CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Glenwood Regional Medical Center **Provider** **vs.** **Mutual of Omaha Insurance Company** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 8/31/95** **Review of: PRRB Dec. No. 2004-D23 Dated: June 7, 2004**

This case is before the Administrator, Centers for Medicare and Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board).[1] The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act). The Center for Medicare Management (CMM), the Intermediary, and the Provider requested review. The parties were notified of the Administrator's intent to review this case. Accordingly, this decision is now before the Administrator for final agency review.

BACKGROUND

The Provider is a hospital-based (HB) skilled nursing facility (SNF) that provided SNF services during the cost year ending August 31, 1995. On August 28, 1996, the Provider requested an exception for full relief from the SNF routine cost limits (RCLs) based on data from the as-filed cost report in the amount of $724,625, calculated at $148.30 per day for 4886 Medicare SNF patient days.[2] On

[1] "CMS" is the agency within the Department of Health and Human Services that administers the Medicare program. Prior to July, 2001, CMS was known as the Health Care Financing Administration ("HCFA") See 66 Fed. Reg. 39,450 (July 31, 2001) (announcing name change).

[2] See Provider Exhibit (Ex.1), Intermediary Ex. 1.

November 4, 1996, the Intermediary granted an interim exception in the amount of $76.67 per day. On May 30, 1997, the Intermediary issued a Notice of Program Reimbursement (NPR) for the cost year. On June 7, 1997, the Intermediary recommended to CMS that the Provider be granted a final exception of $80.93 per day, for a total of $386,198 in additional reimbursement.[3] On June 16, 1997, the Provider requested a hearing before the Board to dispute the SNF exception granting partial relief ($76.67 per day). On September 9, 1997, CMS responded to the Intermediary, that applying the methodology in Provider Reimbursement Manual (P.R.M.) § 2530 (Transmittal 378),[4] it agreed with the Intermediary's recommendation.[5] On October 9, 1997, the Intermediary notified the Provider of CMS' determination.[6] On October 15, 1997, a revised NPR was issued.[7]

ISSUE AND BOARD'S DECISION

The issue before the Board was whether CMS' methodology for determining an exception from the RCLs for HB SNFs, as set forth in P.R.M. § 2534.5, was proper. Specifically, the issue is whether it is proper for CMS to allow the exception for atypical costs for HB-SNFs only to the extent that total routine costs exceed 112 percent of the peer group mean, rather than to the extent that routine costs exceed the HB-SNF RCL.[8]

The Board found that the methodology applied by CMS, in partially denying the Provider's exception request for per diem costs which exceeded the RCL, was inconsistent with the controlling statutes and regulations. The Board explained that in 1984 Congress established that the RCLs applicable to SNFs, applies to the cost reporting periods at issue in this case. For freestanding (FS) SNFs, the RCLs are equal to 112 percent of the mean per diem routine service costs of other FS-SNFs (the peer group). For HB SNFs, the RCLs were lowered to the sum of the corresponding FS-SNF RCL plus 50 percent of the amount by which 112 percent of the mean per diem routine services costs of other HB SNFs (the peer group) exceed the FS-SNF RCL.

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[3] See Provider Ex. 2 and Intermediary Ex. 2.

[4] §§ 2530 - 2537 of the P.R.M. provide instructions relating to routine service cost limits for SNFs.

[5] Intermediary Ex. 3.

[6] Provider Ex. 3, Intermediary Ex. 4.

[7] Provider Ex. 4.

[8] The Board noted at the outset that the parties agreed that the only issue on appeal before the Board is whether the P.R.M. § 2534.5 methodology is legally permissible.

The Board found that to ensure providers would be reimbursed their full costs for providing additional services and that non-Medicare patients would not subsidize the care of the Medicare patients,[9] providers which incur additional costs associated with atypical services may obtain an exception from its RCL.[10]

The Board stated that it was undisputed that for 15 years, the Secretary interpreted the regulation as permitting providers to recover reasonable costs exceeding the RCL if providers demonstrated that it met the exception requirement. However, pursuant to the issuance of the July 1994 Transmittal No. 378 and the corresponding policy at P.R.M. § 2534.5, CMS measured the atypical services exception for HB-SNFs from 112 percent of the peer group mean for that HB-SNF rather than from the SNF's RCL. As a result, the manual section created a reimbursement "gap" between the RCL and 112 percent of the peer group mean.

The Board indicated that CMS made a conclusion regarding Congress' intent toward reimbursing the HB-SNFs routine costs which provide only typical services and illogically applied that same rationale to HB-SNFs that provide atypical services. The Board claimed that this is contrary to Congress's intention when it implemented the exception process to address the additional costs associated with the provision of atypical services, and it represents a substantive change in CMS' prior interpretation and application of 42 C.F.R. § 413.30(f)(1) and P.R.M. § 2534.5.

Moreover, the Board explained that the controlling regulation states that providers only demonstrate that their costs exceed the applicable limits, not that their costs exceed 112 percent of the peer group mean. The comparison to a peer group mean of "providers similarly classified" required by the regulation is of the "nature and scope of the items and services actually furnished,"(emphasis added) not of their cost. Congress itself established the four "peer groups"[11] that are to be considered in determining reimbursement, and CMS has no authority to establish a new peer group for HB SNFs (112 percent of the peer group mean routine service cost) and determine atypical service exceptions from such new cost limit rather than from the RCL.

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[9] 42 U.S.C. 1395x(v)(1)(A).

[10] The precise language of 42 C.F.R. § 413.30(f)(1) was issued as an amended regulation effective July 1, 1979 under 42 C.F.R.§ 405.460(f)(1). The regulation was redesignated in 1986 at 42 C.F.R. § 413.30(f)(1), the designation by which it was identified at the time of this dispute. See 51 Fed. Reg. 34790 (Sept. 30, 1986).

[11] See 44 Fed. Reg. 29632 (1979) and 44 Fed. Reg. 51,542 (1979). The four SNF peer groups are HB urban, HB rural, FS urban, and FS rural.

Additionally, the Board contends that P.R.M. § 2534 is invalid because it was not adopted pursuant to notice and comment rulemaking required by the Administrative Procedure Act (A.P.A.). Because the P.R.M. carves out a per se exception in the applicable regulation and is a change in the unwritten CMS policy of 15 years, it was a substantive change. However, even if § 2534 is considered an interpretive rule, it nevertheless constitutes a significant revision of the Secretary's interpretation of the 42 C.F.R. § 413.30 and CMS' unwritten policy; therefore, § 2534 is invalid because it was not issued pursuant to notice and comment rulemaking.

The Board explained that Congress gave the Secretary broad authority to establish, by regulation, the methods to be used and the items to be included in determining reimbursement. The Board also commented that had the "gap" methodology been subjected to the rulemaking process under the A.P.A., it would have been a legitimate exercise of that power. The Board was also persuaded by the District Court's decision in St. Luke's Methodist Hospital v. Thompson[12] that § 2534.5 does not reasonably interpret § 413.30.

COMMENTS

CMM submitted comments recommending that the Administrator overturn the Board's decision. CMM explained that § 223 of the Social Security Amendments of 1972 authorized the Secretary to establish RCLs as a presumptive test of reasonable costs, with exceptions where necessary. The general authority for the procedures for establishing the RCLs and the exception process is set forth in the regulation at 42 C.F.R. § 413.30.

Prior to issuing the first set of cost limits, effective October 1, 1979, CMS recognized that the average per diem costs of HB-SNFs were higher than those of FS-SNFs. CMS recognized that the cost differences between HB and FS facilities, establishing separate cost limits for different classifications, or peer groups, of SNFs. CMS observed, however, that studies were needed to determine the reasons for the cost differences, especially where differences may be related to the Medicare cost allocation process and variations in intensity of care.[13]

CMM explained that Congress also began to address the issue of cost differences between HB-SNFs and FS-SNFs. In the belief that no cost differences should be recognized and in the absence of data to show otherwise, Congress enacted the

[12] 182 F. Supp. 2d 765 (N.D. Iowa 2001). The Administrator notes that the Eighth Circuit Court of Appeals affirmed the District Court's decision 315 F.3d 984 (8th Cir. 2003).
[13] 44 Fed. Reg. 51542 (Aug 31, 1979).

Tax Equity and Fiscal Responsibility Act (TEFRA) in 1982, mandating the same RCLs for HB-SNFs and FS-SNFs based on FS-SNF costs. This provision, however, was repealed and separate limits were reestablished until further studies were performed. Several studies were undertaken in 1983 and 1984, and reported in 1985, concluding that approximately 50 percent of the cost differences were attributable to variations in intensity of care, or case mix. Since none of the other variables tested were significant, inefficiency remained as a possible cause of the cost differences.

CMM stated that § 1888 of the Act was enacted as part of DEFRA in 1984 as a result of these studies. Section 1888 recognized 50 percent of the cost differences between HB-SNFs and FS-SNFs in setting the HB-SNF RCLs. Under § 1888(a), the FS-SNF RCLs are set at 112 percent of mean per diem costs of FS-SNFs (their peer group mean per diem costs), whereas the HB-SNF RCLs are computed by adding 50 percent of the cost differences between HB-SNFs and FS-SNFs to the appropriate FS-SNF RCL. In addition, § 1888(b) mandated that any cost differences related to the Medicare cost allocation process would be recognized. Any remaining cost differences were not recognized as reasonable costs in setting the HB-SNF RCLs.

CMM stated that § 1888(c) of the Act sets forth the Secretary's authority to make adjustments in the RCLs based upon case-mix or circumstances beyond the control of a facility. Pursuant to the statute, the regulations at 42 C.F.R. § 413.30(f) allow for adjustments to the RCLs only to the extent that costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

CMM explained that the first step of the exception process is to determine if costs exceeding the applicable RCL are reasonable. CMM observed that § 1888 of the Act, related legislative documentation, and the studies which identified legitimate cost differences in setting the HB-SNF RCLs, guided the policy not to deem the remaining cost differences, that is, those costs between the HB cost limit and 112 percent of the HB peer group mean costs, as reasonable. Accordingly, these costs are removed from the provider's costs in excess of the limit before advancing in the exception process.

CMM continued that the second step of the exception process of attributing the remaining costs in excess of the limit to the circumstances specified. The regulations at 42 C.F.R. § 413.30(f)(1)(i) dictate that atypical services can be shown if "actual costs of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified…" The regulation is further interpreted by the P.R.M. which states that

the maximum amount of an exception is the amount by which a SNF's costs exceed those of the peer group. The peer groupings are similar to those used to establish the limits. The peer group costs are based on 112 percent of the mean per diem costs of freestanding/urban, rural or hospital-based urban, rural SNFs as appropriate.

In summary, CMM stated that the policy published in Chapter 25 of the P.R.M. is a reasonable interpretation of the statute and implementing regulations. Furthermore, the Court of Appeals for the Sixth Circuit has upheld the Intermediary's position that Provider's receive relief from 112 percent of the peer group mean.[14] CMM's position on this issue is further buttressed by subsequent legislation enacting the SNF Prospective Payment System in § 1888 of the Act in which rates for HB SNFs are based on 105 percent of the average costs for all facilities. This is an amount less than fifty percent of the difference between HB and FS costs added to the FS costs. CMM also disagrees with the Board's interpretation that because the agency's policy, for 15 years prior to the issuance of Chapter 25 of the Manual, was to measure exceptions from the cost limit, the issuance was a substantive change in existing law or policy requiring the notice and rulemaking process. CMM noted that its position has been consistently upheld by the Board in the past, and the Board has not provided substantive reasons for its departure from its previous position.

The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Intermediary cited the Board's decision in Providence Hospital-Centralia SNF Centralia v. Blue Cross and Blue Shield Association/Premera Blue Cross,[15] which upheld CMS's methodology for measuring the entitlement of HB SNFs to exception relief .

The Provider submitted comments requesting that the Administrator affirm the Board's decision. The Provider cited two cases decided subsequent to the final briefing before the Board. The Provider noted that the Court of Appeals for the Eighth Circuit in St Luke's[16] concluded that because P.R.M. § 2534 denies reimbursement above the RCL, its effect may be to discourage efficient HB-SNFs from providing atypical services to patients who need them. The St. Luke's Court concluded that such result contradicts Medicare's intent to reimburse costs "necessary in the efficient delivery of needed health services."[17]

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[14] St. Francis Health Care Centre v . Shalala, 205 F.3d 937 (6th Cir. 2000).
[15] PRRB Case No. 2002-D50, September 30, 2002, Medicare and Medicaid Guide (CCH) ¶ 80909.
[16] Supra, note 12.
[17] 42 C.F.R. §413.30(f)(1)(ii).

Additionally, the District Court for the District of Columbia issued a Memorandum Order in consolidated cases[18] in which the Court ruled that § 2534.5 "violates the APA because it constitutes a change in the Secretary's definitive interpretation made without following the required notice and comment procedures."

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All timely comments received after entry of the Board's decision have been made a part of the record and have been considered.

At its inception in 1965, Medicare paid for the "reasonable cost" of furnishing covered services to beneficiaries.[19] Medicare reimbursement for services provided in SNFs is largely on the basis of "reasonable cost" as defined by § 1861(v)(1) of the Act. In addition, § 1861(v)(1)(A) sets forth the requirement that Medicare shall not pay for costs incurred by non-Medicare beneficiaries and vice-versa, i.e. Medicare prohibits cross-subsidization of costs.

Section 1861(v)(1)(A) also authorizes the Secretary to establish limits on the allowable costs incurred by providers of health care services. The limits are based on estimates of the costs necessary for the efficient delivery of needed health care services. The limits on inpatient general routine service costs set forth at § 1861(v)(1)(A) apply to SNF inpatient routine costs, excluding capital related costs.

Rather than defining "reasonable cost" with precision, § 1861(v)(1)(A) empowered the Secretary to issue appropriate regulations setting forth the methods

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[18] Mercy Medical Skilled Nursing Facility, et al. v. Thompson, C.A. 9902765 (TPJ) (mem.) (D.D.C. May 14, 2004), appeal docketed, July 8, 2004.The Mercy Court found the case of Alaska Professional Hunters Association v. FAA, 177 F.3d 1030 (D.C. Cir. 1999) to be dispositive.

[19] The Social Security Amendments of 1965, Pub. L. No. 89-97, established Title XVIII of the Social Security Act, which authorized the establishment of the Medicare program to pay part of the costs of the health care services furnished to eligible beneficiaries. The Medicare program primarily provides medical benefits to eligible persons over the age of 65, and consists of two parts: Part A [42 USC §§ 1395c-1395-I-4], which provides reimbursement for inpatient hospital and related post hospital, home health and hospice care; and Part B [42 U.S.C. §§ 1395j-1395w-4], which is a supplementary voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A.

to be used in computing such costs.[20] The regulations at 42 C.F.R. § 413.9 establish that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. If the provider's costs include amounts not related to patient care, or costs that are specifically not reimbursable under the program, those costs will not be paid by the Medicare program. Further, the regulations at 42 C.F.R.§ 413.9(b) provide that the "reasonable cost" of any services must be determined in accordance with regulations establishing the method or methods to be used and the items to be included.

The regulations currently codified at 42 C.F.R. § 413.30 et seq. implement the cost limit provisions of § 1861 (v)(1) of the Act.[21] Prior to 1972, the regulations contemplated reimbursement of the entirety of a provider's services to Medicare patients unless it costs were found to be substantially out of line with those of similar institutions.[22]

In 1972, in response to rising costs, and recognizing that the original Medicare payment structure provided little incentive for providers to operate efficiently in delivering services,[23] Congress amended the statute, specifying that "reasonable costs" meant only those "actually incurred, excluding therefrom any part of incurred cost[s] found to be unnecessary in the efficient delivery of needed health services." Additionally, Congress authorized the Secretary to "provide for the establishment of limits… based on estimates of the costs necessary in the efficient delivery of needed health services" under § 223 of the Social Security Amendments of 1972.[24] The § 223 cost limits were to reflect the maximum expenses incurred by an efficient provider; costs exceeding the limits would be presumed unreasonable and would not be allowed unless they qualified for a regulatory exception.[25]

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[20] Section 1861(v)(1)(A) provides, in pertinent part, that the Secretary "shall" determine reasonable costs "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 of classes of institution, agencies, and services." See Shalala v. Guernsey Memorial Hospital, 514 U.S. 87 (1995).

[21] Supra n. 11

[22] See, e.g., 20 C.F.R. § 405.451(c)(1969). Regulations regarding the determination of reimbursable costs were originally codified at 20 C.F.R. §§ 405.401-405.454 (1967). They have been redesignated twice, first in 1977, at 42 C.F.R. pt. 405, see 42 Fed. Reg. 52826 (1977), and then in 1986, at 42 C.F.R. pt. 413, see 51 Fed. Reg. 34,790 (1986).

[23] See H.R. Rep. No. 92-231, at 82-85 (1971); S. Rep. No. 92-1230, at 188-89 (1972).

[24] Social Security Amendments of 1972, Pub. L. No. 92-603 (1972)

[25] S. Rep. No. 92-603 (1972)

Section 223 cost limits for SNFs were first implemented on October 1, 1979. Pursuant to §1861(v)(1)(A) of the Act, CMS promulgated yearly schedules of limits on SNF inpatient routine service costs and notified participating providers of the exceptions process in the Federal Register.[26] Beginning with the initial implementation of § 223 limits on SNF inpatient routine costs, separate reimbursement limits were derived for HB-SNFs and FS-SNFs on the basis of the cost reports submitted by the two types of providers. These separate limits were implemented because HB-SNFs maintained that they incurred higher costs because of the allocation of overhead costs required by Medicare and higher intensity of care.[27] Of note, effective for cost reporting periods beginning on or after October 1, 1980, these costs limits were based on 112 percent of the average per diem costs of each comparison group.[28]

Section 102 of TEFRA eliminated separate limits for HB-SNFs and FS-SNFs, mandating single limits based on the lower costs of FS-SNFs, subject to appropriate adjustments.[29] However, the single limits based on the lower costs of the FS-SNFs were never implemented. Section 2319 of DEFRA of 1984, rescinded the single TEFRA limit for SNFs and directed the Secretary to set separate limits on per diem inpatient routine service costs for HB-SNFs and FS-SNFs, revising § 1861(v) of the Act and adding a new § 1888 to the Act.[30] Section 1888(a) specifies the methodology for determining the separate cost limits rather than delegating authority to the Secretary to do so by regulation. Under § 1888(a), the RCLs are determined based on per diem limits, which are equal to a percentage of the mean per diem inpatient routine service costs of FS or HB

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[26] See, e.g., 41 Fed. Reg. 36,237 (1976); 44 Fed. Reg. 29,362 (1979); 44 Fed. Reg. 51,542 (1979); 45 Fed. Reg. 58,699 (1980); 46 Fed. Reg. 48,026 (1981); 47 Fed. Reg. 42,894 (1982).

[27] HCFA, Report to Congress on the Study of the Skilled Nursing Facility Benefit under Medicare at 99 (1985).

[28] See, e.g., 45 Fed. Reg 58,699 (1980); 46 Fed. Reg. 48,026 (1981); 47 Fed. Reg 42,894 (1982). See also 51 Fed Reg. 11,234 (1986) (Prior to the schedule of …single limits (required by Pub L. 97-248 (1982)) the SNF cost limits for inpatient routine services were calculated at 112 percent of the mean of the routine costs for freestanding and hospital-based SNFs, respectively. Further, the routine costs considered for each comparison group were the routine costs attributable to the particular group**…"** Id.)

[29] TEFRA of 1982, Pub. L. No. 97-248. See 47 Fed. Reg. 42,894 (1982).

[30] Deficit Reduction Act of 1984, Pub. L. No. 98-369 (Medicare and Medicaid Budget Reconciliation Amendments of 1984), applicable as provided in section 2319(c) and (d) of the Amendments. See also § 2530, et.seq. of the P.R.M.

facilities (qualified by whether the facility is urban or rural). The base for computing the RCLs for both FS-SNFs and HB-SNFs is the amount of the FS-SNF RCL; the RCL for the higher cost HB-SNFs is computed with an add-on to the FS –SNF RCL. Section 1888(a) states that:

> The Secretary, in determining the amount of the payments which may be made under this title with respect to routine service costs of extended care services shall not recognize as reasonable (in the efficient delivery of health services) per diem costs of such services to the extent that such per diem costs exceed the following per diem limits….:(1)[and (2)] With respect to freestanding skilled nursing facilities…., the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities….(3) [and (4)] With respect to hospital-based skilled nursing facilities…, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities…, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital–based skilled nursing facilities…exceeds the limit for freestanding skilled nursing facilities….

In summary, under TEFRA, for cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984, the cost limits for routine services for HB-SNFs and FS-SNFs were to have been 112 percent of the mean inpatient routine service per diem costs for FS-SNFs, the lower cost group; however, because the TEFRA provisions never became effective, there were separate limits during that period for HB-SNFs and FS-SNFs based upon 112 percent of their respective mean peer group cost. For cost reporting periods beginning after July 1, 1984, including the cost reporting periods at issue in this case, the RCLs for FS-SNFs remained at 112 percent of the mean peer group inpatient routine service per diem costs. For those same cost reporting periods, Congress dictated that the RCLs for HB-SNFs would equal the FS-RCL plus 50 percent of the difference between 112 percent of the mean peer group inpatient routine service per diem costs and the FS-RCL. In short, DEFRA rejected the concept of a single set of RCLs for SNFs and established a somewhat more generous reimbursement for HB-SNFs as compared to FS-SNFs. The HB-SNF RCLs are set at an amount halfway between the FS-SNF RCLs, which are 112 percent of the FS-SNF peer group mean per diem costs, and an amount less than what would be an amount directly corresponding to the FS-SNF RCLs using the peer comparison, i.e., 112 percent of the HB-SNF peer group mean per diem costs.

Under the DEFRA provisions, the Secretary was also given broad discretion to authorize adjustments to the cost limits. Section 1888(c) provides:

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

In accordance with the foregoing provisions of § 1861(v)(1)(A), as amended, and § 1888, the regulations at 42 C.F.R. § 413.30 specify the process by which CMS would establish limits on providers' routine costs and allow for various adjustments.[31] Further, in accordance with § 1888(c) of the Act, § 413.30(f) provides for exceptions to the cost limits to the extent that costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the Intermediary. Pertinent to this case, § 413.30(f)(1) specifically provides for an exception for atypical services.

> (1) Atypical services. The provider can show that the—(i) Actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature

[31] The Administrator notes that CMS has published schedules of limits in the Federal Register, which outline the methodology and data used to determine the costs on which the RCLs are based. See also Section 2530.4 of the P.R.M. The methodology for determining the RCL, pursuant to DEFRA, for HB-SNFs was first described in an April 1,1986 notice of the schedule of limits, 51 Fed. Reg. 11234, 11237, 11253. See also 52 Fed. Reg. 37098, 37099 (October 2, 1987); 56 Fed Reg. 13317 (April 1, 1991). CMS explained that it was publishing a revised schedule of limits for cost reporting periods beginning on or after July 1, 1984 in conformity with Section 2319 of DEFRA. The notice explained that DEFRA required that separate RCLs limits apply to HB-SNFs and FS-SNFs; the RCLs for HB-SNFs were required to be equal to the RCLs for corresponding FS-SNFs plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for HB-SNFs exceed the corresponding limit (i.e., the RCL) for corresponding FS-SNFs.

The schedule of limits effective for cost reporting periods beginning on or after October 1, 1989 is applicable to the cost years at issue in this case. For those cost report periods, the HB-SNF RCL continued to be equal to the FS-SNF RCL (112 percent of the average labor related and average nonlabor-related costs) plus 50 percent of the difference between the mean peer group per diem routine service costs of HB-SNFs and the FS-SNF RCL, i.e., higher than the FS cost limit, set at 112 percent of the FS peer group mean cost, but lower than 112 percent of the HB peer group mean cost. 56 Fed. Reg. 13317 (April 1, 1991).

> 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 on the efficient delivery of needed health care.

Consistent with the statute and regulations, CMS set forth the general provisions concerning payment rates for certain SNFs in Chapter 25 of the P.R.M. In July, 1994, to provide the public with current information on the SNF cost limits under § 1888 of the Act, CMS issued Transmittal No. 378.[32] Prior to the issuance of Transmittal No. 378, Chapter 25 of the P.R.M. did not address the methodology used to determine exception requests. Transmittal No. 378 explained that new manual sections, at § 2530 et seq., were being issued to "provide detailed instructions for skilled nursing facilities (SNFs) to help them prepare and submit requests for exceptions to the inpatient routine service cost limits."

Section 2534.5 as adopted in Trans. No. 378 (July 1994), "Determination of Reasonable Costs in Excess of Cost Limit or 112 Percent of Mean Cost," explains the process and methodology for determining an exception request based on atypical services. In determining reasonable cost, a provider's costs are first subject to a test for low occupancy and then are compared to per diem costs of a peer group of similarly classified providers. P.R.M. §2534.5B explains the methodology CMS developed to quantify the peer group comparison that is part of the test for reasonableness.

> B. Uniform National Peer Group Comparison.—The uniform national peer group data are based on data from SNFs whose costs are used to compute the cost limits. The peer group data are divided into four groups: Urban Hospital-based, Urban Freestanding, Rural Hospital-based, and Rural Freestanding. For each group, an average per diem cost (less capital-related costs) is computed for each routine service cost center (direct and indirect) that the provider reported on its Medicare cost report. For each cost center, a ratio is computed as the average per diem cost to total per diem cost. Those cost centers not utilized on the Medicare cost report must be eliminated and all ratios are revised based on the revised total per diem cost…
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> With cost reporting periods beginning prior to July 1, 1984, for each freestanding group and each hospital-based group, each cost center's ratio is applied to the cost limit applicable to the cost reporting

[32] Transmittal No. 378 also deleted section 2520-2527.4 of the P.R.M., adopted in July 1975 under Transmittal No. 129, as obsolete.

> period for which the exception is requested. For each hospital–based group with cost reporting periods beginning on or after July 1, 1984, the ratio is applied at 112 percent of the group's mean per diem cost (not the cost limit), adjusted by the wage index and cost reporting year adjustment factor applicable to the cost reporting period for which the exception is requested. The result is the Provider's per diem cost is disaggregated into the same proportion of its peer group mean per diem cost for each cost center.
>
> The SNF's annual per diem cost or, if applicable, the cost as adjusted for low occupancy for each applicable routine cost center (less capital-related costs) is compared to the appropriate component of the disaggregated cost limit or 112 percent of the hospital based mean per diem cost. If the SNF's per diem cost exceeds the peer group per diem cost for any cost center, the higher cost must be explained Excess per diem costs which are not attributable to the circumstances upon which the exception is requested and cannot be justified may result in either a reduction in the amount of the exception or a denial of the exception.

Contrary to the Board's findings, the Administrator finds that the exception guidelines in Chapter 25 of the P.R.M. are reasonable and appropriate, as they closely adhere to the requirements of § 1888(a) of the Act and are within the scope of the Secretary's discretionary authority under § 1888(c) of the Act to make adjustments in the SNF RCLs, and under the implementing regulations at § 413.30(f)(1)(i). The Administrator rejects the Board's view that § 1888(a) of the Act and the implementing regulation at 42 C.F.R. § 413.30 entitle all SNFs to be paid the full amount by which their costs exceed the applicable RCL

Of particular relevance to this case, the regulation at 42 C.F.R. § 413.30(f) specifically requires a reasonableness determination in granting an exception request.

> (f) Exceptions Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) of this section. An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary (Emphasis added.)

In contrast to the Board, the Administrator finds that the policy interpretation in §2534.5B requiring the HB-SNFs costs to be compared to 112 percent of the group's mean per diem costs, is an appropriate method of applying the reasonable

cost requirements and is not inequitable as the Board suggests. Relevant to the reasonable cost determination, in the case of FS-SNFs, Congress set the RCLs at the peer group mean costs.[33] In the case of HB-SNFs, Congress determined it appropriate to set the cost limits at an amount less than the peer group mean costs. The Administrator agrees with the Board that, presumably, Congress believed there to be no adequate justification for the higher mean per diem costs of HB-SNFs relative to FS-SNFs, other than the possibility that higher HB-SNF costs are due to inefficiencies. Thus, as validated by its Report to Congress**,** [34]CMS properly determined, in developing the exception process, that 50 percent of the difference between the FS-SNF and the HB-SNFs cost limits (i.e., the "gap") was due to HB-SNFs' inefficiencies. As such costs are not reasonable, CMS properly determined that these costs could not be reimbursed pursuant to the exception process.

Moreover, the plain language of 42 C.F.R. § 413.30(f)(1)(i) supports the use of a peer group comparison such as that made under the methodology set forth in P.R.M. § 2534.5B to determine both reasonableness and atypicality. Section 413.30 (f)(1)(i) provides that a provider must show that the:

> Actual costs of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified.

Thus, the policy set forth in the regulations requires examination of both the reasonableness of the amount that a provider's actual cost exceeds the applicable cost limits and the determination of the atypicality of the costs by using a peer group comparison (i.e., the 112 percent threshold). If an HB-SNF can establish that its costs are reasonable and atypical in relation to its peer group, the provider than has the opportunity to demonstrate that, inter alia, its atypical costs are related to the special needs of its patients. The Administrator finds that use of this

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[33] Both Congress and CMS have used 112 percent of, or one standard deviation from, the mean to establish the range of "reasonable costs." See, e.g., § 1861(v)(1) (home health agency cost limits); 57 Fed. Reg. 23,618, 23,635 (June 4, 1992) (explaining that the 108 percent threshold for a wage index reclassification is based on the average hospital wage as a percentage of its area wage (96 percent) plus one standard deviation (112 percent); 58 Fed. Reg. 46,270, 46,286 (September 1, 1993) and 60 Fed. Reg. 45,778, 45,780 (September 1, 1995) (using standard deviation in establishing diagnosis-related group value). The standard deviation is a statistical measure of data about a mean value. See also, e.g., 60 Fed. Reg. 35,854, 35,862 (1995).

[34] See n. 27.

methodology is appropriate and a valid exercise of the Secretary's discretion under § 1888(c) of the Act to make adjustments to the RCLs. In the Administrator's view, CMS properly applied a test of the reasonableness of the amount of the costs in excess of the cost limits claimed to be due to the atypical services based on the 112 per cent of the per diem mean for HB-SNFs.

Furthermore, the Administrator finds use of the methodology set forth in P.R.M. § 2534.5B in no way alters or revises Medicare policy as set forth in the regulations at § 413.30(f)(1)(i) but is one method of applying that policy. Indeed, § 2534.5B did not effect a change in CMS policy. Although Congress changed the RCLs for HB-SNFs in 1984, the published cost limits since 1980[35] reflect that CMS had previously used a methodology under which the SNFs' per diem costs were compared to a percentage of the peer group mean per diem cost.[36]

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

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[35] 45 Fed. Reg. 41,292 (1980) ("We are proposing that the limits be set at 112 percent of each group's mean cost. We believe that the 12 percent allowance above mean cost is a reasonable margin factor in view of the refinements made in the method used to establish the limits."); 45 Fed. Reg. 58,699 (1980) ("[l]imits set at 112 percent of the average per diem labor-related and nonlabor costs of each comparison group." Id.) 46 Fed. Reg. 48,026 (1981); 51 Fed. Reg. 11,234 (1986).

[36] See, e.g., 44 Fed. Reg. 51,542, 51544 (August 31, 1979) ("We believe the use of a limit based on the average to be superior to a percentile limit. The average is a good measure of the cost incurred in the efficient delivery of services by peer providers…Since these are the first limits we have established for SNFs, the methodology used does not account for any conceivable variable which could affect SNF costs. As we gain information and experience, the methodology will be refined.")

Thus, the Administrator also disagrees with the Board's finding that the methodology for determining an exception for atypical services of an HB-SNF using the uniform peer group comparison, as set forth in § 2534.5 of the P.R.M., constituted a change in policy requiring notice and comment rule-making under 5 U.S.C. § 552 (the Administrative Procedure Act (A.P.A.)). First, as noted, supra, CMS has consistently compared SNFs costs to their comparison group in applying the cost limitations. The Administrator finds that the methodology at issue does not involve application of a "substantive" rule requiring publication of notice and comment under § 553 of the A.P.A. The Secretary has broad authority to promulgate regulations under § 1861(v)(1)(A) and § 1888 of the Act. Relevant to this case, the Secretary has promulgated a regulation at 42 C.F.R. § 413.30(f)(1) establishing a specific exception from the RCLs based on atypical services. The Secretary does not have an obligation to promulgate regulations that specifically address every conceivable situation in the process of determining reasonable costs.[37] Rather, the Intermediary is required to make a determination of the reasonableness of the exception request, applying the existing reasonable cost statute, controlling regulations, and any further guidance that CMS has issued. The methodology set forth in § 2534.5 of the P.R.M. is a proper interpretation of the statute and the Secretary's rules allowing an exception to the limits on reasonable costs based on atypical services.[38]

Accordingly, after review of the record and applicable law, the Administrator finds that the methodology set forth in P.R.M. § 2534.5B is consistent with the plain meaning of §§ 1861(v) and 1888(a) through (c) of the Act, the legislative intent and the regulations at 42 C.F.R. § 413.30.

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

[38] Similarly, the Intermediary's application of the methodology set forth at §2534.5 of the P.R.M. does not constitute a substantive rule, and is consistent with the reasonable costs rules in effect for the cost years at issue. Moreover, the nature of reasonable cost reimbursement requires the determination of allowable costs after the close of the cost reporting period. Application of any reasonable cost comparison determination would constitute a retroactive rulemaking under the Provider's definition of that term.

DECISION

The decision of the Provider Reimbursement Board is reversed. The Intermediary properly applied §2534.5 of the P.R.M. in its partial denial of the Provider's requests for an exception to the RCLs.

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

Date: 8/9/04

/s/

Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services