB-SNF exceptions. Notably, the Provider points out that the instructions contained in the transmittal presume all HB-SNF costs that are above the limit to be unreasonable until they reach the 112 percent per group mean per diem cost level. The assertion here is that there is no logical basis for this "gap." The Board majority, however, believes the 112 percent peer group level is a practical standard for measuring the atypical nature of a provider's services. It is the same level used to determine the amount of exceptions for FS-SNFs, and is a standard based entirely upon HB-SNF data as apposed to the HB-SNF limit which is heavily based upon FS-SNF data.

Finally, the Board acknowledges the Provider's reliance upon the previous Board's decision is St. Francis to help support its position and arguments. The Board majority in this case, however, notes that its findings and conclusions are consistent with the decisions rendered in North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18, 1999, modif'd. HCFA Administrator, April 20, 1999; Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D61, August 20, 1999; and, Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D67, September 2, 1999.

Issue No. 2- Fiscal Years Ended 1991 and 1992:

Medicare regulation 42 C.F.R. § 413.30(c) requires providers to submit RCL exception requests within 180 days of the date of an intermediary's NPR. The Intermediary determined that the Provider submitted its exception request for the subject reporting periods on December 15, 1994, which is more than 180 days from the date of the initial NPRs issued for those reporting periods.[33] In response, the Intermediary recommended that the Provider's request be denied due to untimely filing, and on March 24, 1995, HCFA concurred with the Intermediary and denied the Provider's request.

With respect to its 1992 cost reporting period, the Provider argues that December 15, 1994, was not the first time it requested an exception to the cost limits. Rather, the Provider maintains that it informed the Intermediary that it sought exception relief for its 1992 cost reporting period when it filed its Medicare cost report for that period. Specifically, the Provider asserts that the following language that was included in a letter dated September 30, 1992, and used to submit its cost report, constitutes its initial request for an exception to the RCLs:

> Canonsburg General Hospital's Skilled Nursing Facility has applied for an exception to the 223 Routine Limits. If the exception receives a favorable decision from HCFA, it is our understanding that the exemption (sic: exception) will also be applicable to the fiscal year 92 filed cost report. The impact of a favorable decision concerning the limits is approximately $500,000.

Provider Letter dated September 30, 1992.

The Board, however, finds the Provider's argument without merit. The quoted language is not a request at all but is rather a statement of understanding. Also, the explicit purpose of the letter conveying this language is the submission of a cost report. The Board does not believe this vehicle or specific piece of correspondence can be recognized as an exception request; clearly, it is not direct to the issue. The Board also finds no evidence in the record to indicate how the Provider came to believe

---

[33] The NPR for the Provider's 1991 cost reporting period was issued on April 23, 1993, and the NPR applicable to the Provider's 1992 cost reporting period was issued on March 31, 1994. See Exhibits I-4 and I-5.

an exception granted for a prior cost reporting period would automatically be applied to its 1992 cost reporting period. If such evidence were presented the Board may have been compelled to view the Provider's argument with greater weight.

The Board acknowledges the Provider's argument that had the Intermediary and HCFA acted timely with respect to its September 30,1992 letter, it would have had time to correct any noted defects and obtain the exceptions it sought. Essentially, the Provider asserts that had the Intermediary and HCFA followed the timeliness requirements of the exception process, HCFA would have issued a denial based upon its September 30, 1992 letter within 270 days of its submission, which is long before the issuance of the pertinent NPRs.[34] The Board, however, rejects this argument as well. As discussed immediately above, the Board does not find the quoted language recognizable as an exception request, therefore, the Board would not expect the Intermediary or HCFA to take any action based upon it.

With respect to both its 1991 and 1992 cost reporting periods, the Provider argues that its ability to submit timely exception requests was jeopardized by HCFA. The Provider explains that HCFA's notice regarding the exception requests it filed for fiscal years 1987 through 1990 clearly explains the methodology applicable to exception requests filed for subsequent cost reporting periods. And, had the Intermediary and HCFA acted timely with respect to these earlier requests, the Provider would have received notice of this methodology far in advance of the dates of its 1991 and 1992 NPRs.

The Board agrees with the Provider, in that, both the Intermediary and HCFA have a responsibility to comply with all program rules including all timeliness requirements which apply to them. In this regard, the Board also agrees that HCFA's response to the Provider's prior periods' requests was not issued until long after the prescribed timeliness standard. However, the Board also finds that HCFA's tardiness had no effect on the Provider's ability to file timely exception requests for its 1991 and 1992 reporting periods.

Significantly, the Board finds that the Provider was clearly aware of the 180 day deadline for filing cost limit exception requests and was experienced in doing so. As noted above, the Provider had previously prepared and submitted exception requests for its 1987 through 1990 cost reporting periods. These requests are comprehensive in nature and scope, and contain references to applicable laws and regulations.[35] Also, and importantly, through a letter sent by HCFA to the Intermediary dated February 23, 1993, the Provider was made unquestionably aware of its responsibility to submit exception requests within 180 days from the date of an NPR. Notably, HCFA's letter was issued well before the NPRs applicable to the Provider's 1991 and 1992 cost reporting periods, and specifically addresses the timeliness requirement at issue in this case.[36]

---

[34] The Provider noting that intermediaries are to make recommendations to HCFA regarding provider requests within 90 days of receipt, and HCFA is to issue its decision regarding those requests within 180 days thereafter. 42 C.F.R. § 413.30(c).

[35] See e.g., Exhibits P-3 and P-8.

[36] See Exhibits I-25 and I-26.

DECISION AND ORDER:

Issue No. 1- Fiscal Years Ended 1987-1990 and 1993

The methodology used by HCFA to determine the amount of the subject SNF exception requests is a valid interpretation of Medicare laws and regulations. HCFA's decision limiting the amount of the Provider's exceptions to the SNF routine service cost limits based upon 112 percent of the hospital-based peer group mean per diem is proper.

Issue No. 2- Fiscal Years Ended 1991 and 1992

The Provider did not file its request for an exception to the SNF routine service cost limits within 180 days from the date of the applicable NPRs as required by 42 C.F.R. 413.30. HCFA's denial of the Provider's request due to untimely filing is proper.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq. (Dissenting as to issue No.1)
Charles R. Barker

Date of Decision: December 12, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover Jr., Esquire

I respectfully dissent to Issue no. 1:

The Provider contends that it is entitled to be paid the entire amount of its costs in excess of the cost limit.

In part, 42 U.S.C. § 1395yy(a)(3) states:

> With respect to hospital based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for free standing skilled nursing facilites located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital based skilled nursing facilities located in urban areas exceed the limit for free standing skilled nursing facilities located in urban areas.

42 U.S.C. § 1395yy(a)(3).

The plain language of the statue establishes the cost limits for hospital based skilled nursing facilities located in urban areas.

The implementing regulation 42 C.F.R. §413.30(a)(2) states in part:

> HCFA may establish estimated cost limits....

This regulation appears to be, in my opinion, contrary and in conflict with the statute since the regulation grants to HCFA that which has heretofore been established.

The Board majority notes that 42 U.S.C.§1395yy(c) gives the Secretary broad discretion to adjust limits. The Board majority refers to 42 U.S.C §1395yy which states:

> [t]he Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

42 U.S.C. §1395yy(c).

It is my opinion that this section is limiting rather than discretionary since only two types of adjustments are permitted, adjustments based upon case mix or circumstance beyond the control of the facility.

It is noted that in St. Francis Health Care Center v. Community Mutual Insurance Company, PRRB Dec. No. 97-D38, dated March 24, 1997("St. Francis"), the Board found for the provider using in part the following:

> [t]he Board finds that the Provider's requests should not have been denied. HCFA's comparison of the Provider's routine service cost per diem to the 112 percent level is inconsistent with both the statute and regulation. In addition, HCFA's comparison confuses the concept of "atypical costs" with the concept of "the cost of atypical services," and produces results that are seemingly unsound.
>
> Contrary to HCFA's exception methodology, which fails to reimburse HB-SNFs for routine service costs that exceed the limit but are less than the 112 per cent level (the gap), the Board finds that 42 U.S.C. § 1395yy entitles SNFs, either freestanding or hospital-based, to be paid the full amount by which their costs exceed the applicable cost limit. In part, 42 U.S.C. §1395yy(a) states:
>
> > [t]he Secretary , in determining the amount of the payments which my be made under this title with respect to routine service costs of extended care services shall not recognize as reasonable. . . per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section. . .
>
> The Board also finds there is no authoritative basis supporting HCFA's reliance upon the 112 percent peer group per diem to determine the amount of a HB-SNFS exception. As discussed above, reliance upon the 112 percent level effectively increases the amount or level a provider's cost must exceed before it may be granted an exception. The Board finds it inappropriate for HCFA to establish and rely upon an amount greater than the limit established by Congress as it would find it inappropriate for HCFA to introduce a methodology that would effectively reduce the limits set by Congress.
>
> The Board notes that 42 C.F.R. §413.30 provides HCFA with the general authority to establish cost limits. In part, the regulation states "HCFA may establish limits on provider costs recognized as reasonable in determining program payments. . . .Id. The regulation goes on to state that "HCFA may establish estimated cost limits for direct overall costs or for costs of specific items or services. . . . Id. However, the Board finds that the cost limits applicable to SNFs are not presented in the regulations or in HCFA's manual instructions; Congress has

> superseded HCFA's authority to establish cost limits with respect to SNFs by statutorily mandating them.

St. Francis PRRB Dec. No. 97-D-38.

I concur with the findings and conclusion of the Board in the St. Francis case.

It is my opinion that the methodology used by HCFA to determine the amount of the exception from the routine service cost limits for hospital based skilled nursing facilities is not proper and the denial by HCFA of the Provider's request for full exception to the routine service cost limits should be reversed.

_____

Martin W. Hoover, Jr.