PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

2000-D11

PROVIDER -
St. Luke's Methodist Hospital - SNF
Cedar Rapids, IA

Provider No. 16-0045

vs.

INTERMEDIARY - Blue Cross and Blue Shield Association/Blue Cross and Shield of Iowa

DATE OF HEARING-
June 4, 1999

Cost Reporting Period Ended -
August 31, 1992

CASE NO. 96-0498

INDEX

ISSUE:

Was HCFA's determination denying the Provider's request for an exception to its routine cost limits for its atypical skilled nursing facility costs proper?

STATEMENT OF CASE AND PROCEDURAL HISTORY:

St. Luke's Methodist Hospital ("Provider"), which contains a 28-bed skilled nursing facility ("SNF"), is located in Cedar Rapids, Iowa. The Provider sought an exception for atypical costs from its cost limits for its fiscal year ended ("FYE") August 31, 1992.[1] The Health Care Financing Administration ("HCFA") and Blue Cross and Blue Shield of Iowa ("Intermediary") determined that the Provider was not entitled to any exception.[2] The Provider requested a Provider Reimbursement Review Board ("Board") hearing pursuant to Medicare regulations at 42 C.F.R. §§ 405.1835-.1841 and has meet the jurisdictional requirements of those regulations. The Medicare reimbursement amount is controversy is approximately $195,054. [3]

The facts in this case are not in dispute and have been stipulated to by the parties. [4] The parties agreed that the Provider had atypical costs that would otherwise qualify for an exception to the routine cost limits ("RCLs"). The parties note that HCFA and the Intermediary applied the methodology in HCFA transmittal No. 378, HCFA Pub. 15-1 § 2530 et seq., to the Provider's exception request. Under that methodology, no exception can be granted to hospital-based SNFs until their costs exceed 112 percent of their peer group mean. Since the Provider did not exceed the peer group limit, no exception was granted. The Provider asserts that exceptions should be granted from the RCLs themselves, rather than from the 112 percent peer group mean, and that the methodology, which does not reimburse providers for the difference between the RCLs and the 112 percent figure (" the gap methodology") is arbitrary, capricious, an abuse of discretion, and not in accordance with law.

The Provider was represented by Frank P. Fedor, Esquire, of Murphy, Austin, Adams and Schoenfeld, LLP. The Intermediary was represented by James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the gap methodology in HCFA Pub. 15-1 § 2534.5 is inconsistent with the regulation controlling atypical services exceptions and with the statute prohibiting cross- subsidization between Medicare and other payers. The Provider also contends the gap methodology is invalid because it was not adopted pursuant to the notice and comment rulemaking provisions of the Administrative Procedure Act ("APA"), 5 U.S.C. § 551 et seq., or as a regulation as required by statute. Finally, the Provider contends that HCFA's action in adopting the gap methodology was arbitrary, capricious, an abuse of discretion and not in accordance with law, and should therefore be overturned under other provisions of the APA.

The Provider contends that the gap methodology in HCFA Pub. 15-1 § 2534.5 violates the clear and unambiguous language of 42 C.F.R. § 413.30(f)(1) which controls atypical services exception requests. The Provider contends that according to the language of § 413.30(f)(1), the Provider must establish only three facts: (1) that the Provider's costs exceeded its RCL; (2) that these costs exceeded the RCL because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified; and (3) that the atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care. The Provider contends that HCFA has substituted a new cost threshold for the RCL in item number one which violates the regulation. The Provider points

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1 See Provider Exhibit 2.

2 See Intermediary Exhibit 2.

3 See Provider Post Hearing Brief at 1.

4 See Stipulation of Provider and Intermediary and Tr. at 7.

out that 42 C.F.R. § 413.30 focuses its language on the adjustment of limits, and not on an add-on based on exceeding a threshold higher than the limits.

Section 413.30 sets forth rules governing exemptions, exceptions, and adjustments to limits that HCFA may make in consideration of special needs or situations of particular providers. Section 413.30(f) also expressly states that atypical services exceptions are an adjustment to an RCL, and not an adjustment to some higher threshold set by HCFA. It provides the following:

> (f) 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 . . . . 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)

Subsection (f)(1) expressly states that a provider's costs must only exceed its RCL in order for it to qualify for an exception. Section 413.30(f)(1) states that the "limits" may be adjusted upwards if "[t]he provider can show that the (1) 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." The controlling regulation specifically states that the provider must only show that its cost "exceeds the applicable limit," and not that its cost exceeds 112 percent of the peer group mean.

The Provider also contends that in devising the gap methodology, HCFA has confused the concept of a peer group comparison of atypical services with the concept of a peer group comparison of atypical costs. Section 413.30 requires the peer group comparison to be made in terms of the atypical nature and scope of services, and not in terms of the atypical cost of services.

Under 42 C.F.R. § 413.30, a provider must show that the actual cost of the items and services it furnished exceeded 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." Id. The comparison to a peer group of "providers similarly classified" required by the regulation is of the "nature and scope" of the items and services actually furnished, not their cost.

The Provider points out that HCFA's Transmittal No. 378 does contain a peer group comparison that is consistent with the controlling regulation. Transmittal No. 378 has benchmarks that measure whether the provider has a lower than average length of stay, higher than average ancillary costs per day, and higher than average Medicare utilization. According to the testimony of the HCFA witness at the hearing, once a provider has established that it exceeds these benchmarks, "they have, as far as we are concerned, they have established that they are providing atypical services." [5]

The Provider contends that HCFA plainly goes beyond the language of 42 C.F.R. § 413.30(f)(1) when it states that the regulation requires a comparison of cost to a peer group. That may be an appropriate comparison for the establishment of limits, but it directly contradicts the language of 42 C.F.R. § 413.30(f)(1) when applied to the atypical services exception process. The only peer group costs to which HCFA can compare under 42 C.F.R. § 413.30(f)(1) is the RCL.

The Provider also contends that the gap methodology in HCFA Pub. 15-1 § 2534.5 violates the prohibition against cross subsidization between Medicare and other payers found in 42 U.S.C. § 1395x(v)(1)(A)(i) because it makes it impossible for any hospital-based SNF which provided atypical services whose costs exceeded its RCL, from ever obtaining reimbursement up to all of its costs.

The Provider points out that Medicare is required to reimburse providers for their reasonable costs incurred in treating Medicare beneficiaries. "Reasonable cost" is defined as only those costs "actually incurred, excluding therefrom any part of incurred cost[s] found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395x(v)(1)(A). The reasonable cost "shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be

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[5] Tr. at 92.

included, in determining such costs for various types or classes of institutions, agencies, and services." Id. The Secretary is authorized to establish appropriate cost limits as part of her method of determining reasonable costs. Id. See Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993).

The statute at 42 U.S.C. § 1395x(v)(1)(A)(i) prohibits Medicare and other payers from "cross-subsidizing" each other. It states that "[s]uch regulations shall (1) take into account both direct and indirect costs of providers of services ... in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs." 42 U.S.C. § 1395x(v)(1)(A)(i). The "no cross-subsidization" principle is further required by 42 C.F.R. §§ 413.5(a) and (b)(3) and 42 C.F.R. § 413.50.

The statute at 42 U.S.C. § 1395yy(a) establishes the definition of the RCL applicable to the Provider in this appeal. This section establishes different RCLs, sometimes referred to as "dual limits," for freestanding SNFs and for hospital-based SNFs. The RCL for freestanding SNFs is set at "112% of the mean per the routine service cost; for freestanding skilled it is set at "the limit for nursing facilities," while the Routine Cost Limit for hospital-based SNFs free standing skilled nursing facilities..., plus 50% of the amount by which 112% of the mean per diem routine service cost for hospital-based skilled nursing facilities ... exceeds the limit for freestanding skilled nursing facilities." 42 U.S.C. § 1395yy. The Provider points out that although there is no dispute that Congress established dual cost limits, § 1395yy does not qualify the clear prohibition against cross-subsidization contained in Section 1395x(v)(1)(A)(I) nor does it prohibit hospital-based SNFs from obtaining full reimbursement of reasonable costs.

The Provider points out that the RCL sets only a presumptive, and not a conclusive, limitation on the reimbursement that a provider may receive for its reasonable costs. Indeed HCFA has acknowledged and confirmed the presumptive nature of the RCLs for SNFs in HCFA Transmittal No. 378 which is at issue in this case:

> Section 1861(v)(1)(A) of the Social Security Act (the Act), as implemented in 42 C.F.R. § 413.30, authorizes the Secretary to establish limits on provider costs recognized as reasonable in determining Medicare program payment. The limits are a presumptive estimate of reasonable costs . . . .

The Provider emphasizes a Senate Print which is the only evidence of legislative intent which specifically addresses the issue before the Board. In discussing the Senate Bill that became 42 U.S.C. §1395yy, the Senate Finance Committee report, states that providers, where justified, should be able to receive "up to all of their reasonable costs" through the exception process:

> Under this provision, both hospital based and freestanding facilities could continue to apply for and receive exceptions from the cost limits in circumstances where high costs from more severe than average case mix or circumstances beyond the control of the facility. Indicators of more severe case mix include a comparatively high proportion of Medicare days to total patient days, comparatively high ancillary costs, or relatively low average length of stay for all patients (an indicator of the rehabilitative orientation of the facility). Facilities eligible for exceptions could receive, where justified up to all of their reasonable costs.

Senate Finance Committee Report, Print 98-169.

The Provider contends that the gap methodology in HCFA Pub. 15-1 § 2534.5 also violates the APA because it was not adopted pursuant to the notice and comment rulemaking procedures of 5 U.S.C. § 533. Because the "gap" methodology effects a change in the existing legal requirement contained in 42 C.F.R. § 413.30(f)(1) by requiring a provider to show that its costs exceed 112 percent of the peer group mean instead of the applicable RCL, such a change in the regulation must be made pursuant to the notice and comment provisions of 5 U.S.C. § 533. The Provider also contends that because the gap methodology in HCFA Pub. 15-1 § 2534.5 establishes or changes a substantive legal standard governing the payment for services it must be published as a regulation under the provisions of 42 U.S.C. § 1395hh(a)(2).

The Provider contends that HCFA's action in adopting the gap methodology in HCFA Pub. 15-1 § 2534.5 was arbitrary, capricious, an abuse of discretion and not in accordance with law, and should therefore be overturned under the APA.

The Provider points out that in this case HCFA's methodology is a departure from its earlier method of determining hospital-based SNF exception requests and requires an explanation for its change of direction. The Provider identifies case law which states that it is "a clear tenet of administrative law that if the agency wishes to depart from its consistent precedent it must provide a principled explanation for its change of direction." National Black Media Coalition v. FCC, 775 F.2d 342, 355 (D.C. Cir. 1985). The Provider points to the case of Motor Vehicle Manufacturers Association v. State Farm Mutual, 463 U.S. 29, 43 (1983) as identifying the standard of review:

> [t]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.' Burlington Truck Lines, Inc., v. United et al, 371 U.S. 156, 168, 9 L. Ed. 2d 207, 83 S. Ct. 239 (1962). In reviewing that explanation, we must consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.' Bowman Transportation, Inc. v. Arkansas-Best Freight System, Inc. [419 U.S. 281] at 285, 42 L. Ed. 2d 447, 95 S. Ct. 438; Citizens to Preserve Overton Park v. Volpe, [401 U.S. 402] at 416, 28 L. Ed. 2d 136, 91 S. Ct. 814. Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id.

The Provider points out that it is undisputed that HCFA's stated reason for adopting the gap methodology is its belief that it was the intent of Congress that in implementing its exception process it should not recognize the costs of hospital-based SNFs which fell within the gap. The Provider points to written discovery responses which state this as the reason for the gap methodology. The same explanation was given by the testimony of HCFA's witness at the hearing. This was also stated in HCFA is explanation in St. Francis Health Care Centre v. Community Mutual Insurance Company, HCFA Administrator, May 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,545 on the same issue. The Provider contends that HCFA's stated reason for its adoption of the "gap" methodology failed to consider the only direct evidence of the intent of Congress on this issue. The Provider again points to the aforementioned Senate Print 98-169. This document unequivocally shows that it was the intent of Congress to permit hospital-based SNFs which provide atypical services to obtain up to all of their reasonable costs.

The Provider also contends that HCFA offered an explanation for its decision that runs counter to the evidence before the agency when it illogically chose to penalize those hospital-based SNFs which treat the sickest of patients after Congress took great care to compensate the costs of hospital-based SNFs providing only typical services to sicker patients. Logically, the fact that Congress set a higher RCL for hospital-based SNFs providing only typical services in order to compensate them for the additional cost of treating sicker patients (which is precisely the conclusion that HCFA has drawn for the Deficit Reduction Act of 1984 (“DEFRA”) dual limits) would lead to the similar and parallel conclusion that those hospital-based SNFs which provide atypical services (because they treat even sicker patients than the hospital-based SNF which provides only typical services) should also receive compensation for the cost of treating these sickest of patients. Instead of following this logic, however, HCFA illogically created a reimbursement "gap" which penalizes all hospital-based SNFs which treat the sickest patients by making it impossible for them to receive compensation for all or some significant portion of the cost of providing atypical services. The Provider also contends that HCFA relied on factors which Congress clearly had not intended it to consider. HCFA states that it came up with its methodology "[i]n order to give meaning to Congress's explicit intention that 50 percent of the cost differences between hospital-based and freestanding SNFs not be reimbursed." However, Senate Print 98-169 shows that this intent of Congress applied only to hospital-based SNFs providing only typical services, and not to that minority of hospital-based SNFs which provide atypical services. HCFA could point to no statement by Congress that hospital-based SNFs which provided atypical services should uniformly be denied, as a class, from obtaining up to all of their reasonable costs. The Provider contends that HCFA took factors relied upon by Congress for one purpose (to set discriminatory cost limits taking

into account presumed additional costs in furnishing typical services for sicker patients), and used them for a second and unintended purpose, to create a discriminatory exception process for those minority of hospital-based SNFs which provide only atypical services.

The Provider also contends that HCFA's gap methodology is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. First, the Provider points out that the gap methodology of quantifying the amount of an atypical services exception from 112 percent of the peer group mean leads to the absurd result of treating the costs of atypical services more severely than the costs of typical services. The RCL discounts the last dollars of the cost to a hospital-based SNF of providing typical services; hospital-based SNFs providing only typical services are presumed to have reasonable costs "up to" the RCL. In contrast, the cost of the atypical services provided by a hospital-based SNF are treated much more severely in that the discount is applied to the first dollars of such cost. For example, a hospital-based SNF providing typical services at the RCL and atypical services at below 112 percent of the peer group mean receives no compensation for its cost of providing atypical services. In another example, a hospital-based SNF providing typical services at the RCL and atypical services at an amount above 112 percent of the peer group mean equal to the amount of the gap suffers a 50 percent discount for its cost of providing atypical services.

Second, the Provider points out that the gap methodology of quantifying the amount of an atypical services exception from 112 percent of the peer group mean leads to the absurd result of assuming that a hospital-based SNF's costs above the RCLs are unreasonable, but then become reasonable again above the higher level of 112 percent of the peer group mean. Third, the Provider points out that the gap methodology plays no role in screening out unreasonable costs. Unreasonable costs are screened out by other provisions of HCFA Transmittal No. 378 to which the Provider does not object. The Provider also contends that the gap methodology impermissibly discriminates between freestanding and hospital-based SNFs in that freestanding SNFs which provide atypical services do have an opportunity to obtain reimbursement of up to all of their reasonable costs, while no hospital-based SNF will ever be able to do so. The Provider points out that 42 U.S.C. § 1395yy(c), which gives HCFA the authority to develop and apply an exception procedure, does not articulate any express intent of Congress to discriminate between freestanding SNFs and hospital-based SNFs in the exception process. Although the statute does grant the Secretary broad discretion as to whether or not to make adjustments to the limits, and as to the appropriate extent of the adjustments made, it nowhere permits the Secretary to discriminate against hospital-based SNFs. The Provider cites Addison v. Holly Hill Fruit Products, 322 U.S. 607 (1944) in support of its conclusion that such discrimination is arbitrary, capricious, an abuse of discretion and not in accordance with law.

INTERMEDIARY'S CONTENTIONS:

The Medicare program reimburses SNFs for the reasonable cost of covered services provided to Medicare beneficiaries. 42 C.F.R. § 413.9. Costs of routine services are limited by the RCLs. Cost limits for free-standing and hospital-based SNFs were established in the DEFRA. DEFRA established cost limits for SNFs based on four classifications: urban; rural; free-standing; and hospital-based. Under provisions of the statute, the cost limits for free standing facilities were set at 112 percent of the mean per diem routine service costs of free-standing SNFs by urban and rural location. The cost limit for hospital-based SNFs was set at the free-standing limit plus 50 percent of the difference between the free-standing limit and 112 percent of the mean per diem routine service cost of hospital-based SNF's. The Intermediary pointed out that the statute goes on to grant an extraordinary amount of authority to the Secretary to make adjustments to the cost limits based upon case mix or circumstances beyond the control of the Provider.

In 1994, HCFA issued Transmittal 378, HCFA Pub. 15-1 § 2534.5, an interpretive guideline that set out the methodology to be used in reviewing requests for exceptions to the RCLs. The methodology seeks to compare providers seeking exceptions to the RCLs to other similarly classified providers. The cost limit for hospital-based SNFs would not provide such a comparison because the figure is based on 112 percent of the free-standing SNF mean cost. As a result, the methodology developed a peer group of similarly classified providers. The peer group average per diem cost is 112 percent of the hospital-based mean cost. The rationale for the development of the peer group per diem was found in a report entitled, Study of the Skilled Nursing Facility Benefit Under Medicare, HCFA, January 1985,[6] prepared for Congress by the Secretary of Health and Human Services. That

[6] See Provider Exhibit 31.

report studied the differences in costs of free-standing versus hospital-based SNFs. The report concluded that case mix difference accounted for approximately 50 percent of the difference in costs between hospital-based and freestanding facilities. The remaining 50 percent difference in cost related to such things as provider inefficiency, facility characteristics, and overhead allocations. The Secretary's conclusion was supported by three separate studies described in the report. HCFA has interpreted Congress' action in establishing the hospital-based cost limit as acceptance of the finding in the Secretary's report. That is, setting the hospital-based cost limit at the free-standing limit plus 50 percent of the difference between the free-standing limit and the 112 percent of the mean hospital-based routine service costs, thus recognizing that half of the difference between the free-standing and hospital-based cost may be the result of case mix differences. However, the other 50 percent of the difference represents costs which are unreasonable and should not be reimbursed. This results in the reimbursement gap referred to by the Provider; an amount that a hospital-based facility can never be reimbursed even if it can establish that it exceeded the RCLs because of provision of atypical services. The Intermediary's witness noted that the results of the Secretary's report were communicated to Congress before enactment of DEFRA.[7] HCFA maintains that there was agreement on the part of Congress that the "reimbursement gap"' represents inefficiencies that should not be reimbursed by the Medicare program.

The Intermediary cites St. Francis Health Care Center v. Shalala, 10 F. Supp. 2nd 887 (N.D.Oh. 1998), in which the District Court reviewed and affirmed the application of Transmittal 378 under similar facts. In reviewing the disallowance of the gap amount, the court stated "the two-tier reimbursement system enacted by Congress implicitly recognized that certain systemic inefficiencies, which inefficiencies are associated with unreasonable costs, are associated with HB-SNFs. The Secretary's interpretive guideline does nothing more or less than to incorporate that recognition." Id. at 892. The court went on to find that HCFA PUB. 15-1 § 2534.5, contained in Transmittal 378, "is interpretive, rather than a substantive rule . . . and therefore not subject to the notice and comment requirements outlined in the Administrative Procedure Act, 5 U.S. C. § 553." Id. at 894. The District Court concluded that HCFA Pub. 15-1 § 2534.5 is a valid interpretation of the statutes and regulations governing reimbursement to Medicare providers. See Id. at 894.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395hh(a)(2)	-	Regulations
§ 1395yy et seq.	-	Payment for SNFs for Routine Service Costs

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.5	-	Cost Reimbursement: General
§ 413.9	-	Costs Related to Patient Care
§ 413.30 et seq.	-	Limitations of Reasonable Costs
§ 413.50	-	Apportionment of Allowable Costs

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

§ 2530 et seq.	-	Inpatient Routine Service Cost Limits for SNFs
(Transmittal No. 378, July 1994)		

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[7] Tr. at 85.

4. Cases:

Addison v. Holly Hill Fruit Products, 322 U.S. 607 (1944).

Bowman Transportation, Inc. v. Arkansas-Best Freight System, Inc. 419 U.S. 281 (1974)

Burlington Truck Lines, Inc., v. United et al, 371 U.S. 156 (1962).

Citizens to Preserve Overton Park v. Volpg, 401 U.S. 402 (1970)

Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993).

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

Motor Vehicle Manufacturers Association v. State Farm Mutual, 463 U.S. 29 (1983).

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

North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18, 1999, modif'd, HCFA Administrator, April 15, 1999.

St. Francis Health Care Center v. Community Mutual Health Insurance Company, HCFA Administrator, May 30, 1997, Medicare & Medicaid Guide (CCH) ¶45,545, aff'd sub nom., St. Francis Health Care Center v. Shalala, 10 F. Supp. 2d 887 (N.D.Oh.1998).

5. Other:

5 U.S.C. § 551 et seq. - Administrative Procedure Act

Deficit Reduction Act of 1984, § 2319.

Senate Finance Committee Report accompanying Public Law 92-603, Print 98-169.

Study of the Skilled Nursing Facility Benefit Under Medicare, HCFA, January 1985.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post hearing brief, finds and concludes as follows:

The Board majority notes that the parties have stipulated that the Provider's atypical costs would be allowable except for the fact that the Provider's costs do not exceed the 112 percent peer group mean limit established by HCFA in its Transmittal 378, HCFA Pub. 15-1 § 2534.5B. Since the Intermediary has properly applied the rules, the only issue in the instant case is whether the HCFA gap methodology was invalid for other reasons.

The Board majority finds that the methodology contained in HCFA 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 free-standing and hospital-based 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 a provider's actual costs are compared to the items or services furnished by similarly classified providers. In this regard, the Board majority finds that HCFA Transmittal No. 378 provides the instructions for performing the required comparison.

In addition, the Board majority finds the comparison contained in HCFA Transmittal No. 378 to be a sound approach for determining the amount of HB-SNF exceptions, and rejects the Provider's argument that such an approach is unreasonable. In particular, the Provider points out that the instructions contained in HCFA Transmittal No. 378 presume all hospital-based SNF costs that are above the limit to be unreasonable until they reach the 112 percent per group mean per diem cost level. The Provider asserts 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 freestanding SNFs, and is a standard based entirely upon hospital-based SNF data as opposed to the hospital-based SNF limit which is heavily based upon freestanding SNF data.
Finally, the Board majority acknowledges the Provider's reliance upon the previous Board's decision is St. Francis, supra, to help support its position and arguments. The majority of this Board notes that its findings are consistent with the decisions rendered by a majority of the board 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 15, 1999 and Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Case no. 99-D61, August 20, 1999.

DECISION AND ORDER:

The methodology contained in HCFA Transmittal No. 378 for determining the amount of an exception to the routine service cost limits is a proper interpretation of Medicare laws and regulations. The Intermediary should use this methodology to determine the amount of exceptions, as applicable.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire (dissenting opinion)
Charles R. Barker

Date of Decision: December 14, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover Jr., Esquire

I respectfully dissent:

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 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 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 statute establishes the cost limits for hospital based skilled nursing facilities located in urban areas.

The implementing regulation 42 CFR § 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 finds that 42 U.S.C. §1395yy(c)of the statute gives the Secretary broad discretion to adjust limits. The Board majority refers to 42 U.S.C. § 1395yy(c) 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.

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, 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 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 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 . . .
>
> 42 U.S.C. § 1395yy(a).
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> 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-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.
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> 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-D38.

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