PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2002-D8

DATE OF HEARING-
September 18, 2001

PROVIDER -
Colleton Regional Hospital - Skilled Nursing Facility
Waterboro, SC

Provider No. 42-0030

Cost Reporting Period Ended -
December 31, 1993

vs.

CASE NO. 97-1048

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of South Carolina

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ISSUES:

1. Was the decision of the Health Care Financing Administration ("HCFA"), pursuant to its HCFA Pub. 15-1 § 2534.5, to refuse to grant an exception for that portion of the Provider's per diem costs which exceed the Routine Cost Limit ("RCL"), but which do not exceed 112 percent of the total peer group mean cost, arbitrary, capricious, an abuse of discretion or not in accordance with law?

2. Was the Intermediary's adjustment reclassifying the Provider's costs from direct to indirect cost centers arbitrary, capricious, an abuse of discretion or not in accordance with law?

3. Was the Intermediary's application of the low occupancy adjustment in HCFA Transmittal No. 378, HCFA Pub. 15-1 § 2534.5.A, arbitrary, capricious, an abuse of discretion or not in accordance with law?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Colleton Regional Hospital ("Provider") operates a 15-bed Medicare certified hosptial-based ("HB") skilled nursing facility ("SNF") in Waterboro, South Carolina.

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 15.78 days compared to a national average of 223.64, Medicare utilization of 94.76 percent compared to a national average of 32.69 percent, and Medicare SNF ancillary per diem costs of $99.11 compared to a national average of $24.31. 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.

Pursuant to 42 C.F.R. § 413.30(f)(1), the Provider requested an atypical services exception from HCFA for the cost reporting period ending December 31, 1993. Both Blue Cross and Blue Shield of South Carolina (the "Intermediary") and HCFA recognized that the Provider had provided atypical services, and HCFA granted an exception in the amount of $71.36 per day. The final exception incorporated into the notice of program reimbursement ("NPR") by the Intermediary was $71.36. With 2,587 Medicare SNF patient days at issue, the total amount of the exception granted was $184,608. The Provider appealed HCFA's partial denial of its exception request to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. § 405.1835-.1841. The Medicare reimbursement at issue is approximately $200,000.

The first issue relates to the instruction in HCFA Transmittal No. 378 that the atypical services exception of every HB-SNF must be measured from 112 percent of the peer group mean for that HB-SNF. This amount, 112 percent of the peer group mean of every HB-SNF, is always significantly higher than a provider's RCL. Thus, under HCFA Pub. 15-1 § 2534.5, there is a reimbursement "gap" between the RCL and 112 percent of the peer group mean which

represents costs incurred by the HB-SNF which it can never recover.

The second issue relates to the Intermediary's reclassification of costs from the direct cost center to the Central Supply indirect cost center. The Intermediary reclassified $22,333 from the direct cost center into the nursing administration indirect cost center and $8,579 into the routine central supplies indirect cost center. All of these costs reclassified from the direct cost center had been classified by the Provider in the direct cost center.

The third issue relates to the Intermediary's implementation of a low occupancy adjustment to the Provider's costs during the exception determination. The Provider contends that the Intermediary and HCFA violated HCFA Pub 15-1 § 2534.5.A by "deeming" certain of its direct and indirect costs to be "fixed," while the Provider asserts that they were actually "variable."

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.

PROVIDER'S CONTENTIONS:

Issue 1 - 112 Percent of the Peer Group Mean Adjustment

The Provider's contentions concerning the first issue fall within three broad categories. The Provider contends the "gap" methodology in HCFA Pub 15-1 § 2534.5 is directly inconsistent with the regulation controlling atypical services exceptions. HCFA 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. In addition, the gap methodology in HCFA Pub. 15-1 § 2534.5 is also inconsistent with the statute prohibiting cross-subsidization between Medicare and other payers. The Provider contends the gap methodology in HCFA 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, 5 U.S.C. § 501 et seq., ("APA") or as a regulation as required by statute. The Provider contends that HCFA's action in adopting the gap 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 APA.

The Provider contends that the gap 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. According to the language of § 413.30(f)(1) the Provider must meet only three criteria: 1) that the Provider's costs exceeded its RCL, 2) that these costs exceeded the RCL "because 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 gap methodology in HCFA Pub. 15-1 § 2534.5, HCFA has substituted a new cost threshold in the place of the RCL in the first criteria.

The Provider points out that 42 C.F.R. § 413.30 focuses its language on the adjustment of limits, and not on exceeding a threshold higher than the limits. The regulation at 42 C.F.R. § 413.30 "sets forth rules governing exemptions, exceptions, and adjustments to limits established under this section that HCFA may make as appropriate in consideration of special needs or situations of particular providers." (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 to qualify for an exception. The regulation at 42 C.F.R. § 413.30(f)(1) states that the "limits" may be adjusted upwards if "[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 . . . ." (Emphasis added). The controlling regulation specifically states that the provider must only show that its cost "exceeds the applicable limit," and not that its cost exceeds 112 percent of the peer group mean. Id.

The Provider also contends that in devising the gap 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. 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 "because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified." (Emphasis added). The comparison to a peer group of "providers similarly classified" required by the regulation is of the "nature 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. HCFA 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 HCFA, once a provider has established that it exceeds these benchmarks, "they have, as far as we are concerned, they have established that they are providing atypical services."[1]

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[1] Provider Exhibit 22 at 92.

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)(l) 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 urges the Board to give no deference to HCFA's interpretation of 42 C.F.R § 413.30(f)(l), arguing that deference is only due an agency when it has developed its interpretation contemporaneously with the regulation, when the agency has consistently applied the regulation over time, and when the agency's interpretation is the result of thorough and reasoned consideration. Sioux Valley Hospital v. Bowen, 792 F.2d 715, 719 (8th Cir. 1986). It is undisputed that HCFA did not interpret 42 C.F.R. § 413.30(f)(1) to contain a reimbursement gap contemporaneously with its promulgation, and that the gap methodology in HCFA Pub. 15-1 § 2534.5 is inconsistent with HCFA's longstanding interpretation of the regulation to permit HB-SNFs to receive exceptions measured from their RCL. Moreover, HCFA's recent interpretation is not the result of thorough or reasoned consideration.

The Provider also contends that the gap 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 HB-SNF which provided atypical services and whose costs exceeded its RCL from ever obtaining reimbursement up to all of its costs.

The Provider contends that the gap methodology in HCFA Pub. 15-1 § 2534.5 also violates the APA because it was not adopted pursuant to the notice and comment rulemaking requirement of 5 U.S.C. § 553. It is undisputed that HCFA Pub. 15-1 § 2534.5 is not a regulation and was not adopted pursuant to notice and comment rulemaking procedures. The APA issue in this case is whether HCFA Pub 15-1§ 2534.5 is a "substantive" or "legislative" rule, and thus subject to the notice and comment rulemaking requirements of 5 U.S.C. § 553, or whether it qualifies for the "interpretive" rule exemption. "[T]he APA's notice and comment exemptions must be narrowly construed." United States v. Picciotto, 875 F.2d 345, 347 (D.C. Cir. 1989); Professionals and Patients v. Shalala, 56 F.2d 592, 595 (5th Cir. 1995).

The Provider identifies the principle of administrative law that a rule is substantive, and thus requires compliance with the APA's notice and comment procedures, if it is based on an agency's power to exercise its judgment as to how best to implement a general statutory mandate. United Technologies Corp. v. Enviromental Protection Agency, 821 F.2d 714, 719-720 (D.C. Cir. 1987); American Mining Congress v. United States Department of Labor, 995 F.2d 1106, 1110 (D.C. Cir. 1993).

The Provider argues that HCFA Pub. 15-1 § 2534.5 is substantive because it is HCFA's articulation of how it will exercise its broad discretion granted by 42 U.S.C. § 1395yy(c). The statute at 42 U.S.C. § 1395yy(c) gives HCFA broad authority to make adjustments to the new HB-SNF RCL "to the extent HCFA deems appropriate," but by itself provides no adequate legislative basis for the exercise of HCFA's discretion to grant exceptions to the dual cost limits. HCFA Pub. 15-1 § 2534.5 is not interpretive of the regulation at 42 C.F.R. § 413.30 because that regulation was

not promulgated to implement the broad discretion contained in 42 U.S.C. § 1395yy(c), but significantly predated the statute. Thus, there is no legislative rule implementing HCFA's discretion to grant exceptions to the new HB-SNF RCL created by 42 U.S.C. § 1395yy(a).

The Provider also argues that HCFA Pub. 15-1 § 2534.5 effectively amends 42 C.F.R. § 413.30 by eliminating the discretion of HCFA to reimburse a HB-SNF for its costs incurred between its RCL and 112 percent of its peer group mean. Before HCFA Pub. 15-1 § 2534.5, HCFA applied 42 C.F.R. § 413.30(f)(l) to compensate a HB-SNF for all of its costs incurred above its RCL that the provider could show were (1) reasonable, (2) attributable to the circumstances specified in subsection (f)(1)(i) and (ii), (3) separately identified by the provider, and (4) verified by the intermediary. HCFA so applied 42 C.F.R. § 413.30 to HB-SNFs for ten years during which the new HB-SNF RCLs established by 42 U.S.C. § 1395yy(a) were in existence.

The Provider cites authorities which state that a rule that adds a new requirement to a set of existing requirements is substantive, and requires HCFA to follow notice and comment rulemaking procedures in order to be valid. See Ohio Department of Human Services. v. Department of Health and Human Services, 862 F.2d 1228, 1235 (6th Cir. 1988) ("Ohio") (holding that the department's adoption of a "maintenance amount ceiling" for non-institutionalized spouses of institutionalized Medicaid recipients required notice and comment because it added a requirement that was not compelled by or implicit in the existing regulations); See also Perales v. Sullivan, 948 F.2d 1348, 1352 (2d Cir. 1991) (determining that a rule was substantive when it required state Medicaid submissions to provide assurance that the state possessed supporting documentation); Linoz v. Heckler, 800 F.2d 871, 877 (9th Cir. 1986) (concluding that a department provision excluding payment for ambulance service from one hospital to another solely to obtain the services of a specialty physician was a substantive rule where "instead of simply clarifying a pre-existing regulation, [it] carved out a per se exception").

Similarly, a rule which imposes binding constraints on an agency's existing discretion is also considered to be substantive. See Ohio at 1234 (concluding that a rule was substantive, in part, because it was "mandatory, not advisory"); Guardian Federal Saving and Loan Association v. Federal Savings Loan Insurance Corporation, 589 F.2d 658, 666-67 (D.C. Cir. 1978) ("If it appears that a so-called policy statement is in purpose or likely effect one that narrowly limits administrative discretion, it will be taken for what it is—a binding rule of substantive law.").
The Provider argues that HCFA's conduct in the publication of HCFA Pub. 15-1 § 2534.5 is nothing less that an effort to self-exempt itself from APA rulemaking requirements. Although 42 U.S.C.§1395yy(c) provides HCFA with extraordinary discretion in creating rules which change the exception process, it remains the law that HCFA must in fact promulgate such rules through a regulation. Batterton v. Francis, 432 U.S. 416, 425 (1977) ("In a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term. In exercising that responsibility, the Secretary adopts regulations with legislative effect"). HCFA, however, did not promulgate 42 C.F.R. § 413.30(f)(l) in the exercise of its discretion under 42 U.S.C. § 1395yy(c); that regulation existed long before the statute. Instead, HCFA issued a manual provision, without notice and comment, to do the job of an amendment to the regulation.

HCFA cannot avoid the notice and comment requirements of the APA by creating a new rule through the guise of "interpreting" regulations which predated the statute which HCFA claims as authority for its new rule. See U.S. v. Picciotto, 875 F.2d 345, 346-347 (D.C. Cir. 1989). The pre-existing regulation could not possibly have contemplated the dual limits which were established later. Moreover, for ten years after the establishment of dual limits by 42 U.S.C. § 1395yy(a), the pre-existing regulation was interpreted by HCFA to impose no change in the way free standing ("FS") and HB-SNFs were treated in the exception process, demonstrating what HCFA actually intended its original regulation to mean. In order to create the new rule of HCFA Pub. 15-1 § 2534.5, HCFA should be required to amend its regulation pursuant to the APA.

The Provider next argues that even if, for the sake of argument only, HCFA Pub. 15-1 § 2534.5 is considered an interpretive rule, it must still be implemented following notice and comment rulemaking because it significantly revises the definitive interpretation which the Secretary had previously given 42 C.F.R. § 413.30(f)(l) before the issuance of HCFA Pub. 15-1 § 2534.5.

The Provider points to authority which states "[o]nce 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 comment rulemaking." Paralyzed Veterans of America v. D.C.Area, 117 F.3d 579, 586 (D.C. Cir. 1997)("Paralyzed Veterans"). The Court of Appeals for the District of Columbia subsequently stated that:

> [In Paralyzed Veterans] [w]e . . . explained why an agency has less leeway in its choice of the method of changing its interpretation of its regulations than in altering its construction of a statute. "Rule making," as defined in the APA, includes not only the agency's process of formulating a rule, but also the agency's process of modifying a rule. 5 U.S.C. § 551(5). When an agency has given its regulation a definitive interpretation, and later significantly revises that interpretation, the agency has in effect amended its rule, something it may not accomplish without notice and comment.

Alaska Professional Hunters Association, Inc. v. Federal Aviation Administration, 177 F.3d 1030, 1033-34 (D.C. Cir. 1999)("Alaska Hunters"). Shell Offshore, Inc. v. Babbitt, 238 F.3d 622 (5th Cir. 2001). See also Syncor International Corporation v. Shalala, 127 F.3d 90, 94 (D.C. Cir. 1997) (modification of an interpretive rule construing an agency's substantive regulation will "likely require a notice and comment procedure").

The Provider points out that the facts of this case are squarely on point with Paralyzed Veterans and Alaska Hunters. Since its issuance, HCFA interpreted 42 C.F.R. § 413.30(f)(1) to contain no reimbursement gap for HB-SNFs, but interpreted the regulation to require all HB-SNFs to measure the amount of their exception from their RCL. HCFA changed that interpretation of 42 C.F.R. § 413.30(f)(1) when it issued HCFA Pub. 15-1 § 2534.5. Under Paralyzed Veterans and Alaska Hunters, HCFA must use notice and comment rulemaking to change its interpretation of

42 C.F.R. § 413.30(f)(1).

A separate, but analytically similar, basis upon which the gap methodology of HCFA Pub. 15-1 § 2534.5 must be held to be invalid is that it violates 42 U.S.C. § 1395hh(a)(2), which states:

> [n]o rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

(emphasis added).

For all of the reasons explained immediately above regarding the invalidity of the gap methodology under the APA, the gap methodology is also invalid under 42 U.S.C. § 1395hh(a)(2), because it establishes and changes a substantive legal standard governing the payment for services.

Pursuant to 42 U. S. C. § 1395oo(f)(1), the Secretary's action in issuing HCFA Pub. 15-1 § 2534.5 is also governed by other provisions of the APA, which empower a reviewing court to overturn agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). The Provider contends that HCFA's action in adopting the gap 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.

The Provider points out that in this case HCFA's methodology is a departure from its earlier method of determining HB-SNF exception requests and requires an explanation for its change of direction. The Provider identifies "a 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. Federal Communications Commission, 775 F.2d 342, 355 (D.C. Cir. 1985). The Provider points to the case of Motor Vehicle Manufacturer Association v. State Farm Mutual, 463 U.S. 29, 43 (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 Freight System, Inc. [419 U.S. 281] at 285, 42 L.

> Ed. 2d 447, 95 S.Ct. 438; Citizens to Preserve Overton Park v. Volpe, [401 U.S. 402] at 416, 28 L. Ed. 2d 136, 91 S.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 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.

The Provider points out that it is undisputed that HCFA's stated reason for adopting the gap 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 HB-SNFs which fell within the gap. The Provider points to written discovery responses which state this as the reason for the gap methodology.[2] The same explanation was given by the testimony of a HCFA witness.[3] This explanation was also stated in a HCFA Administrator Decision on the same issue. See St. Francis Health Care Centre v. Community Mutual Insurance Company, 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 1988), Medicare and Medicaid Guide (CCH) 1998-2 transfer Binder ¶ 300,026, aff'd, Case No. 98-3965 (6th Cir. 2000), Medicare and Medicaid Guide (CCH) 1988-2 Transfer Binder ¶ 300,420("St. Francis").

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[2] See Provider Exhibits 5 and 6.

[3] Tr. at 100.

The Provider contends that HCFA's stated reason for its adoption of the gap methodology failed to consider the only direct evidence of the intent of Congress on this issue. The Provider points to Senate Print 98-169.[4] This document unequivocally shows that it was the intent of Congress to permit HB-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 HB-SNFs which treat the sickest of patients after Congress took great care to compensate the costs of HB-SNFs providing only typical services to sicker patients.

Logically, the fact that Congress set a higher RCL for HB-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 for the DEFRA 1984 dual limits) would lead to the similar and parallel conclusion that those HB-SNFs which provide atypical services (because they treat even sicker patients than the HB-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 gap which penalizes all HB-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 "[i]n order to give meaning to Congress's explicit intention that 50 percent of the cost differences between hospital-based and FS-SNFs not be reimbursed".[5] However, Senate Print 98-169 shows that this intent of Congress applied only to HB-SNFs providing only typical services, and not to that minority of HB-SNFs

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[4] Finance Committee of the 98th Congress of the U.S. Senate, senate Print 98-169, Vol. 1. Provider Exhibit 9.

[5] See Provider Exhibit 5 at 3 and Provider Exhibit 6 at 3-4.

which provide atypical services.[6] HCFA could point to no statement by Congress that HB-SNFs which provided atypical services should uniformly be denied as a class from obtaining up to all of their reasonable costs.[7] 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 HB-SNFs which provide atypical services.

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

First, the Provider points out that the gap methodology of quantifying the amount of an atypical services exception from 112 percent of the peer group mean leads to the absurd result of treating the costs of atypical services more severely than the costs of typical services. The RCL discounts the last dollars of the cost to a HB-SNF of providing typical services; HB-SNFs providing only typical services are presumed to have reasonable costs "up to" the RCL. In contrast, the cost of the atypical services provided by a HB-SNF are treated much more severely in that the discount is applied to the first dollars of such cost. For example, a HB-SNF providing typical services at the RCL and atypical services at below 112 percent of the peer group mean receives no compensation for its cost of providing atypical services. In another example, a HB-SNF providing typical services at the RCL and atypical services at an amount above 112 percent of the peer group mean equal to the 12 percent amount of the gap, suffers a 50 percent discount for its cost of providing atypical services.

Second, the Provider points out that the gap methodology of quantifying the amount of an atypical services exception from 112 percent of the peer group mean leads to the absurd result of assuming that a HB-SNF's costs above the RCL are unreasonable, but then become reasonable again above the higher level of 112 percent of the peer group mean.

Third, the Provider points out that the gap methodology plays no role in screening out unreasonable costs. Unreasonable costs are screened out by other provisions of HCFA Transmittal No. 378 to which the Provider does not object.

The Provider also contends that the gap methodology impermissibly discriminates between FS-

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[6] See Provider Exhibit 9.

[7] Provder Exhibit 22 at 102-103.

SNF and HB-SNFs in that FS-SNFs which provide atypical services do have an opportunity to obtain reimbursement of up to all of their reasonable costs, while no HB-SNF will ever be able to do so. The Provider points out that 42 U.S.C. § 1395yy(c), which gives HCFA the authority to develop and apply an exception procedure, does not articulate any express intent of Congress to discriminate between FS-SNFs and HB-SNFs in the exception process. Although the statute does grant the Secretary broad discretion as to whether or not to make adjustments to the limits, and as to the appropriate extent of the adjustments made, it nowhere permits the Secretary to discriminate against HB-SNFs. The Provider cites Addison v. Holly Hill Fruit Products, 322 U.S. 607 (1944) in support of its conclusion that such discrimination is arbitrary, capricious, an abuse of discretion and not in accordance with law.

The financial impact upon the Provider of the Intermediary's and HCFA's improper application of the reimbursement gap is a shortfall of $32,200.14 in the exception amount due to the Provider.[8]

Issue 2 - Reclassification of Costs from Direct to Indirect Cost Centers
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.

The manual at HCFA Pub. 15-1 § 2534.5(B) reads in pertinent part as follows:

[8] Provider Exhibits 32 and 35.

> Uniform National Peer Group Comparison. . . . 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. [9]

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

> [i]n 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 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.[10]

Taking step two of the two-step process is necessary to maintain the integrity of the peer

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[9] Provider Exhibit 15 at 9-10 and Provider Exhibit 17 at 22-23.

[10] Provider Exhibits 8 and 17 at 23-25.

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.[11] The direct and disaggregated indirect costs of the providers in the peer group were obtained from their cost reports.[12] 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,[13] and HCFA Transmittal No. 378 reflects that no reclassifications occurred before the peer groups were constructed.[14] Discovery responses from HCFA describing the process of constructing the peer groups do not mention the reclassification of direct costs.[15] 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.[16]

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[11] Provider Exhibit 17 at 70.

[12] Provider Exhibit 17 at 15-24.

[13] Provider Exhibit 17 at 70-71.

[14] Provider Exhibit 17 at 40-43.

[15] Provider Exhibits 5 and 6.

[16] Provider Exhibit 17 at 26.

Most, if not all, hospitals have significant amounts of direct costs of the type reclassified by the Intermediary.[17] 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.[18] The Chart of Account for Hospitals[19] notes that while "many 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."[20] This latter practice is directed by HCFA Pub. 15-1 § 2144.7 which states "[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." Id.

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.[21] The Provider illustrates this distortion by use of a visual aid.[22]

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 § 2534.10(A)(5).[23]

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[17] Id. at 30-31.

[18] Provider Exhibit 18.

[19] Chart of Accounts for Hospitals, by L. Vann Seawell, and published by the Healthcare Financial Management Association.

[20] Id. Chapter 4, Figure 4-3, Two digit Suffix 15.

[21] Provider Exhibit 17 at 30-31.

[22] Provider Exhibit 13.

[23] Provider Exhibit 15 at 12.

The Provider points out that "[t]he peer group direct per diem cost 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 § 2534.10(A)(5).[24] First, the Provider must determine what percentage of its total direct costs are made up of direct salary costs. Second, the 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 illustrates 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 an overstated comparison point for the Provider's direct salary costs.

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[24] Id.

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.[25]

The Provider notes that HCFA is unable to identify any support for its argument that the peer group does not contain direct costs of the type reclassified by the Intermediary. In defending this position before the Provider Reimbursement Review Board, HCFA's witness, Joseph Menning, admitted that he had not been involved in the calculation of the peer groups.[26] Mr. Menning moreover admitted that he did not 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.[27]

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.[28] 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 "for the purpose of constructing the peer group."[29] Moreover, Mr. Menning was not able to give any

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[25] Provider Exhibit 17 at 30-31.

[26] Id. at 58-59.

[27] Id. at 63.

[28] Id. at 57-58.

[29] Id. at 66-68.

alternative explanation of the meaning of this language.[30]

[30] Id. at 72.

The Provider points out that HCFA's explanation that the September 29 letter was to apply only to "small amounts"[31] is the classic example of administrative action that is arbitrary and capricious. HCFA has no definition of "small amounts" and there is no instruction which would define the threshold between big and small.[32] 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 ("e.g."), 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 $21,679.06.

Issue 3 - Low occupancy adjustment in HCFA Transmittal No. 378, HCFA Pub. 15-1 § 2534.5.A, arbitrary, capricious, an abuse of discretion or not in accordance with law

The Provider contends that the Intermediary and HCFA violated HCFA Pub. 15-1 § 2534.5.A by "deeming" certain of the Provider's costs to be "fixed costs" when these costs were clearly "variable costs" under standard accounting practices.

HCFA Pub. 15-1 § 2534.5.A states HCFA's rule for low occupancy adjustments in determining SNF exception requests. It reads in relevant part as follows:

> (A) Low Occupancy.— If a provider's occupancy rate is lower than the average occupancy rate of the provider used to develop the cost limits, an adjustment to the provider's per diem cost may be made . . . . For the purpose of this adjustment, fixed costs are defined as those costs considered fixed by standard accounting practices and those costs that must be incurred by all SNFs in order to meet the conditions of participation in the Medicare program. The provider must identify and quantify all per diem costs, by cost center, that vary with occupancy and, accordingly, must be excluded from the adjustment for low occupancy. In the absence of a specific identification, all per diem costs are deemed fixed and adjusted accordingly . . . .

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[31] Id. at 54-55.

[32] Id. at 58.

HCFA Pub. 15-1 § 2534.5.A (emphasis added).

The Provider points out that the stated purpose of the low occupancy adjustment is to avoid the reimbursement of unreasonable per diem costs which result when fixed costs must be spread over a smaller population than that which typically occupies a peer group SNF. HCFA has explained the purpose as follows:

> Basically, the biggest part that concerns us in terms of when a provider's occupancy level is below 75 percent is the fixed costs. The fixed costs are being spread over a lower number of days, which means your per diem costs are going to be higher in relationship to your occupancy level. So we would look for the provider to identify what cost in each cost center is fixed and which costs are variable.[33]

This rationale has also been articulated in HCFA Administrator decisions. It indicates that since the inception of the skilled nursing facility cost limit exceptions process, HCFA has interpreted 42 C.F.R. § 413.30(f)(1) to provide for the evaluation of all applications to ensure that excess costs are not due to excessive staffing or idle capacity (low occupancy), resulting in fixed expenses being spread over fewer inpatient days, creating unnecessarily high costs per patient day. See Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, HCFA Administrator Decision, October 20, 1995, Medicare and Medicaid Guide (CCH) ¶43,722 ("Southfield").

The Provider notes that Section 2534.5.A creates only a rebuttable presumption that all of the provider's costs are fixed. A provider is expressly permitted to demonstrate that its costs are in fact variable, and not fixed, and that no low occupancy adjustment is appropriate:

> [B]oth the Board and the Administrator have recognized in similar cases that the occupancy adjustment applied to skilled nursing facility exception requests operates as a rebuttable presumption, and not as an inflexible rule. That is, a provider may rebut application of the adjustment by identifying costs subject to the limitation that, in fact, vary with occupancy and/or by furnishing a sufficient explanation of why, in its particular case, the lower occupancy level was reasonable.

Southfield, at 46,858.

The dispute regarding direct costs focuses solely on registered nurse ("RN") costs. HCFA

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[33] Provider Exhibit 20 at 80.

deemed $37,706 of the Provider's RN costs to be fixed. This was based on a minimum staffing of one RN, 2,080 hours a year (40 hours x 52 weeks) multiplied by an average hourly rate of $18.13.[34]

The Provider contends that HCFA's "deeming" that these RN costs are fixed is arbitrary, capricious and an abuse of discretion because this summary conclusion violates HCFA's own instructions which define how fixed costs are found. HCFA Pub. 15-1 § 2534.5(A) defines fixed costs as those that are both defined as fixed costs by standard accounting principles and required by the Medicare conditions of participation. The RN costs at issue are not defined as fixed costs under standard accounting principles.

Simply "deeming" any cost to be fixed in the abstract is inconsistent with any standard accounting practice or principle. Accounting practices typically apply accounting principles or rules to particular facts. There is no accounting practice of simply declaring some cost as fixed or variable.

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34 See Provider Exhibit 1 (Exception Request), internal Exhibit 10, at 2.

The definition of fixed costs by standard accounting principles is contained in the leading textbook on cost accounting, Cost Accounting: A Managerial Emphasis by Charles T. Horugren.[35]

A fixed cost is defined by standard accounting practices as one which "remains unchanged in total for a given time period despite wide changes in the related level of total activity or volume." A variable cost is defined by standard accounting practices as one which "changes in total in proportion to changes in the related level of total activity or volume."

Standard accounting practices identify four principles as significant to the definition of a cost as fixed or variable:

> Cost Object: This is the item of expense which is being evaluated as to whether it is fixed or variable. Nursing salaries is an example of a Cost Object.
>
> Cost Driver: This is the level of activity or volume that causally affects cost over a given span of time. Patient days is an example of a Cost Driver.
>
> Time Horizon: This is the period of time relevant to the evaluation of the fixed or variable nature of the cost object. A fiscal year is an example of a Time Horizon.
>
> Relevant Range: This is the range of activity in which the Cost Object may vary in reaction to the causal affects of the Cost Driver. The range over which nursing hours vary in reaction to the rise and fall of patient census is the relevant range for nursing hours.

The Provider contends that under these standard accounting principles, when the patient census is between 4 and 15 patients (the bed capacity of the Provider), all RN hours are variable because the Provider follows the standard industry practice of efficiently varying nursing hours with the demands of the patient census. That census is the level of activity that causally affects cost, i.e., the cost driver. If, and only if, the patient census dipped below 4 patients, does the patient census no longer causally affect cost. When the patient census drops below 4 the Medicare conditions of participation still require that one RN be present even if no patients, or only 1 to 3 patients, were admitted. Only when the census ceases to function as the cost driver do the RN costs become fixed.

HCFA's deeming that 40 hours a week were fixed assumes that there is a census of zero 40 hours every week or a census at some level below 4 every day of the year. That is not

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[35] See Provider Exhibit 14.

statistically possible. The Provider had a 15 bed unit with 50 percent occupancy (49.86 percent to be exact). Thus the Provider had an average occupancy of 7.5 patients.

The Provider contends that HCFA's conclusion that this provider had fixed costs of 24 hours of nursing care each day is a misapplication of HCFA's instruction in HCFA Pub. 15-1 § 2534.5.A. What HCFA is concluding is that no matter how efficient this provider is, or how variable its nursing hours are in reality, HCFA will always deem the first 24 hours of nursing care each day to be a fixed cost. If this were a very small hospital-based skilled nursing facility with only five beds, it might frequently have fixed nursing hour costs, because its small size combined with low occupancy could cause the staffing requirement of the conditions of participation to actually operate as a fixed cost. However, that was simply never the case for this provider in this fiscal year. HCFA' s conclusion that this provider had 24 hours of fixed nursing hours every day is unsupported by the facts or by standard accounting practices. It therefore violates HCFA's instruction and is arbitrary, capricious and an abuse of discretion.

The Provider contends that HCFA also improperly applied its low occupancy instruction in HCFA Pub. 15-1 § 2534.5.A to the Provider's indirect costs in every indirect cost center except operation of plant and housekeeping. HCFA Pub. 15-1 § 2534.5.A specifies that the low occupancy adjustment is made "to the provider's per diem cost." As explained above, the premise of the whole adjustment is that when fixed costs must be spread over a lower than typical census, the per diem cost is unreasonably raised.

This premise works well when applied to a free standing skilled nursing facility. For example, the free standing facility is required to have the services of a dietician, some portion of those costs are fixed, and the logic of a per diem cost adjustment to instances of low occupancy applies.

However, this premise does not apply to HB-SNFs because the costs of the general service cost centers of a HB-SNF are statistically allocated by the cost reporting instructions. Thus they are by their very nature variable. Because they are completely variable on a statistical basis, rises and falls in occupancy do not result in any changes in "per diem" expenses. Thus, the "provider's per diem cost" is self-adjusting under the cost reporting instructions on the basis of occupancy, and no further "low occupancy" adjustment is logical or appropriate. The costs that are allocated to the hospital-based skilled nursing facility already reflect the SNF's lower occupancy and are therefore a variable cost; they require no further occupancy adjustment.

Recognizing the indirect costs of a HB-SNF as variable is also consistent with standard accounting practices. Because of the statistical allocation of costs to the SNF's indirect cost centers required by the cost reporting instructions, the traditional analysis of attempting to identify fixed and variable costs within these cost centers does not apply. As far as the "cost object" of the indirect costs of the skilled nursing facility is concerned, they are all variable because of the method by which they were allocated. Indeed, in light of the cost reporting methodology by which these indirect costs are required to be assigned, it would be a

misapplication of standard accounting practices to attempt to identify fixed and variable costs within each indirect cost center which are statistically assigned to routine cost centers.

With the treatment of an additional $37,706 of the Provider's RN direct costs as variable, and with the treatment of all of its indirect costs except Operation of Plant and Housekeeping as variable, the application of the low occupancy adjustment changes. The Provider presented a calculation of the low occupancy adjustment when these costs are treated as variable instead of fixed.[36] The Provider presented a summary of the impact upon the amount of the exception of this change in the low occupancy adjustment and determined it to be an additional exception amount of $17.14 per diem, or $44,341.18 in the aggregate for the fiscal year.[37] The Provider asks the Board to award it an additional $44,341.18 in Medicare reimbursement resulting from the proper application of the low occupancy adjustment.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that §§ 1861(v)(1) and 1888 of the Social Security Act (the "Act"), codified at 42 U.S.C. § 1395x(v) and 1395yy, authorize the Secretary to set prospective limits on allowable costs. The implementing regulations are at 41 C.F.R. § 413.30. The Federal Register, 51 F.R. 11253 (April 1, 1986), explains how the limits are set for hospital-based SNFs. It indicates that the hospital-based limit equals the revised freestanding limit plus 50 percent of the difference between the freestanding limit and 112 percent of the mean per diem routine service costs of hospital-based SNFs. Separate limits are calculated for labor and non-labor portions. There is an add-on for administrative and general costs, adjustments for wage index differences, and adjustments for cost reporting periods beginning after the effective date of the limits.

Under the exception process, a provider's limits may be adjusted to reflect additional costs. The regulation at 42 C.F.R. § 413.30 provides for exceptions where "costs are reasonable, attributable to the circumstances specified, separately identified by the provider and verified by the intermediary." The Provider is requesting exceptions to the limits based on atypical direct and indirect costs and extraordinary circumstances. The regulation states:

(1) Atypical services. The provider can show that:

> (i) The 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,

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[36] See Provider Exhibit 34.

[37] See Provider Exhibit 32.

compared to the items or services generally furnished by providers similarly classified; and

(ii) 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.

(2) Extraordinary circumstances. The provider can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include, but are not limited to, strikes, fire, earthquake, flood, or similar unusual occurrences with substantial cost effects.

. . .

(5) Unusual Labor Costs: The provider has a percentage of labor costs which varies more than 10 percent from that included in the promulgation of the limits.

42 CF.R. § 413.30.

The exception amounts granted and requested are shown below:

	HCFA Response (Granted)	Provider Request
Atypical direct nursing services	$39.49	39.49
Employee benefits	9.62	9.62
A&G	8.44	8.44
Laundry	.63	.63
Cafeteria	1.83	1.83
Nursing Administration	8.65	11.14
Contract supplies	2.56	2.56
Social services	.14	.14
Dietary	0.00	0.00
Total	$71.36	73.85

The Provider is also requesting an exception for extraordinary circumstances of $21.93 per day, based on its labor costs.

The Provider is contesting the difference between the full exception it requested and the exception granted by HCFA and the Intermediary. The Intermediary contends that HCFA has properly adjusted the Provider's cost limit for atypical nursing salaries and indirect costs.

According to Intermediary’s position paper, the Provider contends as follows:

- HCFA’s reclassification of some of the Provider’s salary and non-salary costs from direct

to indirect cost centers on the peer group comparison reduced the Provider's exception in a manner that was arbitrary, capricious and not in accordance with law or HCFA Pub. 15-1.

- By refusing to grant an exception for the portion of the Provider's cost per diem in excess of 112 percent of the total peer group mean cost, HCFA has created a reimbursement gap that is arbitrary, capricious, and not in accordance with law or HCFA Pub 15-1.

- The provisions of HCFA Pub. 15-1 requiring that exceptions from the RCL for hospital-based SNFs be measured from 112 percent of the peer group mean are invalid because they have not been adopted pursuant to the comment prior to the changing and adoption of substantive rules and regulations.

Issue 2 - Reclassification of Costs from Direct to Indirect Cost Centers

The Provider contends that HCFA's reclassification of nursing costs from direct to indirect; specifically, reclassification of the nurse manager salaries and non-chargeable medical supplies to Nursing Administration and Central Supply, improperly reduced its exception payment.

The Provider cites a HCFA letter dated Sept. 29, 1997[38] in support of its contention. HCFA states that an exception for direct salary costs is computed as the provider's direct salary per diem cost in excess of the peer group direct salary per diem cost. 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.

HCFA's position on the classification of costs for the determination of the exception amount is based on the comparability of provider costs to the peer group costs. The provider and peer group cost centers must have the same composition of costs to ensure reliable comparisons. Therefore, the Provider should have determined if the costs in question were included in the peer group cost centers for comparability. The Intermediary based its reclassification on the composition of the peer group cost centers.

The Provider cites HCFA Pub. 15-1 § 2307, which permits the direct costing of general service costs to revenue producing cost centers for certain situations. This is not at issue for the determination of the exception request in terms of direct nursing salaries. HCFA is clear that the

[38] Intermediary Exhibit 3.

Provider costs in question must reflect the peer group cost centers for comparison. The direct costing of general services on the cost report cannot be applied for purposes of comparison with the peer group costs because the peer group direct costs do not contain general service costs. Therefore, the provider costs would be artificially inflated and the exception would be overstated.

The Intermediary contends that its reclassifications of costs were proper, in light of the determination of the exception request.

Issue 1 and 3 - 112 Percent of the Peer Group Mean and Low Occupancy Adjustment

HCFA follows HCFA Pub. 15-1 § 2534.5, Determination of Reasonable Costs in Excess of Cost Limit or 112 Percent of Mean Cost, Revision 378, which is effective for exception requests submitted to intermediaries on or after July 20, 1994. It states:

> [i]n determining reasonable cost, the provider's per diem costs in excess of the cost limit are subject to a test for low occupancy and are compared to per diem costs of a peer group of similarly classified providers.
>
> A. Low Occupancy.--If a provider's occupancy rate is lower than the average occupancy rate of the providers used to develop the cost limits, an adjustment to the provider's per diem cost may be made. The average occupancy rate for all SNFs is approximately 92 percent with a standard deviation of approximately 9 percentage points. Accordingly, the threshold occupancy rate of 75 percent (the average less 2 standard deviations, rounded up to the next whole percentage point) is used to determine if an adjustment is necessary. If a provider's occupancy rate is below 75 percent, all fixed per diem costs, by cost center, are adjusted to reflect its per diem equivalent at the 75 percent occupancy rate. For the purposes of this adjustment, fixed costs are defined as those costs considered fixed by standard accounting practices and those costs that must be incurred by all SNFs in order to meet the conditions of participation in the Medicare program. The provider must identify and quantify all per diem costs, by cost center, that vary with occupancy and, accordingly, must be excluded from the adjustment for low occupancy. In the absence of a specific identification, all per diem costs are deemed fixed and adjusted accordingly. An example of HCFA's low occupancy adjustment is contained in the comprehensive example referred to in Appendix B.

B. Uniform National Peer Group Comparison.--The uniform national peer group data are based on data from SNFs whose costs are used to compute the cost limits. The peer group data are divided into four groups: Urban Hospital-based, Urban Freestanding, Rural Hospital-based, and Rural Freestanding. For each group, an average per diem cost (less capital-related costs) is computed for each routine service cost center (direct and indirect) that the provider reported on its Medicare cost report. For each cost center, a ratio is computed as the average per diem cost to total per diem cost. Those cost centers not utilized on the Medicare cost report must be eliminated and all ratios are revised based on the revised total per diem cost. 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. However, maintenance of personnel, paramedical education, interns and residents, nursing school, etc. always have a ratio of 0.00 because HCFA's peer group does not contain a valid sample of providers incurring these costs. (See § 2534.10.)

With cost reporting periods beginning prior to July 1,1984 for each freestanding group and each hospital-based group, each cost center's ratio is applied to the cost limit applicable to the cost reporting period for which the exception is requested. For each hospital-based group with cost reporting periods beginning on or after July 1,1984 the ratio is applied to 112 percent of the group's mean per diem cost (not the cost limit), adjusted by the wage index and cost reporting year adjustment factor applicable to the cost reporting period for which the exception is requested. The result is the provider's per diem cost is disaggregated into the same proportion of its peer group mean per diem cost for each cost center.

The SNF's actual per diem cost or, if applicable, the cost as adjusted for low occupancy for each applicable routine cost center (less capital-related costs), is compared to the appropriate component of the disaggregated cost limit or 112 percent of the hospital-based mean per diem cost. If the SNF's per diem cost exceeds the peer group per diem cost for any cost center, the higher cost must be explained. Excess per diem costs which are not attributable to the circumstances upon which the exception is requested and cannot be justified may result in either a reduction in the amount of the exception or a denial of the exception.

Pages 1 through 4 of Appendix 4 show the deviation of the per diem adjustment ratios

(column (B) applicable to each of the four peer groups. Page 5 of Appendix A shows the calculation of the hospital-based peer group mean cost.
Appendix B, pages 1 through 4, illustrates a comprehensive example of a hospital-based provider located in San Francisco, CA, which has low occupancy and has timely filed for an exception in accordance with § 2531.1.A.2. The maximum exception that this provider can receive is $78.44 per day, assuming the requirements of § 2534 for filing a request have been met.

HCFA's use of the 112 percent of the peer group mean per diem and low occupancy adjustment were consistent and proper, based on the application of the HCFA Pub. 15-1. The Provider cites St. Francis, supra, in which the HCFA Administrator found that HCFA's methodology was reasonable and proper.

The Intermediary requests that the Board affirm HCFA's determination on the Provider's SNF exception payment.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395hh et seq.	-	Regulations
§ 1395oo et seq.	-	Provider Reimbursement Review Board
§ 1395x(v)(1) et seq.	-	Reasonable Cost
§ 1395yy et seq.	-	Payment to Skilled Nursing Facilities for Routine Service Costs

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.30 et seq	-	Limitations on Reimbursable Costs

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

§ 2144.7	-	Accounting for Fringe Benefits
§ 2307	-	Direct Assignment of General Services Costs
§ 2534 et seq.	-	Request for Exception to SNF Cost Limits

4. Cases:

Addison v. Holly Hill Fruit Products, 322 U.S. 607 (1944).

Alaska Professional Hunters Association, Inc. v. Federal Aviation Administration, 177 F. 3d 1030 (D.C. Cir. 1999).

American Mining Congress v. United States Department of Labor, 995 F.2d 1106 (D.C. Cir. 1993).

Batterton v. Francis, 432 U.S. 416 (1977).

Bowman Transportation, Inc. v. Arkansas-Best Freight System. Inc., 419 U.S. 281 (1974).

Burlington Truck Lines, Inc., v. United States, 371 U.S. 156 (1962).

Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402 (1971).

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

Guardian Federal Saving and Loan Association v. Federal Saving and Loan Insurance Corp, 589 F.2d 658 (D.C. Cir. 1978).

Linoz v. Heckler, 800 F.2d 871 (9th Cir. 1986).

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.

Mercy Medical Center SNF-Daphne v. Mutual of Omaha Insurance Company, PRRB Dec. No. 01-D38, July 27, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,727.

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

National Black Media Coalition v. Federal Communications Commission, 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 & 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.

Ohio Department of Human Services v. Deparment of Health and Human Services, 862 F.2d 1228 (6th Cir. 1988).

Paralyzed Veterans of America v. D.C. Area, 117 F.3d 579 (D.C. Cir. 1997).

Perales v. Sullivan, 948 F.2d 1348 (2d Cir. 1991).

Professionals and Patients v. Shalala, 56 F.2d 592, 595 (5th Cir. 1995).

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

Shell Offshore Inc. v. Babbitt, 238 F.3d 622 (5th Cir. 2001).

Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, HCFA Administrator Decision, October 20, 1995, Medicare & Medicaid Guide (CCH) ¶43,722.

St. Francis Health Care Centre v. Community Mutual Insurance Company, May 30, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,545, aff'd, St. Francis Health Care Centre v. Shalala, Case No. 3:97 CV 7559 (N.D. Ohio 1988), Medicare & Medicaid Guide (CCH) 1998-2 transfer Binder ¶ 300,026, aff'd, Case No. 98-3965 (6th Cir. 2000), Medicare & Medicaid Guide (CCH) 1988-2 Transfer Binder ¶ 300,420.

Sioux Valley Hospital v. Bowen, 792 F.2d 715 (8th Cir. 1986).

Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, HCFA Administrator, October 20, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,722.

Syncor International Corp. v. Shalala, 127 F.3d 90 (D.C. Cir. 1997).

United States v. Picciotto, 875 F.2d 345, 347 (D.C. Cir. 1989).

United Technologies Corporation v. Enviromental Protection Agency, 821 F.2d 714 (D.C. Cir. 1987).

4. Other Sources:

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

Chart of Account for Hospitals, by L. Vann Seawell, published by the Healthcare Financial Management Association

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Cost Accounting: A Managerial Emphasis, Charles T. Horngreen, Prentice-Hall, Inc., Upper Saddle River, NJ, 2000.

51 F.R. 11253 (April 1, 1986).

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:

Issue 1 - 112 Percent Reimbursement Gap

The Board 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 Deficit Reduction Act of 1984, the Secretary was given broad discretion in authoring adjustments to the RCLs. The Board finds that Section (c) of the statute gives HCFA great flexibility in setting limits, stating as follows:

> [t]he Secretary may make adjustments in the limits set forth in subsection (A) 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 finds that the regulation affords HCFA a two prong test in which it can compare costs and types of services. Accordingly, the policy set forth in the regulations requires an examination of both the reasonableness of the amount that a provider's actual cost exceeds the applicable cost limit and the determination of the atypicality of the costs by using a peer group comparison.

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

The Board further finds that 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 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 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 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 acknowledges the Provider's reliance upon the previous Board's decision in St. Francis, supra, to help support its position and arguments. The Board notes that its findings are consistent with the circuit court ruling which upheld the HCFA Administrator's reversal of the Board's decision in St. Francis and 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 & Medicaid Guide (CCH) ¶ 80,443.

- Mercy Medical Center SNF-Daphne v. Mutual of Omaha Insurance Company, PRRB Dec. No. 01-D38, July 27, 2001, Medicare & Medicaid Guide (CCH) ¶ 80,727.

Issue 2- 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 §§ 2534.5B 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.[39] Although the Board agrees that it may be appropriate to make adjustments to correct

[39] Tr. at 49 and 50.

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 were improperly constructed was not presented.

Issue 3 - Application of Low Occupancy Adjustment

The Board finds that HCFA Pub. 15-1 § 2534.5A applies to this situation. That section established an appropriate level of occupancy (75 percent) and requires an adjustment to "fixed" cost where a provider's occupancy falls below that level. The Board notes that the Intermediary's use of minimum staffing requirements as a fixed cost for the HB-SNF appears appropriate. The Board finds that the Provider did not meet the required proof that its costs were variable and not fixed.

DECISION AND ORDER:

Issue 1 - 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 partial denial of the Provider's exception request was proper. HCFA's determination in this area is affirmed.

Issue 2 - Reclassification of costs and calculation of the exception from the RCLs

HCFA Pub 15-1 § 2534.5B properly applies to the Provider's factual situation. The Intermediary properly reclassified various overhead costs as indirect costs. The Intermediary's adjustment is affirmed.

Issue 3 - Application of Low Occupancy Adjustment

HCFA Pub. 15-1 § 2534.5A properly applies to the Provider's factual situation. The Provider has not proven that its HB-SNF costs were variable. The Intermediary's adjustment is affirmed.

Board Members Participating:

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

Date of Decision: February 21, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman