CENTERS FOR MEDICARE AND MEDICAID SERVICES

Order of the Administrator

In the case of:	**Claim for:**
Alameda Hospital—SNF	**Cost Reporting Period Ending: December 31, 1995**
Provider	
vs.	
BlueCross BlueShield Association/ First Coast Service Options, Inc.	**Review of:**
	PRRB Dec. No. 2012-D10
Intermediary	**Dated: February 10, 2012**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in §1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. §1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Provider submitted comments requesting that the Administrator affirm the Board's decision. The Center for Medicare (CM) submitted comments requesting that the Administrator reverse the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider (Alameda Hospital-SNF) is a hospital-based skilled nursing facility (SNF) in Alameda, California and its routine cost limits (RCL) for the fiscal year ended December 31, 1995, exceeded the RCL limits. The Provider requested an atypical services exception from CMS and then appealed the Intermediary's final determination regarding the request. The Provider challenged the Intermediary's calculation of the low occupancy adjustment as well as the methodology of the 112 percent reimbursement "gap" that arises in atypical services exception requests.

On September 27, 2002, the Board issued a decision in PRRB Case No. 98-0460 in which the Board found that the Intermediary properly applied both the low occupancy adjustment

methodology and the 112 percent reimbursement "gap" that affects atypical service exception requests. The Administrator declined to review the Board's decision and the Provider subsequently filed suit in federal court.

On May 14, 2004, the United States District Court for the District of Columbia issued a memorandum decision and order finding that the Secretary's methodology for calculating "atypical" costs in excess of the RCL was improper. The Court's decision related solely to the 112 percent reimbursement "gap" issue. The Court held that the Secretary had a long established methodology for granting atypical cost exceptions from the RCL limit, and failed to follow the Administrative Procedure Act (APA) notice and comment rulemaking when it shifted policy by issuing the revised PRM §2534.5.

With regard to the low occupancy adjustment, the Court remanded the case to the Secretary of the Department of Health and Human Services for further proceedings in accordance with its decision.

On January 12, 2009, the Administrator issued an Administrator's Order remanding the case to the Board. The Administrator ordered that the Board's decision in PRRB Case No. 98-0460 be vacated in accordance with the court's memorandum and order; that the Board consider the Provider's remaining claims(s) consistent with the procedures of 42 C.F.R. §405.1801, et seq., and the court's opinion and order; that the Board allow the parties to brief the matter of how the court's memorandum is to be implemented, with respect to the remaining low occupancy issue; that the Board issue a decision on the remaining claims(s); and that the Board's decision will be subject to 42 C.F.R. §405.1875.

On April 3, 2009, the Board issued a Notice of Reopening and Board Order implementing the Administrator's Order. On February 12, 2011, the Board issued its' decision.

ISSUE AND BOARD'S DECISION

The issue is whether the United States District Court's memorandum decision, finding the Secretary's methodology was improper under the precedent established in Alaska Professional Hunters Association, Inc. v. FAA, 177 F.3d 1030 (D.C. Cir. 1999) (Alaska Hunters), also applies to the Secretary's low occupancy adjustment.

The Board found that the District of Columbia District Court's memorandum decision applies to the Secretary's low occupancy adjustment. The Board stated that Secretary's new policy regarding the low occupancy adjustment should have been promulgated through notice and comment rulemaking. The Board remanded the case to the Intermediary to recalculate the SNF exception request utilizing the pre-1994 policy regarding low occupancy adjustments.

SUMMARY OF COMMENTS

The Provider submitted comments requesting affirmation of the Board's decision. The Provider contended that the statute requires the Secretary to take into account direct and indirect costs, and to exclude costs that are unnecessary in the efficient delivery of needed health services. The Provider stated that costs are determined by a two step process: first, costs must be found to be reasonable; and second, it must be determined whether costs that fall above the cost limit are attributable to the regulatory basis of an exception.

The Provider asserted that the Secretary's rules concerning excess staffing and the application of the low occupancy adjustment changed in July 1994 with the release of HCFA Transmittal No. 378 which revised PRM §§2530-2541.1. The Provider stated that prior to the release of HCFA Transmittal No. 378, CMS did not apply the low occupancy adjustment to nursing services when considering low occupancy exception requests, and applied the adjustment only to the fixed costs of underutilized space. In support of this contention, the Provider cites to Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, HCFA Adm. Dec. October 20, 1995 (Southfield). In that case the CMS Administrator applied the low occupancy adjustment only to the fixed costs and underutilized space, which it referred to as "idle capacity." The adjustment was never applied to nursing services. The Provider argued that with the release of HCFA Transmittal No. 378, CMS changed the rule by applying the low occupancy adjustment to nursing services.

The Provider affirmed that under Alaska Hunters, when an agency has given a regulation a definitive interpretation, it cannot later significantly revise that interpretation without notice and comment. The Provided concludes that the rationale in Alaska Hunters applies to the low occupancy adjustment in this case.

CMS submitted comments requesting reversal of the Board's decision. CMS disagreed with the Board's findings that CMS' low occupancy adjustment policy changed under Transmittal No. 378. According to CMS, the policy to adjust fixed costs for low occupancy has never changed. CMS stated that the Congressional intent of mandating that Medicare only pay for reasonable costs is reflected in the statute since 1972 and clearly directs the Secretary to disallow standby costs that are equivalent to those costs associated with low occupancy.

CMS stated that the Board was wrong in concluding that the Secretary's methodology for calculating the low occupancy adjustment was improper under the precedent established in Alaska Hunters. According to CMS, Alaska Hunters does not prohibit the low occupancy adjustment described in Transmittal No. 378.

CMS points out that in the 2002 PRRB decision on this case and as it has in other cases, the PRRB agreed with CMS' application of the low occupancy adjustment to those fixed costs associated with the SNFs. Furthermore, any decision that does not adjust all fixed per diem costs incurred for low occupancy would allow providers to capture those types of costs that are determined to be unnecessary in the efficient delivery of services covered by the Medicare program. The Board order for the intermediary to allow certain fixed costs to be paid through the exception process without an adjustment for low occupancy is in direct violation of the Federal statute and implementing regulations and, therefore, should be overturned by the Administrator.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

The Medicare program was established to provide health insurance to the aged and disabled. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program.

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 the proportion of those costs to be allocated to Medicare. CMS' payment and audit functions under the Medicare program are contracted to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Board within 180 days of the issuance of the NPR.

Section 1861(v)(1)(A) of the Social Security Act establishes that Medicare pays for the reasonable cost of furnishing covered services to program beneficiaries, subject to certain limitations. This section of the Act also defines reasonable cost as "the cost actually incurred, excluding there from any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." The Act further authorizes the Secretary to promulgate regulations establishing the methods to be used and the items to be included in determining such costs. In part, section 1861(v)(1)(A) of the Act states:

> Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding there from any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs…

The Committee Report associated with §223 of the Social Security Amendments of 1972 (Pub. Law 92-603) states that "providers would, of course, have the right to obtain… relief from the effect of the cost limits on the basis of evidence of the need for such an exception." The Committee Report states, in part, that:

> The committee believes that it is undesirable from the standpoint of those who support the Government mechanisms for financing health care to reimburse health care institutions for costs that flow from marked inefficiency in operation or conditions of excessive service … when the high costs flow from inefficiency in the delivery of needed health care services the institution should not be shielded from the economic consequences of its inefficiency. Health care institutions, like other entities in our economy should be encouraged to perform efficiently and when they fail to do so should be expected to suffer the financial consequences. Unfortunately a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. The committee believes that the objectives can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonable prudent and cost-conscious management.

As indicated above, in establishing the cost limits and the exception process for payment of costs in excess of the limit, Congress intended to reimburse providers only for reasonable costs incurred in the efficient delivery of needed health care. This would exclude excess costs associated with standby or low occupancy levels.

Consistent with the statute, the regulation at 42 C.F.R. §413.9 states that all payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries.

Pursuant to the regulation at section 42 C.F.R. §413.9 and §413.30, the Secretary established reasonable cost provisions and limits on routine costs, referred to as routine cost limits (RCLs). The regulation at 42 C.F.R. §413.30 contain the procedures for establishing RCLs

and an appeal mechanism regarding the applicability of the cost limits known as the cost limit exception process.

CMS published notice in the Federal Register (44 FR 51542, August 31, 1979) in anticipation of the first set of SNF cost limits that were effective on October 1, 1979. The Federal Register notice indicated that CMS established separate per diem cost limits on routine services furnished by hospital-based and freestanding SNFs (which also recognized geographical locations) that resulted in four peer groups which were; 1) Hospital-based/Urban, 2) Hospital-based/Rural, 3) Freestanding/Urban, and 4) Freestanding/Rural. The per diem cost limit is equal to 112 percent of the mean per diem costs for all SNFs within each of the four peer groups.

The Deficit Reduction Act of 1984 (DEFRA '84), enacted on July 18, 1984, established §1888 of the Act. The DEFRA '84 contained a provision to recognize 50 percent of the cost differences between hospitalbased and freestanding SNFs in setting the hospital-based limits. Under the methodology prescribed in §1888(a), freestanding SNF cost limits are set at 112 percent of mean per diem costs of freestanding SNFs, whereas hospital-based limits are computed by adding 50 percent of the cost difference to the appropriate freestanding cost limit. In addition, §1888(b) mandated that any cost differences related to the Medicare cost allocation process would be recognized. The remaining cost differences would not be recognized as reasonable costs in setting the hospital-based cost limit.[1]

Under §1888(c), the Secretary may make adjustments in the limits set forth in §1888(a) above 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. This section of the statute was implemented in 42 C.F.R. §413.30(f) which allows for an adjustment to the limit only to the extent "that costs are reasonable, attributable to the circumstances specified, separately identified by the provider and verified by the intermediary." These general regulatory requirements must be met before CMS grants an exception to the per diem cost limit. The Medicare regulation at 42 C.F.R. §413.30(f)(1)(1995) permits providers to obtain an exception from cost limits for "atypical services" if the provider can show that:

> (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

[1] The per diem cost limits are a presumptive test of reasonable costs. All routine service per diem costs incurred in excess of the per diem cost limit are deemed to be unreasonable. However, a provider may receive payment for its costs in excess of the cost limits through the exception process.

> 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.

A Provider must demonstrate that the actual cost of items or services exceeds the limit because, inter alia, of the special needs of patients. Moreover, under the cost limit exception process, a provider must demonstrate that its per diem costs in excess of the per diem cost limit are reasonable. This policy recognizes that a portion of a provider's per diem costs is made up of fixed costs. Fixed costs are those costs that a provider must incur without regard to the number of days the provider's available beds are occupied. As a provider's occupancy level or rate decreases, the fixed costs are spread over a smaller number of days which effectively increases the provider's per diem costs.

In July 1994, CMS (formerly HCFA) released HCFA Transmittal No. 378 which set forth instructions in the PRM section regarding Requests for Exception to SNF Cost Limits. PRM §2534.5A addresses CMS' rule for low occupancy adjustments in determining SNF exception requests and reads in relevant part as follows:

> 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…. 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. (Emphasis added.)

As an illustration of how adjustments are made, PRM §2534, Exhibit B provides a chart that shows the adjustment of costs for low occupancy for a hypothetical provider, namely "ABC Hospital." In the hypothetical scenario, ABC Hospital listed costs for direct and depreciation, employee, administrative, operation of plant, laundry, housekeeping, dietary, cafeteria, nursing administration, among other costs. In addressing the identification of costs that vary with occupancy, Exhibit B illustrates how costs should be identified and qualified in order to satisfy the exemption requirements by stating that:

> ABC Hospital SNF could not identify or qualify any costs that vary with occupancy. Therefore all costs are deemed-fixed-and-adjusted for low occupancy. (See section 2534.5)

The Secretary also discussed this adjustment in the response to comments contained in the 1999 Federal Register Notice, (64 Fed. Reg. 42610-01) with respect to the application of Transmittal No. 378. A commenter stated that "intermediaries ignore low occupancy arguments and calculations made by SNFs and either make arbitrary partial adjustments or 100 percent low occupancy adjustments." In response to the commenter, HCFA (now CMS) stated that:

> We have instructed fiscal intermediaries to submit all alternative proposals to low occupancy adjustment to us for determination. We have received many alternative proposals to the low occupancy adjustment submitted by fiscal intermediaries on behalf of SNFs and their representatives. We issued program instructions to the fiscal intermediaries based on these proposals.

Applying the foregoing provisions to the facts of this case, the Administrator agrees with the Board's remand of the case to recalculate the SNF exception request regarding low occupancy adjustments. However, the Administrator disagrees with the Board's reliance on the Alaska Hunters holding as the basis of remanding the low occupancy issue to the Intermediary and finds a remand to CMS is appropriate in accordance with Transmittal No. 378 in order to determine whether the Provider has submitted sufficient evidence as to rebut the application of the low occupancy adjustment to the subject nursing costs.

The District Court's Order ruled that the Secretary violated the APA and the precedent set by Alaska Hunter since the Secretary did not satisfy the notice and rule making requirements prior to the issuance of new PRM instructions that changed the 112 percent reimbursement "gap" that affects atypical service exception requests. The Administrator acknowledges the District Court's finding as it relates solely to the 112 percent reimbursement issue. However, the Administrator notes that the District Court did not apply the APA, nor the District Court's holding in Alaska Hunter to the Provider's low occupancy issue. Instead, the District Court ordered the Secretary to conduct "further proceedings" in accordance with its decision.

In keeping with the District Court's decision, the Administrator finds that the remand to CMS is not required because the Transmittal No. 378 low occupancy criteria is a violation of the APA rule making requirements, or because of any precedent set by Alaska Hunters. Instead, a remand to the CMS is appropriate since the Transmittal No. 378 low occupancy adjustment policy does allow for providers to submit alternative proposals to the Intermediary / CMS for use as the basis of determining whether certain provider costs are fixed costs or variable costs that change along with occupancy fluctuations when applying

the low occupancy adjustment. In this case, the Provider has submitted an alternative explanation of the costs that are in fact affected by the low occupancy and those costs which are not affected by the low occupancy and therefore should not be subject to the low occupancy adjustment. Allowing the Provider to submit an alternative proposal is in keeping with the PRM instruction addressing the application of the low occupancy adjustment and the Federal Register explanation of Transmittal No. 378 low occupancy adjustment.

Moreover, the Administrator also finds that the Provider's reliance on Southfield is misplaced. The Administrator stated in Southfield that:

> Since the inception of the skilled nursing facility cost limit exceptions, 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.

In addition, in summarizing CMS' original determination under the pre-1994 methodology on the Provider's exception request, the Administrator stated:

> HCFA further advised that the agency reviewed occupancy levels in all exception requests to ensure that costs exceeding the routine cost limits were due to the provision of atypical services and were not the result of inefficiencies in operation or excess staffing.

Thus, contrary to the Provider's contentions, it is not evident that CMS only began to apply the low occupancy adjustment to determine excessive staffing due to idle capacity in Transmittal No. 378. Thus, not only is the application of Alaska Hunters not correct as Alaska Hunters recognizes new circumstances that allows for the application of the same policy to new facts but evidence indicates CMS has historically evaluated excessive staffing costs under the low occupancy adjustment.[2] The Administrator notes that the facts in the Southfield decision was narrowly construed but that CMS' decision stated that the review of occupancy levels in all exception requests were reviewed in order to ensure that costs exceeding the RCL were due to the provision of atypical services and were not the result of inefficiencies in operation or excessive staffing. Hence, the low occupancy adjustment was

[2] Thus, in the Southfield decision the decision language inadvertently narrowed the focus of "fixed costs" to only space costs when the Administrator stated regarding the occupancy adjustment that: "Applied only to fixed costs, the adjustment accounts for excessive expenses that providers incur when the fixed costs [for example] associated with underutilized space, are spread over fewer inpatient days, resulting in higher costs per patient day."

not limited to fixed space costs, but fixed costs that factor into determining whether the Provider's costs exceed the routine cost limits.

Accordingly, the Provider has the right under the Transmittal No. 378 policy to rebut the Intermediary's low occupancy adjustment application to the Provider's "fixed costs." The Provider may "identify or qualify any costs that vary with occupancy." Thus, the case is remanded to the CMS / Intermediary to examine the Provider's alternative proposal for application of the low occupancy adjustment as provided for in §2534.5A of the PRM.

Date: 4/10/12

/s/

Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services