PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2001-D38

PROVIDER -
Mercy Medical Center SNF-Daphne
Daphne, AL

Provider No. 01-5049

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING-
June 19, 2001

Cost Reporting Period Ended -
December 31, 1995

CASE NO. 98-2619

INDEX

ISSUES:

1. Was the Health Care Financing Administration's ("HCFA's") methodology as set forth in Transmittal No. 378 for determining the amount of the exception from the routine cost limits ("RCLs") for hospital-based skilled nursing facilities ("HB-SNFs") and as applied by the Intermediary to the Provider for fiscal year ended ("FYE") December 31, 1995, a proper interpretation of the Medicare statute and regulations?

2. Did the Intermediary properly deny the Provider a rollover interim exception for FYE December 31, 1995?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy Medical Center SNF - Daphne ("Provider") is a hospital-based skilled nursing facility ("HB-SNF") located in Daphne, Alabama. For its cost reporting period ended December 31, 1995, the Provider requested and obtained an exception to Medicare's RCLs based upon the provision of atypical services. However, in evaluating the Provider's request and calculating the amount of the exception to which the Provider was entitled, Mutual of Omaha Insurance Company ("Intermediary") applied program instructions contained in Transmittal No. 378 that was issued by the Health Care Financing Administration ("HCFA") in July of 1994. As a result, the amount of the exception ultimately granted by the Intermediary was significantly less than the amount sought by the Provider.

On November 4, 1997, the Intermediary issued a Notice of Program Reimbursement ("NPR") which effectuated final settlement of the subject cost reporting period. The NPR was accompanied by a worksheet that indicated the Provider's actual adjusted per diem costs were $158.43, exceeding the applicable RCL ($120.66 per patient day) by $37.77 per patient day. Based on the total Medicare days of 8,148 reflected on the cost report, the total amount of Medicare reimbursement in controversy is approximately $307,700. On April 30, 1998, the Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and has met the jurisdictional requirements of those regulations. The Provider was represented by Thomas C. Fox, Esquire, and Tamara v. Scoville, Esquire, of Reed Smith, LLP. The Intermediary's representative was Terry Gouger, Appeals Consultant, Mutual of Omaha Insurance Company.

In order to assist the Board in deciding the issues in dispute, the parties entered into a Joint Stipulation as to: (1) the precise issues on appeal; (2) certain material facts pertinent to the case; and (3) certain basic facts relating to the validity of Transmittal No. 378, which is at issue. Moreover, the parties narrowed the legal issues by agreeing to certain basic facts relating to the interpretation and effects of Transmittal No. 378. The specific stipulations agreed upon by the parties include the following:[1]

[1] Some items contained in the actual Joint Stipulation submitted by the parties are omitted from the listing included herein since they would reiterate facts contained

1. Mercy Medical Hospital (Mercy") is a non-profit Alabama corporation which is owned and operated by the Sisters of Mercy of the Regional Community of Baltimore. Mercy is part of Eastern Mercy Health System.

2. Mercy is located in Daphne, Alabama, is licensed by the Alabama Department of Health, and is certified as a specialized rehabilitation hospital by Medicare under Provider No. 01-3027.

3. Mercy is accredited by the Joint Commission on Accreditation of Healthcare Organization ("JCAHO"), as a specialized rehabilitation hospital, hospice, hospital-based SNF, and home health service provider.

4. As part of Mercy, Mercy-Daphne is licensed, certified, and accredited as a hospital-based SNF. For the time period at issue in this appeal, Mercy-Daphne was certified by Medicare under Provider No. 01-5049 to furnish hospital-based SNF services.

5. The mission of Mercy and Mercy-Daphne is to provide intensive rehabilitation to patients, enabling them to achieve the highest possible level of independence and helping them return to normal activities of daily living.

6. Because of its emphasis on patient rehabilitation as opposed to patient maintenance, Mercy-Daphne incurs comparatively high per diem costs and has atypically high nursing hours, lower than average lengths of patient stays, and higher than average Medicare utilization. As a result of Mercy-Daphne's unique services and costs, it has, historically, requested and received exceptions to the routine cost limits ("RCLs") applied to SNFs by the Medicare program.

7. For each cost reporting period from June 30, 1983, through December 31, 1993, Mercy-Daphne's actual costs exceeded the applicable RCL for urban freestanding SNFs. Mercy-Daphne requested an exception to the RCL for each of these periods, and Mutual recommended approval of -- and HCFA approved -- the exception request for each period. As a result, although Mercy-Daphne's occupancy adjusted routine per diem costs exceeded the applicable RCL, per patient day, the facility was reimbursed for the difference.

8. Mercy-Daphne first submitted a request for an interim exception to the RCLs for fiscal year ending December 31, 1995 on March 22, 1995. On April 30, 1998, Mercy-Daphne submitted a repeat request application to Mutual for an exception to the facility's

---

in the "Statement of the Case and Procedural History" portion of this decision.

applicable RCL for urban hospital-based SNFs for its fiscal year ending December 31, 1995, a period during which the facility's actual costs exceeded the RCL by more than $307,000. Mercy-Daphne requested an exception in the amount of $37.77 per patient day.

9. By letter dated August 28, 1998, Mutual informed Mercy-Daphne that it recommended to HCFA that Mercy-Daphne qualified for an exception amount for its fiscal year ended December 31, 1995, but in the amount of $0.00 per patient day. By letter dated September 14, 1998, HCFA informed Mutual that it agreed with Mutual's recommendation to deny Mercy-Daphne an exception amount for its fiscal year ended December 31, 1995. By letter dated September 25, 1998, Mutual informed Mercy-Daphne that HCFA denied a final exception amount for its fiscal year ended December 31, 1995. Mutual's request for an exception for this period was evaluated in accordance with Provider Reimbursement Manual ("HCFA Pub. 15-1") §§ 2530-2541 as contained in HCFA Transmittal No. 378, dated July, 1994.

10. Under these provisions, for RCL exception requests submitted to intermediaries on and after July 20, 1994, Medicare fiscal intermediaries are to determine the amount of a hospital-based SNF's exception, if any, to the RCL by subtracting 112% of the peer group mean cost (rather than the RCL) from the provider's actual allowable costs.

11. Mercy-Daphne's requests for exceptions to the RCLs for periods prior to fiscal year ending December 31, 1994, were not calculated on such a basis and were not subject to Transmittal No. 378. In this instance, this meant that $938,138 (112% of the peer group mean per diem cost), rather than $1,290,850 (the applicable RCL), was subtracted from Mercy-Daphne's actual allowable adjusted costs of $158.43 per patient day in determining Mercy-Daphne's exception amount for the fiscal year ended December 31, 1995. As a result , instead of qualifying for an exception amount of $37.77 per patient day, Mercy-Daphne was ultimately denied an exception.

12. Prior to HCFA Transmittal No. 378, HCFA Pub.15-1 did not contain any provisions specifically addressing RCLs and RCL exception requests for SNFs, as opposed to RCLs and RCL exception requests generally for various types of providers. Such requests were handled by the Secretary [of Health and Human Services] and Medicare fiscal intermediaries pursuant to relevant provisions of the Medicare statute (42 U.S.C. §§1395x(v)(1) and 1395yy), the Secretary's published regulations (42 C.F.R. § 413.30, formerly, 42 C.F.R. § 405.460), and information published in the Federal Register when the actual RCLs for SNFs were periodically updated.

13. For cost reporting periods prior to and not covered by HCFA Transmittal No. 378, the Secretary and Medicare fiscal intermediaries calculated the amount of any RCL exception for a hospital-based SNF from the applicable RCL itself.

14. HCFA Transmittal No. 378 including HCFA Pub.15-1 § 2534.5 ("Determination of Reasonable Costs in Excess of Cost Limit or 112 Percent of Mean Cost") summarizes the

difference between the pre- and post- HCFA Transmittal No. 378 RCL exception principles.

15. HCFA Transmittal No. 378 differentiates the RCL principles based upon whether a hospital-based SNF's cost reporting period begins prior to or on and after July 1, 1984. HCFA Transmittal No. 378 is only effective for exception requests submitted to intermediaries on and after July 20, 1994.

16. HCFA Transmittal No. 378 was not mandated by any explicit statutory directive from Congress or any express legislative history requiring that any RCL exception for hospital-based SNF's be measured from 112% of the peer group mean per diem cost as opposed to the actual RCL itself.

17. HCFA Transmittal No. 378 was not promulgated pursuant to notice and comment rulemaking under the federal Administrative Procedure Act, 5 U.S.C. § 553.

18. The Secretary's regulations on the RCLs, 42 C.F.R. § 413.30 (formerly, 42 C.F.R. § 405.460), and the various amendments to the regulations have not specified the exact formula(e) used to set the RCLs for SNFs.

19. HCFA Transmittal No. 378 was not mandated by any explicit regulation of the Secretary or by any express change in the Secretary's regulations specifically requiring that any RCL exception for hospital-based SNFs be measured from 112% of the peer group mean per diem cost as opposed to the actual RCL itself.

20. Although the Secretary has published the actual SNF RCLs periodically since 1979, the principles contained in HCFA Transmittal No. 378, as they relate to calculation of the amounts of any RCL exceptions for hospital-based SNF exception requests submitted on and after July 20, 1994, are not mandated by or even reflected in any of those publications of the actual RCLs.

21. As a result of HCFA Transmittal No. 378 and for cost report periods to which it is applied, any exceptions to the RCLs for hospital-based SNFs are not calculated from the applicable RCLs. However, for the same periods, any exceptions to the RCLs for freestanding SNFs are computed from the applicable RCLs for those facilities.

22. Because the applicability of HCFA Transmittal No. 378 depends upon the date of submission of the RCL exception request, similarly situated hospital-based SNFs with the same fiscal years and identical costs could have their RCL exception amounts differ based solely on the dates when their RCL exception requests were submitted.

23. For exception requests governed by HCFA Transmittal No. 378, hospital-based SNFs qualifying (or otherwise qualifying) for exception to the RCLs may never recover or be reimbursed by Medicare for any portion of their incurred costs between the hospital-

based RCLs and 112 percent of the applicable mean per diem routine service costs for hospital-based SNFs.

24. For the hospital-based SNF exception requests to which it applies, HCFA Transmittal No. 378 creates an irrebuttable presumption that any and all portions of the incurred costs between the hospital-based RCLs and 112 percent of the applicable mean per diem routine service costs for hospital-based SNFs are unreasonable.

25. Hospital-based SNFs subject to HCFA Transmittal No. 378 are the only type of provider for which the amount of any exception to the RCL is not measured from the relevant RCL but from a different, higher number than the RCL.

26. HCFA Transmittal No. 378 is not utilized in calculating the amount of any Medicare reimbursement paid to a hospital-based SNF that qualifies for an exemption from the routine cost limits as a new provider.

27. Mercy-Daphne requested a rollover interim exception for its fiscal year ended December 31, 1995 in accordance with HCFA's August 11, 1994 memorandum.

28. By letter dated August 28, 1998, Mutual recommended that Mercy-Daphne be "granted a final exception of $0.00 per day, for total of $0." By letter dated September 14, 1998, HCFA informed Mutual that it agreed with Mutual's recommendation to "deny" Mercy-Daphne an exception amount for its fiscal year ended December 31, 1995. By letter dated September 25, 1998, Mutual informed Mercy-Daphne that HCFA denied a final exception amount for its fiscal year ended December 31, 1995.

29. Mutual has not granted any hospital-based SNF the rollover interim exception permitted under HCFA's August 11, 1994 memorandum.

Issue 1 - RCL Exception:

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's calculation of its exception to the RCL is improper because it was based upon instructions contained in HCFA Transmittal No. 378, which is invalid. The Provider asserts that the validity of Transmittal No. 378 was resolved by the Board in the provider's favor in St. Francis Health Care Centre v. Community Mutual Insurance Company, PRRB Dec. No. 97-D38, March 24, 1997, Medicare and Medicaid Guide (CCH) ¶45,159, rev'd, HCFA Administrator, May 30, 1997, Medicare and Medicaid Guide (CCH) ¶45,545, aff'd St. Francis Health Care Centre v. Shalala, Case No. 3:97 CV 7559 (N.D. Ohio)("St. Francis"). The Provider argues that there are no material differences between the instant case and St. Francis that would warrant a different ruling by the Board. With respect to the decisions rendered by the HCFA Administrator and the federal district court in St. Francis, the Provider contends that both rulings are not persuasive and that the Board should adhere to its

original position. The Provider also notes that the Board ruled on the same issues for its FYE December 31, 1994 in 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, aff'd in part, rev'd in part, HCFA Administrator, October 25, 1999, Medicare and Medicaid Guide (CCH) ¶80,417 ("Mercy Medical"). The Provider contends that the Board's majority decision in Mercy Medical was erroneous and, thus, urges the majority to return to its previous analysis, as articulated in St. Francis and the dissenting opinion in Mercy Medical.

The Provider points out that in St. Francis, the Board correctly ruled that HCFA's methodology for computing HB-SNF RCL exceptions under Transmittal No. 378 was improper. The Board reasoned that utilizing the 112 percent level, rather that the actual RCL, was "inconsistent with both the statute and regulation" (Medicare and Medicaid Guide (CCH) ¶45,159 at p.53,321). The statute, 42 U.S.C § 1395yy (a), specifies that the Secretary is not to recognize costs in excess of the statutorily prescribed RCLs as reasonable except as otherwise allowed through the exceptions and exemptions process. Under 42 U.S.C. § 1395yy(c), the Secretary may make exceptions and exemptions adjustments in the statutory specified RCLs. Obviously, the statute envisions exceptions and exemptions being measured from the actual RCLs, not some other higher standard that is not even specified. Here the Secretary's absolute refusal even to consider that HB-SNF costs between the RCLs and the 112 percent level might be reasonable and related to exceptional circumstances, such as atypical services, flatly contravenes the statute.

Likewise, as the Board emphasized in St. Francis, Transmittal No. 378 cannot be squared with the language of the applicable regulation. Under 42 C.F.R. § 413.30(f), upward adjustments may be made to the RCLs "under the circumstances specified in paragraph (f)(1) through (f)(8) of this section"-- the exceptions and exemptions. As the Board explained, the adjustments are not to be computed from some unstated benchmark; rather, they are supposed to be derived from the RCLs themselves:

> [c]learly, the cost limits established by Congress and implemented at 42 C. F.R. § 413.30 are the gauge for evaluating the routine service costs of a SNF, and represent the upper most diem amount a SNF can be reimbursed absent an exception.

St. Francis, Medicare and Medicaid Guide (CCH) § 45,159 at 53,321.

The Provider notes that the Board, in the same fashion, rejected the notion that there was any "authoritative basis" to support the use of the 112 percent level as the proper measuring stick. HCFA argued that the Secretary had issued a report to Congress in 1985, entitled Study of the Skilled Nursing Facility Benefit Under Medicare, recognizing several studies suggesting that about 50% percent of the differences in the costs of HB-SNFs and freestanding SNFs can be accounted for by case mix differences while the remaining 50 percent relates to provider efficiency, facility characteristics, overhead allocations, and similar factors. Nonetheless, Congress did not alter the RCLs or the exceptions to elevate the 112 percent level to definitive status:

> [r]eliance upon the 112 percent level effectively increases the amount or level a provider's costs 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. . . .
>
> Congress has superseded HCFA's authority to establish cost limits with respect to SNFs by statutorily mandating them.

St. Francis, Medicare & Medicaid Guide (CCH) ¶45,159 at 53,321. See also Id. at 53,323 (no evidence that Congress intended atypical service HB-SNFs to bear the financial losses created by Transmittal No. 378).

The Provider further notes that the Board concluded in St. Francis that HCFA's inflexible use of the 112 percent level is inappropriate and indiscriminate as a means of determining reasonable costs. Id at 53,322. This policy is especially illogical because it assumes irrefutably that HB-SNF costs between the RCL and the 112 percent level are unreasonable but that higher costs above the 112 percent level become reasonable thereafter if the facility qualifies for an exception. Id. at 53,323. Moreover, Transmittal No. 378 is inequitable because it permits a freestanding SNF to be paid more than a HB-SNF for providing the same services at the same cost. Where the freestanding SNF has costs greater than the HB-SNF RCL, it will qualify for payment of all of its costs if it obtains an exception; meanwhile, a HB-SNF with the same costs will be limited to the RCL plus only the amount, if any, over the 112 percent level if it is granted an exception. Id. In this regard, it is worth noting the Intermediary's concessions that:

- As a result of HCFA Transmittal No. 378 and for cost report periods to which it is applied, any exceptions to the RCLS for hospital-based SNFs are not calculated from the applicable RCLs. However, for the same periods, any exceptions to the RCLs for freestanding SNFs are computed from the applicable RCLs for those facilities.

- Because the applicability of HCFA Transmittal No. 378 depends upon the date of submission of RCL exception request, similarly situated hospital-based SNFs with the same fiscal years and identical costs could have their RCL exception amounts differ based solely on the dates when their RCL exception requests were submitted.

- For exception requests governed by HCFA Transmittal No. 378, hospital-based SNFs qualifying (or otherwise qualifying) for exceptions to the RCLs may never recover or be reimbursed by Medicare for any portion of their incurred costs between the hospital-based RCLs and 112 percent of the applicable mean per diem routine services costs for hospital-based SNFs.

- For the hospital-based SNF exception requests to which it applies, HCFA Transmittal No. 378 creates an irrebuttable presumption that any and all portions of the incurred costs between the hospital-based RCLs and 112 percent of the applicable mean per diem routine service costs for hospital-based SNFs are unreasonable.

- Hospital-based SNF's subject to HCFA Transmittal No. 378 are the only type of provider for which the amount of any exception to the RCL is not measured from the relevant RCL but from a different, higher number than the RCL.

- HCFA Transmittal No. 378 is not utilized in calculating the amount of any Medicare reimbursement paid to a hospital-based SNF that qualifies for an exemption from the routine cost limits as a new provider.

Parties' Joint Stipulation ¶¶ 21-26.

The Provider fully concurs with the Board's analysis in St. Francis and incorporates the Board's reasoning and the facility's arguments in that case by reference herein. Moreover, the Provider asserts that the accuracy of this analysis is further underscored by the parties' stipulation that Transmittal No. 378 is not the product of any express statutory or regulatory mandate. In sum, HCFA Transmittal No. 378 is at odds with the statute and regulations and establishes a policy that is arbitrary and irrational.

In light of the Board's cogent reasoning in St. Francis, the Provider finds the Board majority's decision in Mercy Medical to be unsound. Accordingly, it is not surprising that the majority directly evaded addressing its own contradictory reasoning with a vague reference to its decision in 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 ("North Coast"). The Provider notes that North Coast concerned a provider's 1989 cost reporting period, a time frame well before the issuance of Transmittal No. 378. Thus, while North Coast did address the application of the 112 percent peer group mean, the Board majority in Mercy Medical presented no justification for abandoning its reasoning in St. Francis, which addressed the same exact issue as Mercy Medical and the instant matter concerning the validity of Transmittal No. 378. Whereas the dissenting Board member in Mercy Medical remained consistent in finding HCFA's use of the 112 percent peer group mean was inconsistent with both the statute and regulation, the Board majority refused to explain its abrupt change in reasoning. In light of the Administrator and district court decisions in St. Francis, the Provider believes the Board majority's change in reasoning to be suspect. Accordingly, the Provider urges the majority to revisit its analysis of this issue and preserve the integrity of its reasoning in St. Francis.

The Provider contends that the HCFA Administrator's reversal of the Board's decision in St. Francis is not persuasive or controlling, nor does it withstand scrutiny or provide a convincing basis for the Board to alter its position. In his decision, the Administrator found that the exception guidelines under HCFA Transmittal No. 378 are reasonable and appropriate because:

(1) they " closely adhere" to the mandate of 42 U.S.C. § 1395yy(a); (2) they are "within the scope" of the Secretary's discretionary authority under 42 U.S.C. § 1395yy(c) to make adjustments (i.e., exceptions and exemptions) to the RCLs to the extent deemed appropriate; and (3) they conform with the Secretary's obligation under 42 C.F.R. § 413.30(f) to make such adjustments only to the extent that the underlying costs are reasonable. Medicare and Medicaid Guide (CCH) ¶45,545 at p. 54,758. The Provider argues that this reasoning is seriously flawed as follows:

- First, it is hard to see how the imposition of the 112% percent level under HCFA Transmittal No. 378 represents close adherence to the requirements of 42 U.S.C. § 1395yy(a). This statutory provision sets the RCLs for HB-SNFs at one level while Transmittal No. 378 effectively rewrites this congressional mandate to establish those RCLs at a different, higher level. In plain terms, HCFA has simply defied Congress and is refusing to carry out an express statutory mandate.

- Second, the Secretary's authority under 42 U.S.C. § 1395yy(c) to make adjustments to the RCLs in appropriate circumstances is not the authority to determine the RCLs themselves. That determination has been made by Congress under 42 U.S.C. § 1395yy(a) where the RCL formulae are detailed. Rather, the Secretary's authority to make appropriate adjustments relates simply to defining the circumstances and criteria needed to qualify for an exception or exemption (e.g., atypical services, new provider status, extraordinary circumstances, unusual labor costs, etc.).

- Finally, the Secretary's duty under 42 C.F.R. § 413.30(f) to make adjustments to the RCLs only where the costs are reasonable is similarly circumscribed. This regulatory duty is based upon the Secretary's statutory authority under 42 U.S.C. §1395yy(c), and the regulations cannot be used as a bootstrapping device to enlarge the Secretary's power beyond that conferred in the statute. As such, the Secretary's obligation to determine reasonable costs is not the ability to impose the agency's own version of RCLs; Congress has pre-exempt that. Instead, it is simply the power to define the criteria for a RCL adjustment through rulemaking (which the Secretary did not employ here) and then to apply published regulatory criteria on a case-by-case basis to ensure that only reasonable costs are reimbursed. The use of the agency's own RCLs to deny or limit, on a wholesale basis, exceptions and exception amounts mandated by the statute and regulations is a

> perversions, rather than a legitimate exercise, of the Secretary's limited authority.

With respect to the federal district court's opinion in St. Francis, the Provider argues that the court's decision is not persuasive or controlling. In granting the government's motion, the court issued a "Memorandum Opinion" that is unsound and does not withstand scrutiny. The Provider further notes that the Board is not bound by the Judgement Entry and corresponding Memorandum Opinion of the District Court for the Northern District of Ohio which upheld the Administrator's reversal of the Board's decision in St. Francis. The Provider explains that federal district court opinions from one state are not accorded precedence in other states. Since the Provider is located in Alabama, the opinion from the federal district court in Ohio has no impact on the instant case. In addressing the district court's flawed opinion, the Provider organized its analysis according to the same five consolidated concepts presented in the Memorandum Opinion, which include: (1) Overbreadth: (2) Impermissible Distinction Between FS and HB-SNFs: (3) Plain Language of the Statute and Implementing Regulations; (4) Public Policy; and (5) Notice and Comment. The Provider's response to each of these arguments is as follows:

1. Overbreadth

The district court mistakenly attempts to combine a number of the complex arguments into a neat category and label it "overbreadth." This consolidation allowed the district court to avoid directly addressing the merits of the individual arguments, and further obscured the sound reasoning initially developed by the Board.

First, the district court claims that it is not unreasonable that Transmittal No. 378 declares costs between the free standing ("FS") SNF 112 percent level and the HB-SNF 112 percent level unrecoverable. This is because, the court asserts, that Congress has recognized that these costs are the result of certain systematic inefficiencies associated with HB-SNFs, and, therefore, the costs are unreasonable. However, the district court completely avoids taking its own reasoning to the logical end. If, as the court claims, Congress was attempting to target various costs of inefficiency, why would it carve a hole out of the middle of allowable costs? What is actually unreasonable -- and illogical -- is the theory advanced by the district court that the costs of atypical services provided by a HB-SNF that are above the RCL are considered unreasonable, until, however, the costs exceed the 112 percent mean per diem level, when they become reasonable again. The district court does not explain why it believes that costs above the RCL up to the 112 percent mean are the result of more onerous inefficiencies, and are more unreasonable than costs above the 112 percent mean. In fact, the opposite is more likely to be true; that is, the costs above the 112 percent group are more likely to be unreasonable as they deviate further from the mean, and therefore are more likely to represent inefficiencies. The Board correctly identified this lapse of logic in its decision in St. Francis, and noted that the results produced by Transmittal No. 378 were "unsound," and stated that it " disagree[d] with the concept that costs are unreasonable once they exceed the cost limit but become reasonable again

once they exceed the even greater 112 percent level." The Board supported its finding by holding that this "gap" is an impermissible interpretation made by HCFA, and that if an exception is granted, the provider is entitled to "each and every dollar that its costs exceed the limit." The Board's finding is clear and its reasoning cogent. The district court's disregard of this logic is indefensible.

Second, the district court's misguided attachment to its overbreadth argument ignores the fact that full and complete reimbursement of costs upon the grant of an exception is a fundamental assumption of the Medicare reimbursement scheme. As highlighted by the Board in St. Francis, this fact is well settled in case law and legislative history, as well as prior decisions of HCFA's Administrator, which the district court has also chosen to disregard. In Sacramento Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 80-D56, August 1, 1980, Medicare and Medicaid Guide (CCH) ¶30,826, rev'd in part, aff'd in part, HCFA Administrator, September 29, 1980, Medicare and Medicaid Guide (CCH) ¶30,859, the Administrator held that "an exception to the cost limits may be granted upon the provider's demonstration that certain conditions are present. Regulation 42 C.F.R. § 405.460(f)(2) [redesignated as 413.30(f)(1)] provides an exception for the cost of atypical services or items. . . . These 'atypical services' may be reimbursed in full over and above the routine cost limits." Medicare and Medicaid Guide (CCH) ¶30,859. Similarly, the only relevant legislative history of the portion of the Medicare statute at issue provides that "facilities eligible for exceptions" from the RCL can receive, "all of their reasonable costs." Finance Com. 98th Cong., Senate Print 98-169, v. 1 at 947 (1984) (emphasis added). In sum, the very concept of an "exception" incorporates the notion that the grantee will receive something not otherwise available if the exception was denied. Had Congress intended to target alleged inefficiencies associated with HB-SNFs and withhold reimbursement, they would have done so. Instead, the legislative history and relevant case law, as well as HCFA's earlier policy, demonstrates the contrary: that the exceptions process was intended to fully reimburse providers for amounts exceeding the RCLs. This is reinforced by the long-standing practice of fiscal intermediaries in fully reimbursing providers that qualified for an exception, including the Provider's Intermediary, which fully reimbursed the Provider for amounts exceeding the RCLs for ten years.

2. Impermissible Distinction Between FS and HB-SNFs

The district court's finding that HB-SNFs have systematic inefficiencies to which FS-SNFs are not subject is inaccurate and insupportable. The district court claims that the disparate treatment of HB and FS-SNFs and the corresponding reimbursement gap is grounded in Medicare statute and the two-tiered system it has established, and that it is based on empirical findings that HB-SNFs are systematically more inefficient. To reach this conclusion, the district court misinterprets the purpose of the two-tiered system and the distinction between FS and HB-SNFs. The distinction between FS and HB-SNFs is based on the undisputed fact that HB-SNFs generally treat patients with higher acuity, i.e., they require more intense utilization of resources. Accordingly, the Board in St. Francis noted that the Deficit Reduction Act of 1984 ("DEFRA") effectively increased HB-SNF cost limits over the levels that would have been effectuated by the

preceding Tax Equity and Fiscal Responsibility Act ("TEFRA") because Congress was concerned that TEFRA limits would not adequately provide reimbursement to HB-SNFs. As follows from this finding, there was no congressional intent to disadvantage HB-SNFs by imposing a reimbursement scheme that compensated for some type of "inefficiencies." Rather, the Board correctly concluded that Congress expected the Secretary to provide an exception process to fully reimburse providers under certain circumstances. As the legislative history of DEFRA indicates: "[e]xceptions [to RCLs] could be granted based upon case mix or circumstances beyond the control of the facility, be it either a freestanding or hospital-based facility." H. Conf. Rep. To P.L. 98-369 (1984).

In addition, while the district court implies that the two tiered system was intended to treat FS and HB-SNFs differently and inequitably with respect to exceptions to the RCLs, the legislative history proves otherwise. When Congress implemented the two-tiered system in 1984, the exception methodology as set forth in the regulation (42 C.F.R. § 413.30, formerly 42 C.F.R. § 405.460) had already been in place for several years. Moreover, at that time, HCFA was interpreting the regulation in the manner currently advanced by the Provider here and by the Board in St. Francis, i.e., that all costs above the applicable limit for atypical services could be reimbursed. Thus, Congress was fully cognizant that the regulation allowed reimbursement for all costs of atypical services in excess of the two-tiered cost limits it established. Had Congress wished to limit available reimbursement for all costs of atypical services in excess of the cost limit by the gap amount, it would have so provided in the two-tiered system by limiting HCFA's authority to grant the exception by the gap amount. It did not do so, and thus HCFA is not now free to interpret the regulation in a manner unsupported by Congress' statutory framework.

Moreover, the two-tiered reimbursement system was not designed to have a gaping hole in the middle of reasonable costs, as is simply asserted by the district court, without any supporting authority. On the contrary, a report from the Senate Finance Committee, which proposed the two-tiered system, notes:

> [u]nder this provision, both hospital-based and freestanding facilities could continue to apply for and receive exception from the cost limits. . . . Facilities eligible for exceptions could receive, where justified, up to all of their reasonable costs.

Finance Com. 98th Cong., Senate Print 98-169, v. 1 at 947 (1984) (emphasis added).

Accordingly, the district court's conclusion that a gap in reimbursement was intended by Congress is wrong. On the other hand, the Board in St. Francis, after a careful analysis of the relevant statutory enactments and legislative history, found that Congress never intended this type of disparate treatment and that HB-SNFs which are granted an exception should be reimbursed for every dollar that exceeds the limit.

3. Plain Language of the Statute and Implementing Regulations

Despite the district court's cursory analysis to the contrary, the Provider insists that Transmittal No. 378 conflicts with the plain language of the Medicare statute and implementing regulations. In order to support its erroneous conclusion, the district court noted that the statute and the regulations are "couched in permissive" terms, and that the regulations grant the Secretary discretion in making adjustments. The underlying assumption of this argument is that discretion completely forecloses the possibility that Transmittal No. 378 could contradict the statute or regulations. This assumption is false and the district court's argument is unpersuasive.

First, just because the Secretary was granted a certain amount of discretion in devising a methodology for granting exceptions does not mean that any method devised would be automatically sanctioned as consistent with the statute. Rather, the method would still be subject to the plain language, scope, intent, and purpose of the statute, and limited accordingly.

Second, HCFA is incorrect in stating that the statute and regulations are silent. Even the district court recognized that the statute addresses this issue, albeit, in terms that are couched in permissiveness. Rather, the statute grants the Secretary the authority to adjust the RCLs as appropriate and requires that the criteria for any adjustment be published. 42 U.S.C. § 1395yy. A regulation promulgated by the Secretary utilizing this authority, 42 C.F.R. § 413.30, sets forth the relevant criteria for the adjustment and the corresponding methodology. More specifically, an upward adjustment may be made if the actual costs of atypical services are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary. 42 C.F.R. § 413.30(f).

Third, the legislative history reveals the intent of Congress -- that all SNFs should be eligible to receive full reimbursement of reasonable costs. The legislative history of the only relevant statute notes that both HB and FS-SNFs "eligible for exceptions could receive, where justified, up to all of their reasonable costs." Finance Com. 98th Cong., Senate Print 98-169. In other words, inequitable, differential, treatment between FS and HB-SNFs was never intended by Congress. Accordingly, the district court's assertion that Transmittal No. 378 is not and cannot conflict with the enabling statute and regulations is erroneous.

4. Public Policy

The Provider contends that the district court's decisions will lead to a result that would produce a health care policy that is arbitrary and unsupported by law. The first reason proffered by the district court for its curt dismissal of the provider's public policy argument as "unavailing," is that it is unsure whether it is appropriate for the court to consider policy arguments. Despite the irony of this statement the court continues, stating that "this is simply the wrong forum in which to make public policy arguments." The district court uses this reasoning in order to ignore further errors in its logic and to divert focus from its misinterpretation of statutes and legislative history, on which it relied in its decision. While the Provider would agree that a court should not base its decision solely on public policy, it finds it difficult to fathom that a court, or any judicial body, renders its decision in a vacuum. The Provider submits that any decision-maker must

attempt to ascertain the context in which the decision is being made. The district court's total disregard as to the effects of its decision indicates that the court did not consider the larger context in which its decision was rendered. See Brown v. Allen, 344 U.S. 443, 537 (1953)(Jackson, J., concurring) (cited by the district court in its Memorandum Opinion). Thus, instead of recognizing that Transmittal No. 378 was merely a small component in a much larger health care system, Medicare, the district court cursorily dismisses the provider's arguments and conveniently ignores the impact of its decision on the Medicare program. In St. Francis, the Board noted that one of the reasons that HCFA's methodology in Transmittal No. 378 was improper and not supported by any legislative history was because identically situated HB and FS-SNFs would be reimbursed inequitably due to the gap created by HCFA.

The second reason the district court characterizes the provider's policy arguments as unavailing is because it believes that HB and FS-SNFs are systematically under-compensated in the exact same manner, and hence, there is no disincentive for HB-SNFs to provide atypical services. However, this statement is not supported by the record in St. Francis, or the stipulation in this case. In St. Francis, the Board stated:

> [t]he Board also questions the equity within HCFA's methodology, in that it allows FS-SNFs to be reimbursed more than HB-SNFs under identical circumstances. In the case where two SNFs, one freestanding and the other hospital-based, provide identical services at the exact same cost, and that cost is greater than the HB-SNF limit but is less than the 112 percent level, the freestanding SNF would be paid its entire per diem under HCFA's exception methodology. However, the hospital-based facility would not be paid the entire amount of its per diem cost, although identical to that of the freestanding facility, because of the gap created by HCFA's methodology.

Medicare and Medicaid Guide (CCH) ¶45,545.

5. Notice and Comment

The district court points out that Provider Reimbursement Manual provisions are interpretive rules, exempt from notice and comment requirements under the Administrative Procedure Act ("APA"). The court continues stating that, since Transmittal No. 378 is codified in the manual, it therefore is an interpretive rule, not subject to notice and comment rulemaking. In support of this conclusion, the district court cites numerous cases which held that reimbursement manual provisions are interpretive rules. However, the district court fails to conduct the appropriate analysis to determine whether or not Transmittal No. 378 is, in fact, an interpretive rule. If the court had conducted this analysis, it would have concluded that Transmittal No. 378 does not qualify as an interpretive rule because it effects a substantive change contrary to the enabling statute and regulations, and conflicts with a policy that had been well established for at least ten

years. The Provider argues that the proper test is whether the manual provision adopts a "new position inconsistent" with existing laws and regulations. See Mt. Diablo Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 96-D40, July 1, 1996; See also Henry County Memorial Hospital v. Shalala, No. IP-92-1044-C (S.D. Ind. 1996). The Provider maintains that Transmittal No. 378 clearly establishes a new position inconsistent, not only with prior policy, but with the contemporaneous statute and regulations. Accordingly, these facts render Transmittal No. 378 impermissible under the APA and should be considered invalid.

The Provider contends that there are additional reasons why HCFA Transmittal No. 378 is unlawful, which neither the Board nor the Administrator explored in the St. Francis case. The Provider insists that Transmittal No. 378 not only deserves no deference, but is in violation of the notice and comment rulemaking procedures of the APA, 5 U.S.C. § 553. The instructions contained in Transmittal No. 378 represent an about-face from HCFA's long standing policy of granting HB-SNF exceptions to the RCL based upon the RCLs themselves. See Samaritan Health Service v. Bowen, 811 F. 2d 1524, 1529 (D.C. Cir. 1987). As the Supreme Court explained.

> [a]n Agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is "entitled to considerably less deference than a consistently held agency view.

INS v. Cardoza Fonseca, 480 U.S. 421, 446 n. 30 (1987) (quoting Watt v. Alaska, 451 U.S. 259, 273 (1981). See also New York City Health and Hospital v. Perales, 954 F.2d 854, 861 (2d. Cir.), cert denied, 506 U.S. 972 (1992).

Moreover, Transmittal No. 378 runs counter to plain statutory language. Therefore, it deserves little or no deference as an agency interpretation of the statute:

> [w]here an issue is a question of law involving statutory construction and analysis of congressional intent, and the meaning of the statute is clear, an agency interpretation is entitled to less deference.

Perales, 954 F. 2d at 861. See Cardoza Fonseca, 480 U.S. at 445-48; Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844 (1984).

Most importantly, even assuming for the sake of argument that HCFA could somehow utilize the 112 percent level as an additional limit, Transmittal No. 378 is violative of the APA's notice and comment rulemaking procedures. Under the APA, 5 U.S.C. § 553, federal agencies must publish general notice of a proposed rule in the Federal Register, furnish interested parties with an opportunity to comment, and incorporate a concise general statement of basis and purpose in the rules. Id. National Association of Home Health Agencies v. Schweiker, 690 F. 2d 932, 948-49 (D.C. Cir. 1982). For such purposes, a rule is defined as "an agency statement of general or

particular applicability and future effect designed to implement, interpret or prescribe law or policy. . . . " 5 U.S.C. § 551 (4). Clearly, Transmittal No. 378 is a rule, particularly insofar as it seeks to engraft a new and previously unstated limitation onto the existing statute and regulations for future purposes. Equally clear, HCFA did not engage in such rulemaking -- a fact conceded by the Intermediary in the instant case.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly calculated the Provider's RCL adjustment. The Intermediary maintains that the calculation is based upon instructions contained in HCFA Transmittal No. 378, which is a proper interpretation of the Medicare statute and regulations, and fully consistent with Congress' intent on reducing reimbursement for HB-SNFs.

The Intermediary explains that Congress set per diem limits for the routine service costs of extended care facilities at 42 U.S.C. § 1395yy(a). In part, the statute provides.

> (1) With respect to freestanding skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in urban areas.
>
> (2) With respect to freestanding skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine service costs for freestanding skilled nursing facilities located in rural areas.
>
> (3) With respect to hospital-based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in urban areas exceeds the limit for freestanding skilled nursing facilities located in urban areas.
>
> (4) With respect to hospital-based skilled nursing facilities located in rural areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in rural 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 rural areas exceeds the limit for freestanding skilled nursing facilities located in rural areas.

42 U.S.C. § 1395yy(a).

The Intermediary points out that Congress was concerned that the cost differences between HB and FS-SNFs were attributable to efficiencies. This concern was generated by a series of studies conducted in 1983 and 1984 which concluded that approximately 50 percent of the cost

differences between HB and FS-SNFs were attributable to variations in intensity of care or case-mix. As a result of these studies, Congress prohibited the Secretary from reimbursing excessive indirect costs. The statute at 42 U.S.C. § 1395yy(b) states:

> (b) With respect to a hospital-based skilled nursing facility, the Secretary may not recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities attributable to excess overhead allocations.

42 U.S.C. § 1395yy(b).

Accordingly, in setting the RCL, Congress plainly chose not to reimburse any portion of an urban, HB-SNF's routine service costs in excess of 50 percent of the amount by which 112 percent of the mean per diem routine service costs for similarly classified SNFs exceeds the limit for FS-SNFs located in urban areas.

The Intermediary explains that 42 U.S.C. § 1395yy(c) provides for an exception to the cost limits described above, as follows:

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

42 U.S.C. § 1395yy(c).

The regulation governing exceptions to the routine cost limit for atypical services is published at 42 C.F.R. § 413.30(f)(1). This regulation permits an adjustment to the RCL where the cost of items or services furnished by a provider are atypical in nature and scope as compared to the items or services generally furnished by similarly classified providers.

The Intermediary maintains that in order to properly implement this regulation, HCFA issued Transmittal No. 378. This transmittal, among other things, requires a SNF to demonstrate that the actual cost of items or services it furnished exceeds the applicable peer group cost. In the instant case, the applicable peer group for the Provider is HB-SNFs, and 112 percent of the peer group mean per diem cost for HB-SNFs during the cost reporting period under appeal was $157.34. This amount was subtracted from the Provider's actual per diem routine service cost of $157.80, in order to calculate the adjustment amount of $0.[2]

---

[2] See Intermediary Exhibit I-9 for calculations.

The Intermediary contends that this comparison is not explicitly mandated by 42 C.F.R. §413.30(f), however, it is in accordance with the regulation. Before an adjustment to the limit can be made for atypical services, 42 C.F.R. § 413.30(f)(1)(i) requires a comparison of items or services generally furnished by providers similarly classified. The peer group data gathered by HCFA serves this purpose. Moreover, HCFA's data form a more accurate basis for comparing the items or services furnished by similarly classified providers than the congressionally mandated RCL set by 42 U.S.C. § 1395yy(a)(3). Factually, the RCL is only partially based upon cost data gathered from HB-SNFs. That is, HB-SNF cost data is only used to calculate the 50 percent difference between HB and FS-SNF routine service costs. In the main, the RCL is based upon cost data gathered by HCFA from FS-SNFs not HB-SNFs. Therefore, the 112 percent level, which is calculated from cost data gathered from HB-SNFs, is a more accurate benchmark for identifying atypical items and services than the RCL.

The Intermediary also asserts that Congress gave the Secretary a wide berth to decide the amount of adjustments to the cost limits. As noted above, 42 U.S.C. § 1395yy(c) 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 Intermediary maintains that the peer group comparison made by HCFA does not violate the authority that Congress delegated to the Secretary.

The Intermediary rejects the Provider's argument that, where a FS-SNF has costs greater than the 112 percent level for a HB-SNF, that under Transmittal No. 378 the FS-SNF could be paid more than the HB-SNF for providing the same services at the same cost. The data used to compute the FS-SNF RCL is based upon cost data gathered from other FS-SNFs, therefore, the amount of this RCL provides a basis for comparison that is fully in accordance with the regulatory requirement of 42 C.F.R. §413.30(f)(1)(i). That is, the RCL is an accurate benchmark for determining whether a FS-SNF furnished atypical items and services. In contrast, the HB-SNF RCL, as argued above, is only partially based on data gathered from other HB-SNFs and, for this reason, is not an accurate benchmark.

The Intermediary is aware of the Board's decision in St. Francis, wherein the Board ruled that the methodology set forth in Transmittal No. 378 was improper.[3] However, the Intermediary notes that this decision was subsequently reversed by the HCFA Administrator.[4] Further, the St. Francis case was also heard in the U.S. District Court, Northern District of Ohio, and a decision was rendered on June 13, 1998.[5] In upholding the Administrator's reversal of the Board's decision, the court ruled that Transmittal No. 378 and HCFA Pub. 15-1 §2534.5 represented a

---

[3] See Intermediary Exhibit I-10.

[4] See Intermediary Exhibit I-11.

[5] See Intermediary Exhibit I-12.

proper interpretation of 42 U.S.C § 1395yy and 42 C.F.R. § 413.30(f) for purposes of determining the RCL exception amount imposed by the Medicare program on HB-SNFs. Based on the foregoing, the Intermediary concludes that HCFA properly used 112 percent of the peer group mean for HB-SNFs to determine the amount of the Provider's RCL exception

Issue 2 - Rollover Interim Exception:

PROVIDER'S CONTENTIONS:

The Provider contends that it is entitled to a rollover interim exception for its FYE December 31, 1995, regardless of the legal fate of Transmittal No. 378. This would effectively allow the amount of the Provider's exception to be determined in accordance with procedures in effect prior to HCFA Transmittal No. 378. In support of this position, the Provider refers to the decision in Mercy Medical where the Board found that Regional Intermediary Letter ("RIL") No. 94-18, entitled Instructions for Finalizing Interim Exception Amounts Determined Prior to the Implementation of HCFA Pub. 15-1, Section 2530, provides two different ways in which a provider may be held harmless from the effects of Transmittal No. 378.[6]

Under the first method set forth in RIL No. 94-18, a provider is granted hold harmless protection where it was operating under an interim exception at the time Transmittal No. 378 was issued. The second method is a "rollover" exception, which extends hold harmless protection to providers that were not operating under an interim exception when Transmittal No. 378 was issued, "but are accustomed to requesting and qualifying for final exceptions." Mercy Medical (emphasis added). The Board further stated that it "believes the RIL clearly intends to provide all HB-SNFs accustomed to receiving an exception to the RCLs at least one year's relief from Transmittal No. 378. . . ." Id. (Emphasis added).

---

[6] See Provider Exhibit P-4.

The Provider contends that it is eligible for hold harmless protection under the second method, and that it qualified on the basis of two requests filed at different times. Moreover, the Intermediary concedes in the "Joint Stipulations" that the Provider requested a rollover interim exception for its FYE December 31, 1995 in accordance with HCFA's August 11, 1994 memorandum. Parties Joint Stipulation ¶27. First, the Provider asserts that interim exception requests were filed for the 1993, 1994 and 1995 cost reporting periods in August of 1993, and that these requests were "under review" by the Intermediary at the time Transmittal No. 378 was issued. Second, since the Board found in Mercy Medical that the RIL does not specify a date for the submission of a rollover exception request, the Provider argues that its March 22, 1995 submission should be deemed an acceptable request because it specifically referenced HCFA Pub. 15-1 § 2534.3.A.4, and was within the timeliness requirements of HCFA Pub. 15-1 § 2531.1.[7] Accordingly, the Provider's contends that its request meets each of the requirements articulated by the Board in Mercy Medical.

The Provider also contends that it was accustomed to requesting and qualifying for exceptions to the RCLs and, thus, its request for a rollover exception is consistent with the purpose of the RIL. The Board expressly noted in Mercy Medical that the rollover exception was intended to provide relief to providers that had historically relied on the exception process, and that this relief was not limited to a single cost reporting period. Therefore, the Provider concludes that it is entitled to a rollover interim exception under the RIL, and the Board's interpretation thereof in Mercy Medical.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider was not entitled to a rollover interim exception for the FYE December 31, 1995, and that it properly denied the Provider's request pursuant to RIL No. 94-18. RIL No. 94-18 sets forth the conditions that must be met before a SNF is entitled to a rollover interim exception. In applying these conditions to the instant case, the Intermediary notes that the Provider must have submitted its request for FYE December 31, 1995 prior to July 20, 1994. Since the Provider first submitted its interim exception request for the 1995 cost report on March 22, 1995,[8] the request was made subsequent to July 20, 1994. Accordingly the rollover provisions do not apply, and the request was properly evaluated according to the methodology in Transmittal No. 378.

The Intermediary points out that the provisions in RIL 94-18 merely place a limit on the interim exception requests that may be reviewed under the rules that applied prior to Transmittal No. 378. In establishing the hold harmless provisions for interim exceptions, RIL No. 94-18 states in part:

---

[7] See Provider Exhibit P-5.

[8] See Intermediary Exhibit I-14.

> If a provider files an exception request prior to July 20, 1994, and requests a rollover interim exception for [more] than one subsequent cost reporting period, the Health Care Financing Administration will consider an exception only for the first subsequent cost reporting period. Any exception for the second subsequent cost reporting period must be determined by you in accordance with the rules set forth in Transmittal No. 378. Therefore, the hold harmless provisions will only apply to the exception for the first subsequent cost reporting period.

RIL No. 94-18.

The Intermediary concludes that it properly denied the Provider's request for a rollover interim exception in accordance with the applicable rules that were in place under Transmittal No.378.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.

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

2. Law - 5 U.S.C.

§ 551(4)	-	Definitions - "Rule"
§ 553	-	Rule Making

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.30 et seq. (formerly § 405.460)	-	Limitations on Reimbursable Costs

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

§ 2530 et seq.	-	Inpatient Routine Service Cost Limits for Skilled Nursing Facilities

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, rev'd, HCFA Administrator, May 30, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,545, aff'd., St. Francis Health Care Center v. Shalala, Case No. 3:97 CV 7559 (N.D. Ohio).

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, aff'd in part, rev'd in part, HCFA Administrator, October 25, 1999, Medicare and Medicaid Guide (CCH) ¶ 80, 417.

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.

Samaritan Health Service v. Bowen, 811 F. 2d 1524 (D.C. Cir. 1987).

INS v. Cardoza Fonseca, 480 U.S. 421 (1987).

New York City Health and Hospitals v. Perales, 954 F. 2d 854 (2d Cir.), cert. denied, 506 U.S. 972 (1992).

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

National Association of Home Health Agencies v. Schweiker, 690 F. 2d 932 (D.C. Cir. 1982).

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

Brown v. Allen, 344 U.S. 443 (1953).

Mt. Diablo Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 96-D40, July 1, 1996, Medicare and Medicaid Guide (CCH) ¶ 44,495, decl'd rev HCFA Administrator, July 29, 1996.

Henry County Memorial Hospital v. Shalala, No. IP-92-1044-C (S.D. Ind. 1996).

Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D67, September 2, 1999, Medicare and Medicaid Guide (CCH) ¶80,311, decl'd

rev HCFA Administrator, October 22, 1999.

New England Rehabilitation Hospital v. C&S Administrative Services for Medicare, PRRB Dec No. 2000-D53, May 24, 2000, Medicare and Medicaid Guide (CCH) ¶80,443, decl'd rev HCFA Administrator, June 14, 2000.

San Joaquin Community Hospital-SNF v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 2001-D17, April 17, 2001.

6. Other:

HCFA Transmittal No. 378

HCFA Memorandum, August 11, 1994.

Deficit Reduction Act of 1984 (DEFRA of 1984)

Tax Equity and Fiscal Responsibility Act (TEFRA)

Regional Intermediary Letter No. 94-18

Parties' Joint Stipulation

Finance Com. 98th Cong., Senate Print 98-169 (1984).

H. Conf. Rep. to P.L. 98-369 (1984).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration and analysis of the controlling law, regulations, and program instructions, the facts of the case, documentary evidence presented, and the parties' contentions, finds and concludes as follows:

Issue 1 - RCL Exception:

The Board majority finds that the HCFA methodology applied by the Intermediary in determining the amount of the exception from the RCLs for the Provider's FYE December 31, 1995, was an appropriate application of policy in accordance with the statutory and regulatory provisions set forth under 42 U.S.C. § 1395yy et seq. and 42 C.F.R. § 413.30 et seq.

Pursuant to DEFRA of 1984, the majority of the Board finds that the Secretary was given broad

discretion in authoring adjustments to the RCLs. The Board majority 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) 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).
Consistent with the forgoing 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(f) provides for exceptions to the RCLs to the extent that costs are reasonable, attributable to the circumstances specified, separately identified and verifiable. The Board majority 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 regulation 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 HB-SNFs is set at 112 percent of the mean hospital-based inpatient routine service costs, and not at the HB-SNF's cost limit. HCFA compares the HB-SNF's costs to those of the typical facility to determine the amount of its costs that are atypical. Under this methodology, if a HB-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 HB-SNFs, the Board majority 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 FS-SNFs, and is a standard based entirely upon HB-SNF data as opposed to the HB-SNF cost limit which is heavily based upon FS-SNF data.

The Board majority further notes that HCFA's methodology of using the standard of 112 percent of the HB-SNF peer group mean when reviewing exception requests is clearly set forth in a subsequent publication of HCFA Pub. 15-1 § 2534.5, as adopted in Transmittal No. 378 (July 1994). This transmittal explained that 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 majority concludes that it was not unreasonable for HCFA to use the 112 percent peer group level as the standard for reviewing exception requests for HB-SNFs.

Finally, the Board majority acknowledges the Provider's reliance upon the previous Board's decision in St. Francis to help support its position and arguments. The majority of this 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:

- North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D-22, 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, aff'd in part, rev'd in part, HCFA Administrator, October 25, 1999, Medicare and Medicaid Guide (CCH) ¶ 80, 417.

- Riverview Medical Center SNF v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D67, September 2, 1999, Medicare and Medicaid Guide (CCH) ¶80,311, decl'd rev HCFA Administrator, October 22, 1999.

- New England Rehabilitation Hospital v. C&S Administrative Services for Medicare, PRRB Dec No. 2000-D53, May 24, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,443, decl'd rev HCFA Administrator, June 14, 2000.

- San Joaquin Community Hospital-SNF v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 2001-D17, April 17, 2001.

Issue 2 - Rollover Interim Exception:

The Board finds that RIL No. 94-18, issued on August 16, 1994, established specific procedural instructions for finalizing interim exception amounts determined prior to the implementation of Transmittal No. 378, and also provided clarification of the rules for continuing/repeating requests for atypical services or items. Under the caption "Interim Exceptions - Hold Harmless Provision," RIL No. 94-18 states the following:

> If a provider submitted an interim exception prior to July 20, 1994 (the implementation date of Transmittal No. 378), the exception will be reviewed under the rules in place prior to Transmittal No. 378. If the provider submits its final exception after July 19, 1994, the final exception will be reviewed in accordance with the new rules in Transmittal No. 378. . . .
>
> In addition, all exceptions currently being reviewed under the rules

> prior to Transmittal No. 378 will be allowed a rollover interim exception for only the first subsequent cost reporting period. If a provider files an exception request prior to July 20, 1994, and requests a rollover interim exception for [more] than one subsequent cost reporting period, the Health Care Financing Administration will consider an exception only for the first subsequent cost reporting period. Any exception for the second subsequent cost reporting period must be determined by you in accordance with the rules set forth in Transmittal No. 378. Therefore, the hold harmless provisions will only apply to the exception for the first subsequent cost reporting period.

RIL No. 94-18.

The Board finds that there is no evidence in the record to support the Provider's allegation that it requested a RCL exception or a rollover interim exception for FYE December 31, 1995 prior to July 20, 1994. The record shows that the Provider first submitted a request for an interim exception to the RCLs for the FYE December 31, 1995 on March 22, 1995.[9] The record further shows that the provider filed its request for exception to the RCLs for FYE December 31, 1995 on April 30, 1998.[10] The basis cited for this exception request was the NPR issued on November 4, 1997, wherein the routine cost limit was applied without exception. In the absence of supportable documentation that the Provider met the cut-off date of July 20, 1994, the Board concludes that the Provider does not qualify for a rollover interim exception, and that the Provider's exception request for the FYE December 31, 1995 was properly reviewed in accordance with the rules set forth under Transmittal No. 378

DECISION AND ORDER:

Issue 1 - RCL Exception:

The methodology set forth in HCFA Transmittal No. 378 for determining the amount of the exception from the RCLs for HB-SNFs is a proper interpretation of Medicare statute and regulations, and the Intermediary properly applied the methodology to the Provider's FYE December 31, 1995. The Intermediary's determination is affirmed.

Issue 2 - Rollover Interim Exception:

The Intermediary's denial of a rollover interim exception for the Provider's FYE December 31, 1995 was proper and is affirmed.

---

[9] See Intermediary Exhibit I-14.

[10] See Intermediary Exhibit I-2.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire (Dissenting Opinion - Issue 1)
Charles R. Barker
Stanley J. Sokolove

Date of Decision: June 27, 2001
FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover Jr.

I respectfully dissent to Issue No. 1:

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

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

> With respect to hospital based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for free standing skilled nursing 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 C.F.R. § 413.30(a)(2) states in part:

> HCFA may establish estimated cost limits....

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

The Board majority finds that section 42 U.S.C. §1395 yy(c) et seq. gives the Secretary great flexibility in setting 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 the 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).
>
> 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.
>
> 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