PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D17

PROVIDER -
San Joaquin Community Hospital - SNF
Bakersfield, CA

Provider No. 05-0455

vs.

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

DATE OF HEARING-
October 13, 1999
Date of Hearing on the Record -
August 4, 2000

Cost Reporting Period Ended -
December 31, 1995

INDEX

ISSUES:

1. Was the Intermediary=s adjustment reclassifying the Provider=s costs from direct to indirect cost centers proper?

2. Was the Health Care Financing Administration=s (AHCFA=s@) refusal to grant an exception from that portion of the Provider=s per diem cost which do not exceed 112 percent of the total peer group mean cost proper? - **on the record**

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

San Joaquin Community Hospital (AProvider@) operates a 21-bed Medicare certified hospital-based skilled nursing facility (ASNF@) in Bakersfield, California.

For the fiscal year at issue the Provider exceeded all of the benchmarks established by HCFA to determine whether it provided atypical services. The Provider had an average length of stay of 13.11 days compared to a national average of 132.34, Medicare utilization of 97.88 percent compared to a national average of 52.39 percent, and Medicare SNF ancillary per diem costs of $230.52 compared to a national average of $62.73. A lower than average length of stay, combined with a higher than average Medicare utilization and Medicare SNF ancillary costs all point to the provision of atypical services to higher acuity patients.

The regulation at 42 C.F.R. ' 413.30(f)(1) permits the Provider to request from HCFA an exception from its routine cost limits (ARCLs@) because it provided such atypical services. The Provider requested such an atypical services exception from HCFA for the cost reporting period ending December 31, 1995. Both the Intermediary and HCFA recognized that the Provider had provided atypical services and granted first an interim, and then a final atypical services exception request.[1] More recently, the Provider=s cost report was reopened to reclassify directly expensed nursing management cost from the routine cost centers to the nursing administration cost center, and a revised Notice of Program Reimbursement (ANPR@) was issued on April 2, l999. Based on this revised NPR, a new final exception amount of $92.92 was determined and communicated to the Provider by the Intermediary=s letter of September 7, 1999.

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

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[1] See Provider Exhibits 2-6.

Jurisdictional Arguments:

PROVIDER=S CONTENTIONS:

The Provider asserts that in accordance with 42 C.F.R. ' 405.1841, it has properly appealed the Intermediary=s final determination relating to the SNF RCL exception.

The Intermediary has refused to sign the List of Issues because it believes that the SNF RCL exception determination appealed by the Provider was an interim, not a final, determination. In its June 6, 1997 request for hearing, the Provider clearly stated that it was appealing the March 31, 1997 notice of Program Reimbursement (ANPR@), so the Intermediary cannot be under the impression that the Provider was appealing the January 21, 1997 interim determination. Therefore, the Intermediary must be contending that the March 31, 1997 NPR incorporating the SNF RCL exception amount is an interim determination. The Provider believes that the January 21, 1997 determination became final when it was incorporated into the March 31, 1997 NPR. That NPR included an adjustment for the exception amount of $90.78 and also notified the Provider of its right to appeal any adjustments with which it disagreed, thereby making the exception determination a final determination.

HCFA Pub. 15-1 ' 2908, states: A[t]he intermediary=s determination contained in an NPR is final and binding unless a timely request for hearing is filed with the intermediary or the [Board] . . . Therefore, the intermediary=s NPR is the base determination for appealing . . . to the Board.@[2] In the Provider=s situation it is apparent that the $90.78 per diem exception amount granted is an intermediary@s determination contained in an NPR, and is therefore final and subject to appeal.

The Provider claims that the Intermediary twice implicitly acknowledged that the issuance of the NPR makes the determination final. First, in its January 21, 1997 interim determination, the Intermediary notified the Provider that A[s]ince the type of exception granted is an AInterim@ (cost report has not been settled and an NPR has not been issued), it is subject to change to incorporate any audit adjustments made during settlement.@ This can only be interpreted to mean that once the cost report has been settled and the NPR issued, the determination will no longer be Ainterim.@ Then, in its August 27, jurisdictional challenge the Intermediary defines an interim exception by stating: A[t]his means that the cost report has not been settled at that time and would be subject to change to incorporate any audit adjustments made during settlement.@ Again, by making that statement the Intermediary is clearly recognizing that an interim determination based on as-filed data will become final after audit.

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[2] See Provider=s Jurisdiction Brief, Exhibit 7.

In this case, it was the March 31, 1997 NPR incorporating and finalizing the exception amount that the Provider appealed**C**not the January 21, 1997 interim determination**C**so the Provider is confused by the Intermediary=s claim that the determination has not been finalized.
Furthermore, if the Intermediary continues to contend that the determination incorporated into the March 31, 1997 NPR is an interim determination, the Provider wonders when the Intermediary believes the determination will become final. Because the January 21, 1997 determination is an interim determination, and by refusing to acknowledge that the March 31, 1997 NPR finalizes the determination, the Intermediary has effectively denied the Provider=s right to appeal the SNF RCL exception determination.

Concerning the Intermediary=s statement that Provider has the right to request a redetermination based on the audited cost report, the Provider notes that the Intermediary did not adjust the exception amount in its audit, and therefore the final determination is identical to the January 21, 1997 interim determination. There are no audit adjustments to be considered for redetermination. In addition, it is HCFA=s methodology of calculating the exception request that is at issue in this appeal. The Provider believes that the Intermediary followed HCFA=s instructions in calculating the exception, and therefore recognizes that a request for redetermination would be denied.

INTERMEDIARY=S CONTENTIONS:

The Intermediary also claims that there are jurisdictional impediments regarding this case. The Provider timely appealed the March 31, 1997 NPR, but did not dispute the adjustments therein. Instead, the Provider disputed the Intermediary=s determination of the Provider=s interim request for its hospital-based SNF=s exception from the RCL, which was based on the as-filed cost report data.[3] HCFA Pub. 15-1 ' 2534.2 distinguishes the interim request from the final request. The final request is the basis for formal appeal under HCFA Pub. 15-1 ' 2537. To date, the Provider has not formally appealed the Intermediary=s final determination of that final request, pursuant to 42 C.F.R. ' 405.1841 and HCFA Pub. 15-1 ' 2921ff. The Provider also has not requested the Intermediary to reopen the cost report to correct the SNF RCL determination, pursuant to 42 C.F.R. ' 405.1885 and HCFA Pub. 15-1 '' 2930ff and 2931ff.

The record indicates that there is a pending Provider=s request for the Intermediary=s reconsideration.[4] It is not apparent, however, if the Provider is still pursuing that request. If it is, that is, by agreeing to furnish the requested additional information and documentation, the Board should remand the case to the Intermediary for further determination. Otherwise, the Board should consider dismissing the Provider=s appeal for the reasons indicated above.

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[3] Intermediary Exhibit 7.

[4] See Intermediary Exhibit 1.

Issue 1 - Reclassification of costs and calculation of the exception from the RCLs

Facts:

The Intermediary=s reclassification of costs from the direct cost center to various indirect cost centers was heard during a live hearing. The Intermediary=s letter of September 7, 1999, informing the Provider of the revised final exception amount, details these reclassifications. The Intermediary reclassified directly assigned costs of $11,668 in consulting fees to the administrative and general (AA&G@) indirect cost center, $202,119 of employee benefits to the employee health and welfare (AEH&W@) indirect cost center, $22,363 of expenses related to special functions and $10,662 of start-up cost amortization to the A&G indirect cost center, $10,228 of pharmacy technician salaries to the pharmacy indirect cost center, $53,412 of social worker salaries to the social service indirect cost center, and $41,922 of medical supplies to the central service indirect cost center.[5]

PROVIDER=S CONTENTIONS:

The Provider contends that the Intermediary and HCFA failed to follow HCFA=s own instructions contained in HCFA Transmittal No. 378 which requires that both steps of a two-step process be taken when the Intermediary reclassifies direct costs to one or more indirect cost centers. HCFA Pub. 15-1 ' 2534.5.B reads in pertinent part as follows:

> Uniform National Peer Group Comparison. C . . . If indirect costs are directly assigned (e.g. nursing administration (indirect cost) assigned to the direct cost center), the indirect cost elements must be identified and reassigned, for the purpose of constructing the peer group, to the indirect cost center identified with the type of cost incurred. The ratios are then based on the averages for the cost centers reflecting the reassigned costs.

This instruction is further explained in a September 29, 1997 letter from James Kenton of HCFA to another intermediary.[6] This letter reads in pertinent part as follows:

> In accordance with a memorandum dated March 13, 1995 from HCFA Central Office to all HCFA Regional Offices, an exception for direct salary costs is computed as the provider=s direct salary per diem cost in

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[5] Provider Exhibit 24 at 4 and Tr. at 15-20.

[6] See Provider Exhibit 12.

> excess of the peer group direct salary per diem cost. The peer group direct salary per diem cost is determined by dividing the provider's actual percent of salary costs by total direct costs and applying this percentage to the peer group direct per diem costs. No exception is allowed for the non-salary direct cost per diem. However, if the provider can disaggregate the items included as non-salary direct costs into another cost center in the peer group, e.g. central services and supply, it could combine these costs with costs already included in that cost center. The portion of the peer group amount for non-salary direct costs associated with costs that were redistributed to the other cost center of the peer group would also need to be combined with the peer group amount for that cost center. This could result in an additional exception amount for some of the provider's costs previously categorized as non-salary direct costs. Any non-salary direct costs that can not be redistributed into a different cost center on the peer group will be left in the peer group as non-salary direct costs and no exception is allowed for these costs.[7]

Taking step two of the two step process is necessary to maintain the integrity of the peer group which is used for comparison. The peer group was constructed using settled cost report data from providers for the fiscal years ending 1988 and 1989. The peer group was constructed by taking the direct and disaggregated indirect costs off of the cost reports of providers in the peer group. There was no reason for the intermediaries settling the 1988 and 1989 cost reports to make the type of reclassifications which the Intermediary made in this case as part of the exception determination process and HCFA Transmittal No. 378 reflects that no reclassifications occurred before the peer groups were constructed. Discovery responses from HCFA describing the process of constructing the peer groups do not mention the reclassification of direct costs. Thus the peer groups which were used by the Intermediary and HCFA to determine the amount of an exception actually classified costs between the direct and indirect cost centers as originally classified by the providers filing cost reports, and before any reclassification had occurred.

The importance of this issue for this particular Provider is magnified by the fact that the original classification in the direct cost center of this Provider=s costs was required by California law, the State in which the Provider is located. The Provider introduced excerpts from the Chart of Accounts maintained by the California Office of Statewide Healthcare Planning and Development (AOSHPD@) which support the direct assignments of the costs the Intermediary reclassified. California accounts for approximately 10 percent of the hospital population.

Moreover, the Provider emphasizes that even outside the State of California most, if not all, hospitals

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[7] Id. at 6.

have significant amounts of direct costs of the type reclassified by the Intermediary. The Provider introduced a summary of reclassifications made by numerous intermediaries throughout the country during the exception determination process to demonstrate the prevalence of direct costs of the type reclassified by the Intermediary. The Chart of Account for Hospitals, in many instances tracks the OSHPD Chart of Accounts. For example, the Chart of Account for Hospitals notes that while Amany hospitals do not charge employees benefits directly to responsibility center expense accounts as a part of the regular accounting routine . . . [o]ther hospitals . . . choose to charge the costs of such benefits to responsibility center accounts as direct expenses.@ This latter practice is directed by HCFA Pub. 15-1 ' 2144.7 which states A[i]f a provider does not charge the cost of fringe benefits directly to the department or cost center where the employee is assigned, then the cost reimbursement forms, which are used to determine Medicare reimbursement, provide the mechanism for the allocation of fringe benefits to the appropriate cost centers.@

The Provider points out that even the spreadsheet used by the Intermediary to make the reclassification in issue reflects that the Intermediary was required to follow the two-step process.

The Intermediary left blank the column in the spreadsheet where the peer group reclassification should have been made. HCFA=s witness testified that the spreadsheet used by the Intermediary was a standard form used in the exception process.

The Provider explains that the failure to complete the two-step process required by HCFA Transmittal No. 378 distorts the peer group comparison to the disadvantage of the Provider. When the Intermediary removes the Provider=s direct costs, and fails to make a corresponding reclassification in the peer group, the costs in the Provider=s direct cost center have now been disproportionately lowered in respect to the corresponding direct costs of its peer group to which it must compare its direct costs. What was a comparison of apples to apples before any reclassification occurred has now become a comparison of apples to oranges. The comparison can only be restored to one of like qualities (apples to apples) by taking the second step of also reclassifying the peer group.[8]

Pursuant to HCFA Transmittal No. 378, the amount of a Provider=s exception for direct costs is determined by subtracting the peer group direct salary per diem cost from the Provider's direct salary per diem cost [Provider=s direct salary per diem cost - peer group direct salary cost = direct salary cost exception]. HCFA Pub. 15-1 ' 2534.l0.A.5.

The Provider points out that A[t]he peer group direct per diem costs does not separately identify salary cost and non-salary cost.@ Id. Thus the Provider=s direct salary per diem cost must be derived through an equation. That equation is set forth in HCFA Pub. 15-1 ' 2534.l0.A.5. First, the Provider must determine what percentage of its total direct costs are made up of direct salary costs. Second, the

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[8] See Provider Exhibit P-27.

Provider must multiply that percentage against the total of the peer group's direct costs. The complete equation to derive the peer group direct per diem salary costs is as follows: [Factor #1: Percent of Provider's direct per diem costs which are salary costs] x [Factor #2: total peer group direct costs] = [peer group direct salary costs].

The Provider indicates that when the Intermediary reclassified the Provider=s direct costs, several of which were non-salary costs, to the indirect cost centers it increased the percentage which becomes Factor #1 in this equation. Indeed, the percentage of the Provider=s direct costs which are made up of direct salary costs becomes very high when most of the direct non-salary costs are reclassified into the indirect cost centers.

The Provider contends that when a corresponding reclassification of direct costs is not made in the peer group a gross distortion occurs. The equation set forth in HCFA Pub. 15-1 ' 2534.10.A.5 results in direct non-salary costs included in the peer group being considered as direct salary costs of the peer group for the purpose of making the peer group comparison to the Provider's direct salary costs. Because the direct costs of the peer group also contain the type of salary and non-salary direct costs which the Intermediary has reclassified out of the Provider=s direct costs, the higher Factor #1 percentage caused by this reclassification sweeps up the direct non-salary costs in the peer group and results in a overstated comparison point for the Provider=s direct salary costs.

The Provider further explains that because the exception process contained in HCFA Transmittal No. 378 drives the determination of the exception amount by the amount of the direct cost comparison to the peer group, the lowering of the Provider=s direct costs caused by the reclassification is not made up by the increase of costs in the Provider=s indirect cost centers.[9]

The Provider notes that HCFA=s argument that the peer group does not contain direct costs of the type reclassified by the Intermediary is unconvincing. HCFA=s witness was not involved in the calculation of the peer groups. Nor does he know whether the intermediaries which settled the cost reports which made up the basis for the peer groups made the type of reclassifications which the Intermediary made to the Provider=s direct costs in this case.[10]

HCFA=s witness, Mr. Joseph Menning, was also unaware that the direct costs which the Intermediary reclassified were properly assigned to the direct cost center by the Provider in this case.[11] He was not aware that providers in California are required by law to follow the chart of accounts maintained by the

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[9] Tr. at 30-31.

[10] Tr. at 60.

[11] Tr. at 59.

California Office of Statewide Health Planning and Development.[12] For example, he was not aware that the directly assigned employee health and welfare costs which the Intermediary had reclassified during the exception determination of the Provider were required to be classified in the direct cost center.

The Provider also points out that HCFA has not provided a rational explanation for the inconsistency between its resistance to the reclassification of the peer group (step number two of the two-step process) and the instruction in HCFA Transmittal No. 378 and in the September 29, 1997 letter from HCFA=s James Kenton requiring the reclassification of the peer group. Mr. Menning was not involved in the preparation of either Transmittal No. 378 or the September 29 letter. Mr. Menning=s interpretation of the portion of HCFA Transmittal No. 378 quoted above fails to follow the language of the manual instructions by disregarding the clause Afor the purpose of constructing the peer group.@ Moreover, he was not able to give any alternative explanation of the meaning of this language.[13]

The Provider points out that HCFA=s explanation that the September 29 letter was to apply only to Asmall amounts@ is the classic example of administrative action that is arbitrary and capricious. HCFA has no definition of Asmall amounts@ and there is no instruction which would define the threshold between big and small. Moreover, the September 29 letter sets no such limitation. It expressly refers to non-salary direct costs in general, and refers to central services and supplies as an example, and not as a limitation on the type of costs for which the peer group should be reclassified.

The financial impact upon the Provider of the Intermediary=s failure to follow the instruction contained in HCFA Transmittal No. 378 is a short fall of $135,541 in the exception amount due to the failure to comply with the manual instructions.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that it did not abuse its discretion in processing and denying the Provider=s exception request. The Intermediary points out that Black=s Law Dictionary defines abuse as a Adeparture from reasonable use;@ or Abeing synonymous with a failure to exercise a sound, reasonable, and a legal discretion.@ In determining the Provider=s exception reopening request, the Intermediary made a logical and reasonable conclusion or judgment based on the information furnished by the Provider and observance of the related law, regulation and instructions. It also timely informed the Provider of its findings and determinations. HCFA authorized the Intermediary to process the Provider=s exception request without HCFA=s further review and approval.

The Intermediary properly made a partial approval of the Provider=s request for its hospital-based SNF

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[12] Tr. at 60.

[13] Tr. at 72.

in accordance with 42 C.F.R. ' 413.30 and HCFA Pub. 15-1 '' 2530ff, 2531ff and 2534ff. The Intermediary submitted exhibits showing the specific reasons why they did not approve the exception request in full.

The Provider did not demonstrate with compelling or convincing evidence that the Intermediary failed to make its determination in accordance with the referenced regulation and instructions. Under the circumstances, the Provider did not furnish sufficient information and documentation to support its exception request. It is therefore not in compliance with the record keeping requirements, pursuant to 42 C.F.R. '' 413.20 and 413.24, and HCFA Pub. 15-1 '' 2300, 2304ff and 2404.2. The referenced regulations and instructions explicitly require the Provider to maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such data must be consistent with its financial records and capable of verification by qualified auditors. The requirements imply that such data be accurate, audited, and in sufficient detail to accomplish the intended purpose.

The Provider is also trying to circumvent the regulation and instructions by insisting on a methodology not consistent with the methodology described therein.

The Intermediary contends that the peer group means for both the direct and indirect expenses associated with the delivery of hospital-based SNFs are an accurate and reliable determination and should be respected as they are presented.[14] The Intermediary contends that its assignment of costs into the peer group categories for purposes of computing the exception was accurate. The Intermediary indicates that the Provider has misinterpreted the significance of correspondence it received from HCFA and that the two step process the Provider is advocating is not the correct methodology for computing exceptions under the rules.[15]

The Intermediary presented a HCFA witness with 15 years of experience adjudicating SNF exception requests.[16] The HCFA witness explained the source of the peer group averages and steps taken to ensure their accuracy.[17] The HCFA witness indicated that he disagreed with the Provider that ' 2534.5.B required an adjustment to the peer groups for purposes of calculating the exception.[18] The witness explained that the language cited by the Provider A[t]he ratios are then based on the averages

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[14] Tr. at 12-13.

[15] Id.

[16] Tr. at 45.

[17] Tr. at 47-50.

[18] Tr. at 51.

for the cost centers reflecting the reassigned costs@ does not mean that you take a portion of the direct base per diem and reassign that to the indirect cost center.[19] Rather the latter merely indicates that some of the direct costs should be reclassified to indirect cost centers and can be used there to qualify for an exemption in those categories.[20]

Issue 2 - 112 Percent Reimbursement Gap

Facts:

This issue was heard on the record. The Provider=s exception request was governed by HCFA Transmittal No. 378 which was issued in July 1994. This issue relates to the instruction in HCFA Transmittal No. 378 that the atypical services exception of every hospital-based SNF must be measured from 112 percent of the peer group mean for that hospital-based SNF. This specific requirement is found in ' 2534.5 of the Provider Reimbursement Manual (AHCFA Pub. 15-1@), 112 percent of the peer group mean of every hospital-based SNF is always significantly higher than its RCL. Thus under HCFA Transmittal No. 378 there is a reimbursement Agap@ between the RCL and 112 percent of the peer group mean which represents costs incurred by the hospital-based SNF which it can never recover.

The Provider appealed its NPR in accordance with the jurisdictional requirement of the Provider Reimbursement Review Board (ABoard@) at 42 C.F.R. '' 405.1835-.1841. The Medicare reimbursement in controversy for this case is greater than $10,000.

PROVIDER=S CONTENTIONS:

The Provider=s contentions concerning the gap methodology fall within three broad categories. First, the Provider contends the Agap@ methodology in HCFA Pub 15-1 ' 2534.5 is directly inconsistent with the regulation controlling atypical services exceptions and with the statute prohibiting cross-subsidization between Medicare and other payers. Second, the Provider contends the Agap@ methodology in HCFA Pub. 15-1 ' 2534.5 is invalid because it was not adopted pursuant to the notice and comment rulemaking provisions of the Administrative Procedure Act or as a regulation as required by statute. Third, the Provider contends that HCFA=s action in adopting the Agap@ methodology in HCFA Pub. 15-1 ' 2534.5 was arbitrary, capricious, an abuse of discretion and not in accordance with law, and should therefore be overturned under other provisions of the Administrative Procedure Act.

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[19] Tr. at 52-53.

[20] Tr. at 54-55.

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

The Provider points out that 42 C.F.R. ' 413.30 focuses its language on the adjustment of limits, and not on an add-on based on exceeding a threshold higher than the limits. The regulation at 42 C.F.R. ' 413.30 Asets forth rules governing exemptions, exceptions, and adjustments to limits established under this section that HCFA may make as appropriate in consideration of special needs or situations of particular providers.@ (Emphasis added).

The regulation at 42 C.F.R. ' 413.30(f) also expressly states that an atypical services exception is an adjustment to a RCL, and not an adjustment to some higher threshold set by HCFA:

> (f) Exceptions. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section.... An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.

(Emphasis added).

Most importantly, 42 C.F. R. ' 413.30(f)(1) expressly states that a provider=s costs must only exceed its RCL in order for it to qualify for an exception. It states that the Alimits@ may be adjusted upwards if A[t]he 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 and scope. . . .@ Id. (Emphasis added). The controlling regulation specifically states that the provider must only show that its cost Aexceeds the applicable limit,@ and not that its cost exceeds 112 percent of the peer group mean.

The Provider also contends that in devising the Agap@ methodology of HCFA Pub. 15-1 ' 2534.5 HCFA has confused the concept of a peer group comparison of atypical services with the concept of a peer group comparison of atypical costs. The regulation at 42 C.F.R. ' 413.30 requires the peer group comparison to be made in terms of the atypical nature and scope of services, and not in terms of the atypical cost of services.

Under the language of 42 C.F.R. ' 413.30, a provider must show that the actual cost of the items and services it furnished exceeded the applicable limit Abecause such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified.@ The comparison to a peer group of Aproviders similarly classified@ required by the regulation is of the Anature and scope@ of the items and services actually furnished, not their cost.

The Provider points out that HCFA Transmittal No. 378 does contain a peer group comparison that is consistent with the controlling regulation. Transmittal No. 378 has benchmarks that measure whether the provider has a lower than average length of stay, higher than average ancillary costs per day, and higher than average Medicare utilization. According to the testimony of the HCFA witness at another hearing, once a provider has established that it exceeds these benchmarks, Athey have, as far as we are concerned, they have established that they are providing atypical services.@[21]

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

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

The Provider points out that Medicare is required to reimburse providers for their reasonable costs incurred in treating Medicare beneficiaries. AReasonable cost@ is defined as only those costs Aactually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services.@ 42 U.S.C. ' 1395x(v)(1)(A)(i). The reasonable cost Ashall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services.@ Id. (emphasis added). The Secretary is authorized to establish appropriate cost limits as part of her method of determining reasonable costs. Id. See also Good Samaritan Hospital v. Shalala, 508 U.S. 402 (1993).

The statute at 42 U.S.C. ' 1395x(v)(1)(A)(i) prohibits Medicare and other payers from Across-subsidizing@ each other. It states that A[s]uch regulations shall (i) take into account both direct and indirect costs of providers of services . . . in order that, under the methods of determining costs, the

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[21] Provider Exhibit 23 at 92.

necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.@ 42 U.S.C.' 1395x(v)(1)(A)(i) (Emphasis added). The Ano cross-subsidization@ principle is further required by 42 C.F.R. '' 413.5(a), 413.5(b)(3) and 413.50.

The statute at 42 U.S.C. ' 1395yy(a) establishes the definition of the RCL applicable to the Provider in this appeal. This section establishes different RCLs, sometimes referred to as Adual limits,@ for freestanding SNFs and for hospital-based SNFs. The RCL for freestanding SNFs is set at A112% of the mean per diem routine service cost for freestanding skilled nursing facilities@ while the RCL for hospital-based SNFs is set at Athe limit for freestanding skilled nursing facilities. . . ,plus 50% of the amount by which 112% of the mean per diem routine service cost for hospital-based skilled nursing facilities . . . exceeds the limit for freestanding skilled nursing facilities.@ 42 U.S.C. ' 1395yy. The Provider points out that although there is no dispute that Congress established dual cost limits, 42 U.S.C. ' 1395yy does not qualify the clear prohibition against cross-subsidization contained in 42 U.S.C. ' 1395x(v)(1)(A)(i) nor does it prohibit hospital-based SNFs from obtaining full reimbursement of reasonable costs.

The Provider points out that the RCL sets only a presumptive, and not a conclusive, limitation on the reimbursement that a provider may receive for its reasonable costs.

Indeed HCFA has acknowledged and confirmed the presumptive nature of the RCL for SNFs in HCFA Transmittal No. 378 which is at issue in this case. Section 1861(v)(1)(A) of the Social Security Act, as implemented in 42 C.F.R. ' 413.30, authorizes the Secretary to establish limits on provider costs recognized as reasonable in determining Medicare program payment. The limits are a presumptive estimate of reasonable costs. The Provider emphasizes a Senate Report which is the only evidence of legislative intent which specifically addresses the issue before the Board. In discussing the Senate Bill that became Section 1395yy, Title 42, United States Code, the Senate Finance Committee report states that providers, where justified, should be able to receive Aup to all of their reasonable costs@ through the exception process:

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

Senate Report 98-169, Vol. 1, April 2, 1984, at 948 (Emphasis added).[22]

The Provider contends that the Agap@ methodology in HCFA Pub. 15-1 ' 2534.5 also violates the Administrative Procedure Act because it was not adopted pursuant to the notice and comment rulemaking requirement of 5 U.S.C. ' 533. Because the Agap@ methodology effects a change in the existing law contained in 42 C.F.R. ' 413.30(f)(l) by requiring a provider to show that its costs exceed 112 percent of the peer group mean instead of the applicable RCL, such a change in the regulation must be made pursuant to the notice and comment provisions of 5 U.S.C. ' 533.

The Provider also contends that because the "gap" methodology in HCFA Pub. 15-1 ' 2534.5 establishes or changes a substantive legal standard governing the payment for services it must be published as a regulation under the provisions of 42 U.S.C. '1395hh(a)(2).

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

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

> [T]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a >rational connection between the facts found and the choice made.= Burlington Truck Lines. Inc.. v. United States, 371 U.S. 156, 168, 9 L. Ed. 2d 207, 83 S. Ct. 239 (1962). In reviewing that explanation, we must >consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.= Bowman Transportation. Inc. v. Arkansas-Best Freniht System. Inc. [419 U.S. 281] at 285, 42 L. Ed. 2d 447, 95 5. Ct. 438; Citizens to Preserve Overton Park v. Volpe, [401 U.S. 402] at 416, 28 L. Ed. 2d 136, 91 5. Ct. 814. Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to

[22] Provider Exhibit 28 at 21.

> consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Id. at 43.

The Provider points out that it is undisputed that HCFA=s stated reason for adopting the Agap@ methodology is that HCFA believed that it was the intent of Congress that in implementing its exception process HCFA should not recognize the costs of hospital-based SNFs which fell within the Agap.@ The Provider points to written discovery responses which state this as the reason for the Agap@ methodology.[23] The same explanation was given by the testimony of HCFA=s witness at another hearing.[24] This explanation was also stated in a HCFA Administrator Decision on the same issue. See St. Francis Health Care Center v. Community Mutual Insurance Company, HCFA Administrator=s Decision, May 30, 1997, Medicare and Medicaid Guide (CCH) & 45,545.

The Provider contends that HCFA=s stated reason for its adoption of the Agap@ methodology failed to consider the only direct evidence of the intent of Congress on this issue. The Provider again points to the aforementioned Senate Report 98-l69, Vol. 1. This document unequivocally shows that it was the intent of Congress to permit hospital-based SNFs which provide atypical services to obtain up to all of their reasonable costs.

The Provider also contends that HCFA offered an explanation for its decision that runs counter to the evidence before the agency when it illogically chose to penalize those hospital-based SNFs which treat the sickest of patients after Congress took great care to compensate the costs of hospital-based SNFs providing only typical services to sicker patients.

Logically, the fact that Congress set a higher RCL for hospital-based SNFs providing only typical services in order to compensate them for the additional cost of treating sicker patients (which is precisely the conclusion that HCFA has drawn from the Deficit Reduction Act of 1984 (ADEFRA@) dual limits) would lead to the similar and parallel conclusion that those hospital-based SNFs which provide atypical services (because they treat even sicker patients than the hospital-based SNF which provides only typical services) should also receive compensation for the cost of treating these sickest of patients.

Instead of following this logic, however, HCFA illogically created a reimbursement Agap@ which

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[23] Provider Exhibits 29 and 30.

[24] Provider Exhibit 23, Tr. at 100.

penalizes all hospital-based SNFs which treat the sickest patients by making it impossible for them to receive compensation for all or some significant portion of the cost of providing atypical services.

The Provider also contends that HCFA relied on factors which Congress clearly had not intended it to consider. HCFA states that it came up with its methodology A[i]n order to give meaning to Congress= explicit intention that 50 percent of the cost differences between hospital-based and freestanding SNFs not be reimbursed.@[25] However, Senate Report 98-169, Vol. 1 shows that this intent of Congress applied only to hospital-based SNFs providing only typical services, and not to that minority of hospital-based SNFs which provide atypical services. HCFA could point to no statement by Congress that hospital-based SNFs which provided atypical services should uniformly be denied as a class from obtaining up to all of their reasonable costs. The Provider contends that HCFA took factors relied upon by Congress for one purpose (to set discriminatory cost limits taking into account presumed additional costs in furnishing typical services for sicker patients), and used them for a second and unintended purpose - to create a discriminatory exception process for those minority hospital-based SNFs which provide atypical services.

The Provider also contends that HCFA=s Agap@ methodology is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

INTERMEDIARY=S CONTENTIONS:

The Provider indicates that the in St. Francis, supra, the HCFA Administrator determined that the use of the methodology set forth in HCFA Pub 15-1 ' 2534.5.B in no way alters or revises the Medicare policy as set forth in 42 C.F.R. ' 413.30(f)(1). It rejected the Board=s view that ' 1888(A) of the Social Security Act, 42 U.S.C. ' 1395yy, and 42 C.F.R. ' 413.30(f) entitles all SNFs to be paid the full amount by which their costs exceed the applicable RCL because of the fact that the statute allows for exception. The Administrator also determined that requiring the hospital based 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 requirement and is not inequitable. See Id.

The referenced program regulations and instructions and HCFA Administrator=s decision in St. Francis support the Intermediary=s determination, adjustment and argument. The Board should therefore uphold the Intermediary=s position, pursuant 42 U.S.C. ' 1395oo, 42 C.F.R. ' 405.1867 and HCFA Pub. 15-1 ' 2924.6.

The statute at 42 U.S.C. ' 1395oo states as follows:

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[25] Provider Exhibit 29 at 3 and Provider Exhibit 30 at 3-4.

> (e) The Board shall have full power to make rules and establish procedures not inconsistent with the provisions of this title or regulations of the Secretary....

The regulation at 42 C.F.R. ' 405.1867 states as follows:

> In exercising its authority to conduct the hearings . . . the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as HCFA rulings issued under the authority of the Administrator of the Health Care Financing Administration . . .

HCFA Pub. 15-1 ' 2924.6 has similar provisions.

Under the circumstances, the Intermediary does not have a basis to revise its determination or adjustment. The Intermediary requests that the Board affirm its determination, adjustment or argument.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

' 1395x(v)(1)(A)	-	Reasonable Costs
' 1395hh(a)(2)	-	Regulations
' 1395oo et seq.	-	Board
' 1395yy et seq.	-	Payment to SNFs for Routine Service Costs

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

'' 405.1835-.1841	-	Board Jurisdiction
' 405.1867	-	Notice of Reopening
' 405.1885	-	Reopening a Determination or Decision
' 413.5 et seq.	-	Cost Reimbursement: General
' 413.20	-	Financial Data and Reports
' 413.24	-	Adequate Cost Data and Cost Finding

' 413.30 et seq.	-	Limitations on Reasonable Costs
' 413.50	-	Apportionment of Allowable Costs

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

' 2144.7	-	Accounting for Fringe Benefits
' 2300	-	Adequate Cost Data and Cost Finding: Principle
' 2304ff	-	Adequacy of Cost Information
' 2404.2	-	Examination of Pertinent Data and Information
' 2530ff	-	Inpatient Routine Service Cost limits for SNFs
' 2531ff	-	Provider Requests Regarding Applicability of Cost Limits
' 2534ff	-	Request for Exception to SNF Cost Limits
' 2537	-	Reclassification, Exceptions, and Exemptions
' 2908	-	Effect of Determination and Notice of Amount of Program Reimbursement
' 2921ff	-	Request for Board Hearing
' 2924ff	-	Responsibility of the Board
' 2930ff	-	Finality
' 2931ff	-	Reopening and Correction

4. Cases:

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

Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Company, PRRB Dec.

No. 99-D61, August 20, 1999, Medicare & Medicaid Guide (CCH) **&** 80,320.

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

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

New England Rehabilitation Hospital v. C&S Administrative Services for Medicare, PRRB Case No. 2000-D53, May 24, 2000, Medicare and Medicaid Guide (CCH) **&**80,443.

North Coast Rehabilitation Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 99-D-22, February 18, 1999, Medicare & Medicaid Guide (CCH) **&** 80,158, modif=d HCFA Administrator, April 15, 1999, Medicare & Medicaid Guide (CCH) **&** 80,195.

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

St. Francis Health Care Center v. Community Mutual Insurance Company, HCFA Administrator=s Decision, May 30, 1997, Medicare and Medicaid Guide (CCH) **&** 45,545.

5. Other:

Administrative Procedure Act - 5 U.S.C. ' 501 et seq.

Black=s Law Dictionary

California OSHPD Chart of Accounts

Deficit Reduction Act of 1984

HCFA Transmittal No. 378

Senate Report 98-169, Volume 1, April 2, 1984

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION**:**

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

Jurisdiction:

The Board finds that it has jurisdiction over the SNF RCL issue. The Board finds that the interim

determination became final when the Intermediary issued the NPR which is a final determination of cost for the fiscal period under 42 U.S.C. '1395oo(A) and 42 C.F.R. '' 405.1835-.1841.

Issue 1 - Reclassification of costs and calculation of the exception from the RCLs

The Board finds that the Intermediary properly followed the instructions for reclassifying the Provider=s costs pursuant to the instruction in HCFA Transmittal 378. The Board notes that the Provider did not provide sufficient evidence to prove that HCFA improperly developed the peer groups.

The Board notes that HCFA Pub. 15-1 '' 2534.5.B and 2534.10 provide that a provider=s directly assigned indirect expenses be reassigned to the appropriate indirect expense cost center in the peer group identified with the type of cost incurred. These costs are then compared with the respective peer group costs in order to determine if an exception is warranted.

The Provider indicates that HCFA constructed its peer groups using settled cost report data. The Provider claims that directly assigned costs were not reassigned in those cost reports. As a result, HCFA=s peer group costs include substantial amounts of unreclassified costs and therefore represent an unfair comparison group. The Provider points out that California law requires direct assignment of costs and that California providers represent at least 10 percent of the group making up the peer group. The Intermediary asserted that the data was from settled cost reports and did not contain widespread misclassification of costs as claimed by the Provider.[26] Although the Board agrees that it may be appropriate to make adjustments to correct classification of data used to create the national peer groups, the Board did not find any evidence in the record that they were constructed in an erroneous manner. The Board finds no specific documentary evidence as to the extent to which data used to construct the national peer groups actually contained unreclassified costs.

The Board finds that the Intermediary properly calculated the Provider=s exception and that sufficient proof that the national peer groups was improperly constructed was not presented.

Issue 2 - 112 Percent Reimbursement Gap

The Board majority finds that the methodology applied by HCFA in denying the Provider=s exception request for atypical social services and medical records costs 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 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

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[26] Tr. at 49 and 50.

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 foregoing statute and the reasonable cost provisions of 42 U.S.C ' 1395x(v)(1)(A), the regulations at 42 C.F.R. ' 413.30 et seq. provide for an adjustment to the cost limits where a provider furnishes atypical services as compared to the items or services furnished by similarly classified providers. The regulation at 42 C.F.R. ' 413.30(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 regulations requires an examination of both the reasonableness of the amount that a provider=s actual cost exceeds the applicable cost limit, and the determination of the atypicality of the costs by using a peer group comparison.

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

The majority of the Board further finds that it was reasonable for HCFA to aggregate all of the indirect cost centers in determining the overall efficiency of the Provider=s operation. Since HCFA uses uniform peer groups to evaluate and quantify providers= exception requests for atypical services related to indirect cost centers, the aggregation of such costs is necessary because a provider=s classification of indirect costs may not be consistent with proportions prescribed by the peer group.

The Board majority further notes that HCFA=s methodology of using the standard of 112 percent of the hospital-based SNF peer group mean when reviewing exception requests is clearly set forth in a subsequent publication of HCFA Pub. 15-1 ' 2534.5, 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 hospital-based 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 & Medicaid Guide (CCH) & 80,158, modif=d HCFA Administrator, April 15, 1999, Medicare & 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 & Medicaid Guide (CCH) & 80,320.

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

- New England Rehabilitation Hospital v. C&S Administrative Services for Medicare, PRRB Case No. 2000-D53, May 24, 2000, Medicare and Medicaid Guide (CCH) & 80, 443.

DECISIONS AND ORDERS:

Issue 1 - Reclassification of costs and calculation of the exception from the RCLs

HCFA Pub 11 ' 2534.5.B properly applies to the Provider=s factual situation. The Intermediary properly reclassified various overhead costs as indirect costs. The Intermediary adjustment is affirmed.

Issue 2 - 112 Percent Reimbursement Gap

HCFA=s methodology for measuring the entitlement of hospital-based SNFs to exception relief under 42 C.F.R. ' 413.30(f) and HCFA=s denial of the Provider=s FY 1995 exception request were proper. HCFA=s determinations in these areas are affirmed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire (Dissenting in Part)
Charles R. Barker
Stanley J. Sokolove

Date of Decision: April 17, 2001

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover Jr.

I respectfully dissent to Issue No. 2:

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 notes that section 42 U.S.C. '1395 yy(c) et seq. gives the Secretary broad discretion 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