PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2004-D23

PROVIDER –
Glenwood Regional Medical Center
West Monroe, LA

Provider No. 19-0160

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING –
February 3, 2004

Cost Reporting Periods Ended
August 31, 1995

CASE NO. 97-2439

INDEX

ISSUE:

Was the Provider's routine cost limit determined in accordance with Medicare law, regulations, and program instructions?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Governing Statutes and Regulations:

The Medicare program was established in 1965 under Title XVIII of the Social Security Act ("the Act") to provide health insurance to the aged and disabled. 42 U.S.C. §§1395 – 1395cc. The Health Care Financing Administration (HCFA), now Centers for Medicare and Medicaid Services (CMS), is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

In order to participate in the Medicare program, a hospital must file a provider agreement with the Secretary. 42 U.S.C. §1395cc. The Secretary's payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS. Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and which portion of these costs are to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement (NPR). 42 C.F.R §405.1803. A provider that is dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Since its inception, the Medicare Program has reimbursed providers the "reasonable cost" of furnishing covered services to program beneficiaries pursuant to Section 1861(v)(1)(A) of the Act. In response to rising costs, and realizing that the original structure provided little incentive for providers to operate efficiently in delivering services, Congress authorized the Secretary (under Section 223 of the Act of 1972) to:

> [p]rovide for the establishment of limits on the direct or indirect overall incurred costs …based on estimates of the costs necessary in the efficient delivery of needed health services….

Recognizing that providers under some circumstances would incur costs in excess of the routine cost limit, exceptions to the routine cost limit (RCL) were established in 42 C.F.R. §413.30(f)[1], which states:

> (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.
>
> (1) Atypical services. The provider can show that the---
>
> (i) Actual cost of items of services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified; and
>
> (ii) 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 intent of Congress in providing an exception to the RCL to compensate providers for the additional costs associated with the provision of atypical services was to ensure providers that they would be reimbursed their full costs for providing those additional services and that patients not covered by Medicare would not be unfairly burdened with subsiding the cost of the care of Medicare patients. 42 U.S.C. §1395yy(a); 42 U.S.C. §1395x(v)(1)(A).

In 1984, as part of the Deficit Reduction Act (DEFRA), Congress lowered the Routine Cost Limit for hospital-based SNFs relative to the Routine Cost Limit for freestanding SNFs. This change was codified at 42 U.S.C. §1395yy(a). The Routine Cost Limit for freestanding SNFs remained at "112 percent of the mean per diem routine service cost for freestanding skilled nursing facilities," while the Routine Cost Limit for hospital-based SNFs was lowered to "the limit for freestanding skilled nursing facilities . . . plus 50 percent of the amount by which 112 percent of the mean per diem routine service cost for hospital-based skilled nursing facilities . . . exceeds the limit for freestanding skilled nursing facilities."

[1] The substance of 42 C.F.R. §413.130(f)(1) was first issued as a regulation effective July 1, 1974. The precise language of 42 C.F.R. §413.130(f)(1) was issued as an amended regulation effective July 1, 1979.

This case concerns the Intermediary and CMS' refusal to approve additional costs to the Provider for providing atypical services that were in excess of Provider's RCL but not by more than 112% of the peer group mean cost.

The Provider requested an exception for full relief from the revised "frozen" SNF RCL based on data from the as-filed cost report in the amount of $724,625, calculated at $148.30 per day for 4,886 Medicare SNF patient days.[2] However, the amount was subsequently changed to incorporate audited data, and the revised limit was decreased to $694,833, or $145.61 per day for 4,772 Medicare days. CMS responded to the Provider's request on September 9, 1997 by granting a partial exception in the amount of $80.93 per day.[3] For the 4,772 Medicare SNF days at issue, the total amount of the exception granted was $386,198.

The Provider was represented by Susan C. Starr of Certus Corporation. The Intermediary's representative was Byron Lamprecht of Mutual of Omaha Insurance Company.

PARTIES CONTENTIONS:

Prior to July 1994, CMS set forth general provisions concerning the payment rates for certain SNFs in Chapter 25 of CMS Pub. 15-1, but this chapter did not address the methodology used to determine exception requests. In July 1994, CMS issued Transmittal No. 378 to provide the public with current information on the SNF cost limits under Section 1888 of the Act and to explain that new manual sections in Chapter 25 of CMS Pub. 15-1 were being used to "…provide detailed instructions for SNFs to help them prepare and submit requests for exceptions to the inpatient routine service cost limits…."[4] The process and methodology for determining an exception request based on atypical services is explained in Section 2534.5 et. seq.

In a "Stipulation of Provider and Intermediary," both parties agree that the only issue on appeal before the Board is "HCFA's methodology (stated in Section 2534.5 (B) of its Provider Reimbursement Manual as issued in HCFA Transmittal No. 378) of determining the amount of an atypical services exception from 112 percent of the peer group mean of a hospital-based SNF, instead of from the routine cost limit of a hospital-based SNF. The Provider contends that this methodology is legally impermissible. The Intermediary contends that this methodology is a reasonable interpretation of the governing laws and regulations."

The Intermediary contends that the methodology utilized in its determination of the Provider's exception request, as set forth in the Provider Reimbursement Manual (PRM), Chapter 25, is consistent with the plain meaning of Sections 1861(v)(1)(A) and 1888 (a) through (c) of the Act, the legislative intent, and the regulations at 42 C.F.R. §413.30.

[2] See Provider's Exhibit P-1.
[3] See Provider's Exhibit P-3.
[4] See Intermediary's Position Paper at 8.

The Provider claims that by refusing to grant an exception for that portion of the Provider's per diem costs which do not exceed 112 percent of the total peer group mean cost, CMS has created a reimbursement "gap" that is arbitrary, capricious, not in accordance with law and denies reimbursement of costs that qualify as an exception for atypical direct nursing hours and indirect costs.

In addition, the Provider contends that the "gap" methodology in CMS Pub. 15-1 §2534.5 is directly inconsistent with the regulation controlling atypical service exceptions. The Provider believes that CMS should be given no deference in interpreting this regulation because it has not applied its interpretation consistently over time, and its interpretation is not the result of thorough and reasoned consideration. The "gap" methodology in CMS Pub. 15-1 §2534.5 is also inconsistent with the statute prohibiting cross-subsidization between Medicare and other payors.

The Provider also believes that the "gap" methodology in CMS Pub. 15-1 §2534.5 is invalid because it was not adopted pursuant to the notice and comment rule making provisions of the Administrative Procedure Act (APA) or as a regulation as required by statute.

Additionally, the Provider contends that the language of regulation 42 C.F.R. §413.30(f)(1) could not have originally been intended to support the reimbursement "gap" of CMS Pub. 15-1 §2534.5. Indeed, the original interpretation of the regulation that measured exceptions from the RCL had been consistently maintained by CMS for fifteen years prior to the issuance of CMS Pub. 15-1 §2534. Because CMS's current interpretation of the regulation was not developed contemporaneously with the regulation's original promulgation and is inconsistent with CMS's earlier interpretations, it is due no deference by the Board or any court.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law, Program instructions, and parties' contentions, finds and concludes as follows:

The Board finds that the methodology applied by CMS in partially denying the Provider's exception request for per diem costs which exceeded the RCL was not consistent with the statutes and regulations relating to this issue.

The regulation, 42 C.F.R. Section 413.30(f)(1), permits the Provider to request from CMS an exception from its RCL because it provided atypical services. It is undisputed that for 15 years the Secretary interpreted the regulation as permitting a provider to recover its reasonable costs that exceeded the RCL if it is demonstrated that it met the exception requirements. The Provider's exception request was processed in accordance with HCFA Transmittal No. 378, which was issued in July 1994 and decreed that the atypical services exception of every hospital-based SNF

must be measured from 112% of the peer group mean for that hospital-based SNF rather than the SNF's RCL. This specific requirement was also established as Section 2534.5 of CMS Pub. 15-1.

In essence, for the purpose of determining atypical service exceptions for hospital-based SNF's, CMS replaced the RCL with an entirely new and separate "cost limit" (112% of the peer group mean routine services cost). It is undisputed that 112% of the peer group mean of every hospital-based SNF is always significantly higher than the hospital's RCL. As a result, under Section 2534.5 of CMS Pub. 15-1, a reimbursement "gap" is created between the RCL and 112% of the peer group mean that represents costs incurred by a hospital-based SNF, which it is not allowed to recover.

CMS has made a conclusion regarding the intent of Congress toward reimbursing the *routine* costs of hospital-based SNFs which provide only *typical* services and illogically applied that same rationale to hospital-based SNFs that provide *atypical* services. This is contrary to what Congress intended when it implemented the exception process to address the additional costs associated solely with the provision of atypical services, and it clearly represents a substantive change in CMS's prior interpretation and application of 42 C.F.R. §413.30(f)(1) and CMS Pub. 15-1 §2534.5. 42 C.F.R. §413.30(f)(1) states that:

> "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 circumstances specified, separately identified by the provider, and verified by the intermediary."

The only limit intended by Congress and imposed by the plain language of the applicable statute and regulation is the RCL. To qualify for an atypical services exception a provider must show that the "actual cost of items and services furnished by the provider *exceeds the applicable limit* (RCL) *because such items are atypical* in nature and scope, compared to the items or services generally furnished by providers similarly classified." (emphasis added). The fact that Glenwood Regional Medical Center was providing atypical services and, but for the methodology described would have been entitled to an exception, was not contested by CMS.

The controlling regulation specifically states that the provider must only show that its cost "exceeds the applicable limit," not that its cost exceeds 112% of the peer group mean. The comparison to a peer group of "providers similarly classified," required by the regulation, is of the "nature and scope of the <u>items</u> and <u>services</u> actually furnished (emphasis added)," not of their cost. Also, it must be noted that Congress itself established the four "peer groups" that are to be considered in determining Medicare reimbursement of skilled nursing facilities: free-standing urban, free-standing rural, hospital-based urban, and hospital-based rural. CMS has

no statutory or regulatory authority to establish a *new* "peer group" for hospital-based SNFs (112% of the peer group mean routine service cost) and determine atypical service exceptions from an entirely *new* cost limit rather than from the RCL as intended by Congress.

In addition, the provisions of CMS Pub 15-1 §2534.5 that require an exception for hospital-based SNFs to be measured from the "112% of the peer group mean" rather than from the routine cost limit are invalid because they have not been adopted pursuant to the notice and comment rulemaking as required by the APA.

In this case, CMS'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. It is a "clear tenet of administrative law that if the agency wished 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).

42 U.S.C. §1395yy only set the formula for determining the cost limit; it did not change the method to be used to determine exceptions to the cost limit nor provide CMS with any legal authorization to adjust its pre-existing policies or regulations. Congressional imposition of a rate that is out of line with economic reality (in a case concerning the composite rate for end-stage renal disease services) "does not give CMS the right to justify using out-of-line-with-reality component numbers to make exception determinations." University of Cincinnati, d/b/a University Hospital v. Shalala, No. C-1-93-841, (S.D. Ohio, Nov. 8, 1994), Medicare and Medicaid Guide (CCH) & 42,976.

Because CMS Pub 15-1 §2534.5 carves out a *per se* exception methodology contained in the applicable regulation and in the unwritten policy of CMS for 15 years prior to adoption of this manual section, it "effected a change in existing law or policy" that is substantive in nature. Linoz v. Heckler, 800 F.2d 871,877 (9th Cir. 1986).

Even if CMS Pub 15-1 §2534.5 should be considered an "interpretive" rule, it nevertheless constitutes a significant revision of the Secretary's definitive interpretation of 42 C.F.R. §413.30 and is invalid because it was not issued pursuant to notice and comment rulemaking. "Once an agency gives its regulation an interpretation, it can only change that interpretation as it would formally modify the regulation itself: through the process of notice and rulemaking." Paralyzed Veterans of America v. D.C. Area, 117 F.3d 579, 586 (D.C. Cir. 1997).

In a District of Columbia Circuit Court decision, Alaska Professional Ass'n., Inc. v. Federal Aviation Admin., 177 F.3d1030 (D.C. Cir. 1999), the Court held that even though a rule is "interpretative" and not "substantive," it must nevertheless be adopted through notice and comment rulemaking if it significantly revises the definitive interpretation by an agency of its regulation. Without question, that is

precisely what CMS did when it changed its methodology of determining atypical services exceptions for hospital-based SNFs after having consistently applied it in a much different manner for 15 years prior to making the change.

There is nothing in the statute or regulation that requires the "gap" methodology interpretation at issue here. Congress gave the Secretary broad authority to establish "by regulation" the methods to be used and items to be included in determining reimbursement. 42 U.S.C. §1395 x(v)(1)(A). Had the "gap" methodology been subjected to the rulemaking process under the APA, 5 U.S.C. §553, it would have been a legitimate exercise of that power. However, it was not, and, in addition to the arguments previously presented, the Board is further persuaded by the District Court's decision in the *St. Luke's Methodist Hospital v. Thompson*, 182 F.Supp. 2d 765 (N.D. Iowa, 2001), that CMS Pub 15-1§2534.5 does not reasonably interpret 42 C.F.R. §413.30. *Id at 784.*

The St. Luke's Court found "CMS Pub. 15-1 §2534.5 invalid as an unreasonable interpretation of 42 C.F.R. §413.30 in light of the language of that regulation and the principles underlying the Medicare statute." The Court reasoned that CMS Pub. 15-1 §2534.5 created an irrefutable exclusion of gap costs that, if permitted to stand, would allow the Secretary to "substantially rewrite the regulation to impose an additional hurdle for exceptions eligibility not clearly contemplated by the language of the regulation or subsequently enacted statutes."[5] *Id.* The Court also found that application of the "gap" methodology would result in non-Medicare payors subsidizing the care of Medicare patients in violation of 42 U.S.C. §1395x(v)(1)(A). *Id.* at 787. Clearly, that cannot be disputed.

The St. Luke's Court stated that:

> [t]he Court does not agree that 42 U.S.C. §1395yy, read in conjunction with 42 C.F.R. §413.30 reasonably results in the interpretation promulgated by the Secretary in CMS Pub. 15-1 §2534.5. There is no inherent conflict between the Secretary's original, longstanding interpretation of 42 C.F.R. §413.30 and Congress' subsequent imposition of a two-tiered RCL measure through 42 U.S.C. §1395yy. Absent persuasive evidence to the contrary, there is no reason to believe that Congress, in enacting 42 U.S.C. §1395yy, meant to override the distinction between typical and atypical service reimbursement eligibility in 42 C.F.R. § 413.30.

Id. at 787.

[5] The Secretary argued that his rational for the "gap" methodology was based on legislative changes to the statute in 1984 in which 112% of the mean was used to calculate new RCLs. There were no changes to the statute or regulation concerning the exemption process, however.

The Court also determined that CMS Pub. 15-1 §2534.5 represents:

> ". . . an abrupt and significant alteration of a longstanding, consistently followed policy and was developed years after the regulation it interprets and the statute it purports to incorporate. The Secretary has failed to persuade this Court that despite its incongruous and inconsistent procedural history, the interpretation is the product of 'thorough and reasoned consideration."

Id. at 781.

The findings and decision of the St. Luke's Court are equally applicable to the present case and support the Board's conclusion that the partial denial of Glenwood Regional Medical Center's request for an atypical service exception should be revised to permit the Provider to recover its costs.

DECISION AND ORDER:

CMS's methodology for measuring the entitlement of hospital-based SNFs to exception relief under 42 C.F.R. §413.30(f) and CMS's partial relief of the Provider's exception request was improper. CMS's determination is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Dr. Gary Blodgett
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani

DATE: June 7, 2004

FOR THE BOARD

Suzanne Cochran, Esquire
Chairman