PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D54

PROVIDER –
Centennial Medical Center – SNF
Nashville, TN

Provider No. 44-0161

vs.

INTERMEDIARY –
Blue Cross/Blue Shield Association/
Riverbend Government Benefits
Administrators

DATE OF HEARING-
August 15, 2001

Cost Reporting Period Ended -
December 31, 1993

CASE NO. 97-1736

INDEX

	Page No.
Issue	**2**
Statement of the Case and Procedural History	**2**
Provider's Contentions	**2**
Intermediary's Contentions	**6**
Citation of Law, Regulations & Program Instructions	**7**
Findings of Fact, Conclusions of Law and Discussion	**8**
Decision and Order	**10**

ISSUE

Was the decision of the Health Care Financing Administration (AHCFA@), pursuant to its Provider Reimbursement Manual (APRM@) ' 2534.5, to deny an exception for that portion of the Provider=s per diem costs which exceed the Routine Cost Limit, but which do not exceed 112% of the total peer group mean cost, arbitrary, caprious, an abuse of discretion or not in accordance with law?[1]

FACTS:

Centennial Medical Center-SNF ("Provider") is a 395 bed, general, short-term, proprietary hospital-based skilled nursing facility, located in Nashville, Tennessee. The Provider is owned and operated by Columbia/HCA Healthcare Corporation. It was licensed for 25 beds during the fiscal year at issue. Average occupancy for this period was 85.0%, with 87.9% Medicare utilization.

The Provider's routine costs exceeded the revised Routine Cost Limit by $115.88. The Provider requested an exception based on atypical services using HCFA's standard criteria of low average length of stay, high Medicare utilization, and high ancillary costs. The exception was requested under 42 C.F.R. '413.30 et seq. for atypical services in accordance with HCFA Pub. 15-1 ' 2530 et seq. Riverbend Government Benefits Administrator ("Intermediary") approved an exception in the amount of $50.86 per day for FYE 12-31- 93. The Intermediary granted an exception only to the extent that the Provider=s total actual per diem cost exceeded 112% of the total peer group mean cost.

The Provider disagreed with the method of calculating the per diem exception and requested a hearing before the Provider Reimbursement Review Board (ABoard@). The Board accepted jurisdiction of the case in compliance with the regulation at 42 C.F.R. ' 1835.1841. The amount of Medicare reimbursement in contention is approximately $ 123,169.

The Provider was represented by Frank Fedor, Esq. of Murphy Austin Adams & Schoenfeld, LLP. The Intermediary was represented by Bernard Talbert, Esq. of the Blue Cross and Blue Shield Association.

PROVIDERS CONTENTIONS:

The Provider argues that HCFA's measurement of an exception to the cost limits for hospital based SNF's from 112% of the mean hospital-based inpatient routine service costs, instead of from the hospital based SNF routine cost limit, is arbitrary, capricious and not in accordance with the law. The Provider contends that its adjusted per diem cost was $248.46. The Intermediary did not award the full amount of the exception request for atypical services to the extent that the Provider's costs did not

---

[1] This issue is commonly referred to as the Agap@ issue.

exceed 112% of the peer group mean of $165.27 per diem. By this refusal to allow an exception request for the amount between the Routine Cost Limit of $132.58 per day and the adjusted per diem cost of $248.46, solely because that part of the actual cost did not exceed 112% of the peer group mean of $165.27, HCFA created a reimbursement gap of efficiently incurred and reasonable costs that qualify for allowance as an exception, but for which HCFA will not pay.

The Provider argues that Routine Cost Limits are presumptive, and not conclusive, limits on reimbursement. The law requires the opportunity to prove an entitlement to full compensation through exception requests established by the Secretary. The Provider argues that "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 included, in determining such costs for various types or classes of institutions, agencies, and services." Id., (emphasis added).

The Provider contends that the regulations promulgated by the Secretary to implement the Routine Cost Limit, permit exceptions, exemptions, and adjustments to the limit. The United States Supreme Court has in part relied on the existence of these exceptions, exemptions, and adjustments in limiting a provider's right to contest the Secretary's method of cost reimbursement. HCFA has also acknowledged and confirmed the presumptive nature of the Routine Cost Limits for SNFs in July, 1994 in HCFA Pub.15-1 '2530 et seq. Not only are the Routine Cost Limits merely a presumptive limitation on reimbursement, but they also contemplate the right of a provider to receive full compensation for its reasonable costs incurred if the provider qualifies within one of the exceptions established by the Secretary. The Provider argues that the mere fact that Congress saw fit to set the Routine Cost Limit for hospital-based SNFs below 112% of the mean per diem routine service costs does not give HCFA the authority to arbitrarily raise, to a level above this legislatively set cost limit, the point from which an exception will be measured, thereby making it impossible for a provider to obtain full relief. This distinction between Congress's authority to set an arbitrary cost limit and HCFA's responsibility to follow the requirements of the APA in implementing the direction of Congress that exception requests to such limits be granted was recognized in University of Cincinnati.d/b/a University Hospital v. Shalala, No. C-1-93-841 (S.D. Oh. Nov. 8, 1994), Medicare and Medicaid Guide ("CCH") & 42,976.

The Provider maintains that HCFA's conclusion that the maximum amount available for an exception is the amount by which actual costs exceed 112% of the peer group mean, rather than the amount by which actual costs exceed the Routine Cost Limit, is an unlawful attempt to repeal this statutory safety valve. If costs, otherwise proven to be reasonable, are still not reimbursed because of HCFA's "gap," then the cross-subsidization expressly prohibited by 42 U.S.C. ' 1395x(v)(1)(A)(i) will occur, and the opportunity for full compensation contemplated by 42 U.S.C. ' 1395yy will be frustrated.

The Provider argues that the regulation defining exception requests states that an exception request is measured from the routine cost limit, and not from some higher undisclosed and unpublished threshold

created by HCFA. The reimbursement gap created by HCFA is nowhere contained in and is wholly inconsistent with HCFA's regulations. The regulation at 42 C.F.R. ' 413.30 "sets forth rules governing exemptions, exceptions, and adjustments to limits established under this section that HCFA may make as appropriate in consideration of special needs or situations of particular providers," Also, 42 C.F.R. ' 413.30 et seq. shows that an exception is an adjustment to a Routine Cost Limit, and not an adjustment to some higher threshold concocted by HCFA.

The Provider points out that 42 C.F.R, ' 413.30 et seq. addressing an exception for atypical services, specifically identifies one of these circumstances as the provider showing that the "[a]ctual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope. . . ." (Emphasis added). Here the controlling regulation specifically states that a provider must show that its cost only exceeds the applicable limit and not that it exceeds 112% of the peer group mean.

The Provider maintains that pursuant to 42 U.S.C. ' 1395oo(f)(1), HCFA's action in adopting its methodology of quantifying the amount of an atypical services exception for a hospital-based SNF from 112% of the peer group mean is governed by the provisions of the Administrative Procedures Act (AAPA@), 5 U.S.C. '701 et seq. The APA empowers a reviewing court to overturn agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. '706(a)(A). "The scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of the agency." Motor Veh. Mfrs. Assn. V. State Farm Mut. 463 U.S. 29,43 (1983). 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. Under the methodology in effect before the implementation of HCFA's Pub. 15 Chapter 25 methodology, the amount of the exception granted was not artificially discounted by a "gap" which makes it impossible for a hospital-based SNF to recover a significant portion of its cost of providing atypical services. The new HCFA Pub. 15, Chapter 25 methodology drastically reduces the amount of an exception that a hospital-based SNF can obtain for providing atypical services in the order of $30 to $60 per patient day.

The Provider contends that HCFA failed to consider, and offered an explanation that runs directly counter to, the only direct evidence of the intent of Congress on the issue. HCFA missed or ignored the only piece of legislative history that speaks directly to the intent of Congress on the precise issue before the Board. In doing so, HCFA's behavior comes squarely within two of the situations which State Farm identified as normally making an agency rule arbitrary and capricious: (1) HCFA entirely failed to consider an important aspect of the problem, and (2) HCFA offered an explanation for its decision that runs counter to the evidence before the agency. The Provider contends that HCFA Pub. 15-1 Chapter 25 methodology of quantifying the amount of a hospital-based SNF's atypical services exception from 112% of the peer group mean is in direct contravention to the unambiguous intent of Congress expressed in the legislative history of DEFRA '84 (which created the dual limits) that hospital-based SNFs could receive up to all of their costs through an exception process for higher costs that result from more severe than average case mix.

The Provider argues that HCFA's policy impermissibly discriminates in favor of freestanding SNFs and against hospital-based SNFs. This discrimination goes beyond the discretionary authority that Congress delegated to the Secretary of Health and Human Services. Freestanding SNFs measure their exceptions from the Routine Cost Limit; hospital-based SNFs must measure their exceptions from 112% of the peer group mean, creating the "gap" between their Routine Cost Limit and their 112% peer group mean. Freestanding SNFs can therefore recover up to all of their reasonable costs while hospital-based SNFs cannot.

The Provider contends that the Ohio District Court in St. Francis Health Care Centre v. Shalala No. 3:97 CV 7559, (N. D. Oh.) Medicare and Medicaid Guide "(CCH") & 300,026, chose not to address whether HCFA had provided a principled explanation for its change of exception methodology. It therefore also did not consider the implications of HCFA's failure to consider the only direct evidence of the intent of Congress on the issue and the logical inconsistencies of HCFA's explanation.

The Provider contends that the provisions of HCFA Pub. 15-1 '2534 et seq. that require an exception for a hospital based SNF to be measured from 112% of the peer group mean rather than from the routine cost limit are invalid because they have not been adopted pursuant to notice and comment rulemaking as required by the APA and/or have not been adopted as a regulation.

The Provider points out that The Administrative Procedure Act (APA), U.S.C. '' 500-576 requires that when a policy acts as a substantive rule and alters an existing regulatory scheme, the Secretary must adopt that policy according to procedures set forth in the APA. These procedures, contained in 5 U.S.C. '553, are commonly called "notice and comment rulemaking" procedures. Mt. Diablo Hosp. Dist. v. Bowen, 860 F .2d 951, 956 (9th Cir .1988). The Provider contends that the issue in this case is whether HCFA Pub. 15-1 ' 2534 et seq. is an interpretive rule, and thus exempt from the notice and comment rulemaking procedures, or whether it is a substantive rule, and thus subject to the notice and comment rulemaking requirements of '553. The Provider further argues that HCFA Pub. 15-1 '2534 et seq. is clearly a substantive rule because it effects a change in existing law and policy. First, it is inconsistent with, and thus effects a change in, existing law articulated in applicable regulations and statutes. Second, it carves out an exception to HCFA's pre-existing practice and methodology for measuring the amount of an exception request for a hospital-based SNF.

The Provider contends that HCFA Pub. 15-1 ' 2534.5 is invalid as it violates 42 U.S.C. ' 1395hh(a)(2), which states in part: "No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (l)." Id.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it is following HCFA instructions when using 112% of the mean hospital-based inpatient routine service costs rather than the Routine Cost Limit in the determination of the Provider's cost limit exception. HCFA Pub. 15-1 ' 2534 et seq states: "For each hospital-based

group with cost reporting periods beginning on or after July 1, 1984, the ratio is applied to 112 percent of the group's mean per diem cost (not the cost limit)..." Id.

The Intermediary maintains that its calculation of the Routine Cost Limit exception is also supported by North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18,1999, Medicare and Medicaid Guide ("CCH") & 80,158. In that case, as well as the instant case, the Provider challenges HCFA's use of the 112 percent of the peer mean group rate as the "limit" and not the RCL as the "limit" as defined in the regulations. The Board majority noted that:

> "HCFA's methodology of using 112 percent of the hospital based peer mean group when reviewing exception requests is supported in the Program instructions. HCFA Pub. 15-1, Section 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."

Id. North Coast was affirmed by the HCFA Administrator in his decision issued April 20, 1999.

The Intermediary disagrees with the Provider's argument that the provisions of HCFA Pub. 15-1 ' 2534 et seq. are invalid because they have not been adopted pursuant to notice and comment rule making as required by the Administrative Procedures Act and/or have not been adopted as regulation. This point was unsuccessfully argued in the U.S. District Court case of St. Francis Health Care Centre v. Shalala. The court's decision issued on July 13, 1998, stated the following:

> . ..Plaintiff argues that PRM Section 2534.5 is void because it was not adopted pursuant to the notice and comment procedures outlined in the Administrative Procedures Act, 5 U.S.C. Section 553(b). Federal agencies are ordinarily required to provide notice and an opportunity for comment before adopting new substantive rules, but notice and comment are not necessary when the agency issues ›interpretive rules, general statements of policy, or rules of agency organization, procedure, or practice... An interpretive rule is one " 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 finds that PRM Section 2534.5 is an interpretive, rather than a substantive rule. The guideline is a colorable interpretation of the statute and regulations, and no showing has been made that PRM Section 2534.5 effected a legislative change in the agency's regulations. ..Since it is an interpretive rule, it is not subject to the notice and comment provisions of the Administrative Procedures Act. The Secretary's failure to comply with the provisions does not, therefore, render the rule void.

Id.

CITATION OF LAW. REGULATIONS AND PROGRAM INSTRUCTIONS:

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

' 1395hh(a)(2)	-	Regulations
' 1395oo(f)(I)	-	Board
' 1395x(v)(1)(A)(i)	-	Reasonable cost
' 1395x(v)(1)(A)	-	Reasonable cost
' 1395yy	-	Payment to Skilled Nursing facilities for routine service costs

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

' 500-576	-	Administrative Procedures Act
' 553	-	Rule making
'701et seq.	-	Administrative Procedures Act
' 706(a)(A)	-	Administrative Procedures Act

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

'' 405.1835-.1841	-	Board Jurisdiction
' 413.30 et seq.	-	Limitation on reasonable cost

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

' 2530 et seq.	-	Inpatient Routine Service Cost Limits for Skilled Nursing facilities
' 2534 et seq.	-	Determination of Reasonable Costs in Excess of Cost Limit or 112 Percent of Mean Cost

5. Case Law:

St. Francis Health Care Center v. Community Mutual Insurance Company, PRRB Dec. No 97-D38, March 24,1997, Medicare and Medicaid Guide (CCH) **&** 45,159, HCFA Administrator, May 30,1997, Medicare and Medicaid Guide (CCH) **&**45,545, St. Francis Health Care Center v. Shalala, Case No. 3:97 CV 7559 (N.D. Ohio) Medicare and Medicaid Guide (CCH) **&**300,026.

North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18,1999, Medicare and Medicaid guide (CCH) &80,158, mod:d HCFA Administrator, April 15, 1999, Medicare and Medicaid Guide (CCH) & 80,195.

University of Cincinnati. d/b/a University Hospital v. Shalala, U.S. District Court for the Southern District of Ohio, Western Division, C-1-93-841, Nov. 8, 1994, Medicare and Medicaid Guide (CCH) & 42,976.

Motor Veh. Mfrs. Assn. V. State Farm Mut., 463 U.S. 29 (1983).

Mt. Diablo Hospital Dist. v. Bowen, 860 F.2d 951 (9th Cir.1988).

San Joaquin Community Hospital-SNF (Bakersfield. CA.) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 2001-D17, April 17, 2001, Medicare and Medicaid Guide (CCH) & 80,654.

Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D61, August 20,1999, Medicare and Medicaid Guide (CCH) & 80,320.

Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D-97, September 2,1999, Medicare and Medicaid Guide (CCH) & 80,311.

New England Rehabilitation Hospital v. C&S Administrative Services, PRRB Case No. 2000-D53, May 11, 2000, Medicare and Medicaid Guide (CCH), &80,443.

FINDINGS OF FACT. CONCLUSIONS OF LAW. AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented finds and concludes that HCFA's methodology for measuring the entitlement of hospital-based SNFs to exception relief under 42 C.F.R. 413.30 et seq. was proper.

The Board finds that the methodology applied by HCFA in denying the Provider's exception request was an appropriate application of policy in accordance with the statutory and regulatory provisions set forth under 42 U.S.C. ' 1395yy and 42 C.F.R. ' 413.30 et seq. Pursuant to DEFRA of 1984, the Secretary was given broad discretion in authorizing adjustments to the RCLs. The Board finds that Section (c) of the statute gives HCFA great flexibility in setting limits stating as follows:

> [t]he Secretary may make adjustments in the limits set forth in subsection (a) of this section 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)

Id.

Consistent with the foregoing statute and the reasonable cost provisions of 42 U.S.C. '1395x(v)(1)(A), the regulations at 42 C.F.R. ' 413.30 et seq., provide for an adjustment to the cost limits where a provider furnishes atypical services as compared to the items or services furnished by similarly classified providers. The regulation at 42 C.F.R. '413.30 et seq. provides for exceptions to the RCLs to the extent that costs are reasonable, attributable to the circumstances specified, separately identified and verifiable. The Board finds that the regulation affords HCFA a two-prong test in which it can compare costs and types of services. Accordingly, the policy set forth in the regulations requires an examination of both the reasonableness of the amount that a provider's actual cost exceeds the applicable cost limit, and the determination of the atypicality of the costs by using a peer group comparison.

The Peer group developed by HCFA for evaluating exceptions to the RCLs for hospital-based SNFs is set at 112 percent of the mean hospital-based inpatient routine service costs, and not at the hospital-based SNF's cost limit. HCFA compares the hospital-based SNF's costs to those of the typical facility to determine the amount of its costs that are atypical. Under this methodology, if a hospital-based SNF can establish that its costs are reasonable and atypical in relation to its peer group, the provider is given an opportunity to demonstrate that its atypical costs are related to the special needs of its patients. Although this peer group criterion for exception eligibility exceeds the RCLs established for hospital-based SNFs, the Board believes the 112 percent peer group level is a practical standard for measuring the atypical nature of a provider's services. Further, 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 cost limit which is heavily based upon freestanding SNF data.

The Board further finds that HCFA's methodology of using the standard 112 percent of the hospital-based SNF peer group mean when reviewing exception requests is clearly set forth in a subsequent publication of HCFA Pub. 15-1 ' 2534 et seq, as adopted in transmittal No. 378 (July 1994). This transmittal explained that the new manual sections were being issued to provide detailed instructions for SNFs to help them prepare and submit requests for exceptions to the inpatient routine service cost limits.

Based on its analysis of the statute, regulations and program instructions, the Board concludes that it was not unreasonable for HCFA to use the 112 percent peer group level as the standard for reviewing exception requests for hospital-based SNFs.

The Board acknowledges the Provider's reliance upon the previous Board's decision in St. Francis to help support its position and arguments. The Board notes that its findings are consistent with the Ohio district court's ruling which upheld the HCFA Administrator's reversal of the Board's decision in St. Francis and subsequent decisions rendered by a majority of the Board in the following cases:

> San Joaquin Community Hospital-SNF (Bakersfield. CA.) v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 2001-D17, April 17, 2001, Medicare and Medicaid Guide (CCH) &80,654.
>
> North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D22, February 18,1999, Medicare and Medicaid Guide (CCH) & 80,158, modif'd HCFA Administrator, April 15, 1999, Medicare and Medicaid Guide (CCH) & 80,195.

Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D61, August 20,1999, Medicare and Medicaid Guide (CCH) & 80,320.

Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D-67, September 2,1999, Medicare and Medicaid Guide (CCH) & 80,311.

New England Rehabilitation Hospital v. C&S Administrative Services, PRRB Case No. 2000-D53, May 11, 2000, Medicare and Medicaid Guide (CCH), &80,443.

DECISION AND ORDER:

HCFA's methodology for measuring the entitlement of hospital-based SNF's to exception relief under 42 C.F.R. ' 413.30 et seq was proper. HCFA's determination is affirmed.

Board Members Participating

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove

Date of Decision: September 28, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman