

# CENTERS FOR MEDICARE AND MEDICAID SERVICES

## *Decision of the Administrator*

**In the case of:**

**Blumberg Ribner 91-99 SNF 112% Peer  
Mean Group**

**Providers**

**vs.**

**BlueCross BlueShield Association/  
Palmetto GBA c/o First Coast Service  
Options**

**Intermediary**

**Claim for:**

**Provider Cost Reimbursement  
Determination for Cost Year  
Ending: June 30, 1991 through  
December 31, 1999**

**Review of:**

**PRRB Dec. No. 2013-D18**

**Dated: May 16, 2013**

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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 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. The Providers submitted comments, requesting that the Administrator affirm the Board's decision. The Intermediary 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 Providers are 18 hospital-based skilled nursing facilities (SNFs) located in six states. The appeal involves cost reporting periods from 1992 through 1999, for a total of 40 Medicare cost reports. For each of these cost reports, the Intermediary followed the instructions in Provider Reimbursement Manual, CMS Pub. No. 15-1 (PRM 15-1), § 2534 in determining the amount of each Providers hospital-based SNF cost limit exception. The Providers timely appealed the methodology used by the Intermediary to determine their cost limit exceptions.

The Providers contend that they should be reimbursed all of their costs in excess of the limit, based on §1888(a)(3) of the Act, which sets the limit for hospital-based SNFs at the limit established for freestanding SNFs, plus 50 percent of the amount by which 112 percent of the mean per diem routine service cost for hospital-based SNFs exceeds the limit for freestanding SNFs.

### **ISSUE AND BOARD'S DECISION**

The issue was whether CMS' methodology for determining the Providers' exception to the hospital-based SNF routine cost limit was proper.

The Board found that the methodology applied by CMS, in partially denying the Providers' exception requests for per diem costs that exceeded the cost limit, was not consistent with the statute and regulations. The Board stated that the regulation at 42 CFR § 413.30(f)(1) permits a provider to request from CMS an exception to the cost limit because it provided atypical services. The Board claimed that it is undisputed that for fifteen years, the Secretary interpreted the regulation as permitting a provider to recover its reasonable costs that exceeded the cost limits if the provider demonstrated that it met the exception requirements. The Providers' exception requests were processed in accordance with PRM 15-1 Transmittal No. 378, which was issued in July 1994 and decreed that the atypical services exception of every hospital-based SNF must be measured from 112 percent of the peer group mean for that hospital-based SNF rather than the SNF's cost limit. CMS incorporated this transmittal into PRM 15-1 at §2534.5.

Thus, the Board continued, CMS replaced the limit with a new "cost limit," i.e., 112 percent of the peer group mean routine services cost. The Board stated it is undisputed that 112 percent of the peer group mean of hospital-based SNFs is significantly higher than the applicable routine cost limit. Thus, under § 2534.5 of the PRM, a reimbursement "gap" is created between the cost limit and 112 percent of the peer group mean that represents costs incurred by a hospital-based SNF, which are not allowed.

The Board stated that CMS reached a conclusion regarding the intent of Congress toward reimbursing the routine costs of hospital-based SNFs, and inappropriately applied that same rationale to hospital-based SNFs that provide atypical services or incur unusual or uncustomary costs. The Board recognized that in 2000, the Sixth Circuit Court of Appeals<sup>1</sup> upheld PRM 15-1 § 2534.5 as an interpretive rule not requiring notice and comment, and recognized that some of the Providers' in this group appeal are located in the Sixth Circuit. However, the Board noted that it is not

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<sup>1</sup> *St. Francis Health Care Ctr. v. Shalala*, 205 F.3d 937 (6th Cir. 2000).

bound by interpretive rules but rather must “afford great weight” to such rules. Notwithstanding the great weight afforded to PRM 15-1 § 2534.5, the Board found that § 2534.5 is inconsistent with the relevant statutory and regulatory provisions and that the Manual provision is arbitrary and capricious. The Board noted that the controlling regulation, 42 C.F.R. §413.30(f), specifically states that a provider must show only that its cost “exceeds the applicable limit”, not that its costs exceed 112 percent of the peer group mean. The Board stated that 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 of their cost.

The Board noted that the controlling regulation specifies that the RCL “[l]imits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(10) through (f)(5) of this section” (e.g., atypical services”). Regarding this, the Board stated, CMS explained in the preamble to the final rule issued on June 1, 1979 that “[i]f a provider receives an exception, it is reimbursed on the basis of the cost limit, plus an incremental sum for the reasonable costs warranted by the circumstances that justified its exception.” However, according to the Board, pursuant to PRM 15-1§ 2534.5, when a hospital-based SNF’s costs exceed the RCL and such excess costs are found to be reasonable under the exception review process, the hospital-based SNF will receive an additional payment only for that fraction (if any) of the excess costs that surpass another specified threshold—112 percent of the mean per diem costs for a peer group of similarly classified providers. In light of this, the Board found that PRM 15-1 § 2534.5 does not comply with the regulation because the Manual provision does not adjust the RCL limit upward, i.e., add “an incremental sum” onto the RCL limit.

The Board also stated that Congress itself established the four “peer groups” that are to be considered in determining Medicare reimbursement of SNFs: freestanding urban, freestanding rural, hospital-based urban, and hospital-based rural. The Board claimed that CMS had no statutory or regulatory authority to establish a new “peer group” for hospital-based SNFs, i.e., 112 percent of the peer group mean routine service cost, and to determine exceptions from a new cost limit rather than from the limit imposed by Congress.

The Board noted that its decision in this matter is consistent with its prior decisions in similar SNF RCL cases<sup>2</sup> and the Eighth Circuit decision in *St. Luke’s Methodist*

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<sup>2</sup> See, e.g., *Toyon 85-98 112% Hospital-Based Peer Group v. BlueCross BlueShield Ass’n*, PRRB Dec. No. 2010-D35 (June 10, 2010), *rev’d*, Administrator Dec. (Aug. 23, 2010); *Canonsburg Gen. Hosp. SNF v. BlueCross BlueShield Ass’n*, PRRB Dec. No. 2009-D37 (Aug. 20, 2009), *rev’d*, Administrator Dec. (Oct. 14,

*Hospital v. Thompson*.<sup>3</sup> In that case, the Eighth Circuit found that “PRM 15-1 § 2534.5 is a ‘plainly erroneous’ interpretation of the provisions that allow the Secretary to grant an upward adjustment to hospital-based SNFs and thus, in any event, PRM § 2534.5 is not entitled to our deference.” Regarding the subset of the Providers located outside of the Eighth Circuit, the Board found that PRM 15-1 § 2534.5 is procedurally invalid based on a lack of notice and comment. The Board noted that it is undisputed that CMS’ revised methodology was a marked departure from its earlier method of determining the amount for hospital-based SNF exception requests, and hence, the revised methodology requires an explanation. The Board stated that it is 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.”<sup>4</sup> Thus, the Board found that because PRM 15-1 § 2534.5 defines an exception methodology contrary to that contained in the applicable regulation and in the unwritten policy of CMS for 15 years prior to adoption of this Manual section, it “effected a change in existing law or policy” that is substantive in nature.

The Board found that PRM 15-1 § 2534.5 constitutes a significant revision of the Secretary’s definitive interpretation of 42 C.F.R. § 413.30, and is invalid because it was not adopted pursuant to the notice and comment requirements of the Administrative Procedure Act (APA). The Board concluded that there is nothing in the statute or regulation that requires the “gap” methodology interpretation at issue, rather, Congress gave the Secretary broad authority to establish “by regulation” the methods to be used and items to be included in determining reimbursement. The Board noted that had the “gap” methodology been subjected to the rulemaking process under the APA, it would have been a legitimate exercise of that power.

### **SUMMARY OF COMMENTS**

The Providers commented, requesting that the Administrator affirm the Board’s decision. The Providers incorporated by reference the arguments made to the Board. The Providers stated that the United State District Court for the District of Columbia in *Montefiore Medical Center v. Leavitt*<sup>5</sup> held in favor of the provider on the basis that the Secretary of Health and Human Services violated the Administrative Procedure Act by failing to comply with notice and comment rulemaking procedures in issuing PRM § 2534.5. In that case, the Court decided in favor of the provider,

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2009); *Quality 89-92 Hospital Based SNF v. BlueCross BlueShield Ass’n*, PRRB Dec. No. 2009-DS (Jan. 26, 2009), *rev’d*, Administrator Dec. (Mar. 10, 2009).

<sup>3</sup> 315 F.3d 984 (8th Cir. 2003).

<sup>4</sup> *National Black Media Coalition v. FCC*, 775 F.2d 342, 355 (D.C. Cir. 1985).

<sup>5</sup> 578 F. Supp. 2d 129 (D.D.C. 2008).

holding that the PRM §2534.5 constituted a change in policy and was issued without notice and comment rulemaking. The Providers noted that the Secretary of Health and Humans Services has settled cases presenting the identical issue as this case, based on *Montefiore*.<sup>6</sup> The Providers stated that they have the right to appeal an adverse decision of the CMS Administrator to the U.S. District Court for the District of Columbia, in which *Montefiore* is persuasive authority, and thus, in the interest of finality, the Administrator should affirm the decision of the Board on the grounds on which it was decided.

The Intermediary commented, requesting that the Administrator reverse the Board's decision. The Intermediary argued that the Board failed to give proper weight to the Secretary's discretion with respect to the RCL. The Intermediary noted that both the statute and the regulation dictate that the Secretary is responsible for making modifications to the RCL, but that the methodology used to determine the allowable costs was established by PRM § 2534.5. The Intermediary noted that the Board gave PRM § 2534.5 little or no deference, despite the Seventh Circuit's holding that the PRM "is best viewed as an administrative interpretation of regulations and corresponding statutes, and as such is entitled to considerable deference as a general matter."<sup>7</sup> The Intermediary also stated that the Board did not give ample weight to *St. Francis Health Care Centre, Inc. v. Shalala*,<sup>8</sup> despite the fact that this was a case from the Sixth Circuit Court of Appeals, and several of the Providers are located in States encompassed by the Sixth Circuit. The Intermediary argued that, had the Board given weight to PRM § 2534.5, it could have reconciled the Preamble with PRM § 2534.5. The Intermediary noted that exceptions are available in exceptional circumstances, such as where a SNF performs "atypical services", where incurred costs are due to "extraordinary circumstances", or where the SNF had "unusual labor costs". The Intermediary claimed that these provisions were designed to protect providers from exceptional circumstances that cause their costs to be much higher than they otherwise would be, and that it makes sense that the Secretary would limit the effect of exceptions triggered by these circumstances to situations where costs significantly exceeded the RCL because of these circumstances. The Intermediary commented that, if PRM § 2534.5 did not apply, providers subject to exceptional circumstances would have no incentive to limit costs once they were subject to these exceptional circumstances. For similar reasons, the statement in the regulation that the limits "may" be adjusted upward also ensures that providers do not assume that extra costs caused by exceptional circumstances will be fully covered, and thus, incentivizes providers to avoid and limit the effect of exceptional circumstances.

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<sup>6</sup> See, e.g., *Glendale Memorial Hospital and Health Center et al. v. Sebelius*, No. 09-0637 (D.D.C.)

<sup>7</sup> *Davies Cty. Hosp. v. Bowen*, 811 F.2d 383, 345 (7th Cir. 1987).

<sup>8</sup> 205 F.3d 937 (6th Cir. 2000).

## DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely submitted have been taken into consideration.

During the cost years at issue, Medicare reimbursed for SNF services largely on the basis of reasonable cost. Prior to 1972, §1861(v)(1) initially set forth that reasonable costs shall be determined, *inter alia*, in accordance with the regulations establishing the method or methods to be used.<sup>9</sup> Generally, providers were able to be reimbursed the cost of services to Medicare patients, unless such costs were found to be substantially out of line with those of similar institutions.

However, in 1972, §1861(v)(1) of the Social Security Act, was amended by section 223 of the Social Security Amendments of 1972<sup>10</sup>, to limit the amount a provider could be reimbursed to those costs that meet the definition of reasonable cost. Section 1861(v)(1)(A) defines reasonable cost broadly as the cost actually incurred, excluding any cost found to be unnecessary in the efficient delivery of needed health services, and authorizes the Secretary to issue appropriate regulations setting forth the methods to be used in computing such costs.

Section 223 also amended §1861(v)(1) to authorize the establishment of limits on allowable costs that will be reimbursed under Medicare. Section 1861(v)(1)(A) authorized the Secretary to establish limits on the direct and indirect overall incurred costs of specific items or services or groups of items or services. The limits are based on estimates of the costs necessary for the efficient delivery of needed health care services. The limits on inpatient general routine service costs set forth at §1861(v)(1)(A) apply to SNF inpatient routine costs, excluding capital-related costs and are referred to as the routine cost limits or RCLs.

The regulations at 42 C.F.R. §413.9 establish the determination of reasonable costs specifically for Medicare. If a provider's costs include amounts not related to patient care, or costs that are specifically not reimbursable under the program, those costs will not be paid by the Medicare program. Further, 42 C.F.R. §413.9(b) provides that the reasonable cost of any services must be determined in accordance with

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<sup>9</sup> See Pub. L. No. 89-97.

<sup>10</sup> Pub. L. No. 92-603.

regulations establishing the method or methods to be used and the items to be included.

The regulations at 42 C.F.R. §413.30, *et seq.*, implement the cost limit provisions of § 1861(v)(1)(A) of the Act by setting forth the general rules under which CMS may establish limits on provider costs, including SNF costs recognized as reasonable in determining Medicare program payments. It also sets forth rules governing exemptions and exceptions to limits.

Pursuant to §1861(v)(1)(A) of the Act, CMS has promulgated annual schedules of limits on SNF inpatient routine service costs since 1979 and notified participating providers of the exception process in the *Federal Register*.<sup>11</sup> Initially, separate reimbursement limits were implemented for hospital-based SNFs and freestanding SNFs. Reimbursement limits for hospital-based SNFs were higher than for freestanding SNFs, due to historically higher costs incurred by hospital-based SNFs. While hospital-based SNFs maintained that they incurred higher costs because of the allocation of overhead costs required by Medicare and higher intensity of care, this was a subject of debate. For cost reporting periods beginning on or after October 1, 1980, the cost limits were changed to 112 percent of the average per diem costs of each comparison group.<sup>12</sup>

However, amid the growing belief that the cost difference between hospital-based and freestanding SNFs was unjustified, Section 102 of the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) eliminated the separate limits for hospital-based SNFs and freestanding SNFs, mandating that Medicare pay no more to hospital-based SNFs than would be paid to the presumably more efficient freestanding SNFs. The effective dates of these cost limits were retroactively postponed twice by Congress, and were never actually implemented.

In 1984, the Deficit Reduction Act (DEFRA) rescinded the single TEFRA limit for SNFs, and directed the Secretary to set separate limits on per diem inpatient routine

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<sup>11</sup> See, e.g., 42 Fed. Reg. 36,237 (1976); 44 Fed. Reg. 29,362 (1979); 44 Fed. Reg. 51,542 (1979); 45 Fed. Reg. 58,699 (1980); 46 Fed. Reg. 48,026 (1981); 47 Fed. Reg. 42,894 (1982).

<sup>12</sup> See, e.g., 45 Fed. Reg. 58,699 (1980); 46 Fed. Reg. 48,026 (1981); 47 Fed. Reg. 42,894 (1982). See also 51 Fed. Reg. 11,234 (1986) (“Prior to the September 29, 1982 schedule of single limits (required by Pub. L. 97-248), we published separate schedules. Under these schedules, the SNF cost limits for inpatient routine services were calculated at 112 percent of the mean of the routine costs for freestanding and hospital-based SNFs, respectively. Further, the routine costs considered for each comparison group were the routine costs attributable to the particular group...” *Id.*).

service costs for hospital-based SNFs and freestanding SNFs, revising §1861(v) of the Act and adding a new §1888 to the Act, specifying the methodology for determining the separate cost limits.<sup>13</sup> Section 1888(a) states that the limit for freestanding SNFs is set at 112 percent of the mean per diem routine service costs for freestanding SNFs. The limit for hospital-based SNFs is equal to the limit for freestanding SNFs plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based SNFs exceeds the limit for freestanding SNFs. Thus, DEFRA allowed higher payments for hospital-based SNFs compared to the proposed payment methodology under TEFRA, but recognized that not all of the cost differences between hospital-based and freestanding SNFs were justifiable.

The rationale behind the limits promulgated in DEFRA can be found in a report prepared for Congress by HCFA, which studied the cost differences between hospital-based and freestanding SNFs.<sup>14</sup> The results of this Report were communicated to Congress before enactment of DEFRA.<sup>15</sup> The Report found that, while case mix difference accounted for approximately 50 percent of the cost difference, the remaining 50 percent was due to such things as provider inefficiency, facility characteristics, and overhead allocations. This conclusion was further supported by three separate subsequent studies.<sup>16</sup>

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<sup>13</sup> Deficit Reduction Act of 1984 (DEFRA), Pub. L. No. 98-369 (Medicare and Medicaid Budget Reconciliation Amendments of 1984), applicable as provided in § 2319(c) and (d) of the amendments. See also §2530, *et. seq.* of the PRM.

<sup>14</sup> *Health Care Financing Administration Report to Congress: Study of the Skilled Nursing Facility Benefit Under Medicare*, U.S. Government Printing Office, January 1985.

<sup>15</sup> See *St. Luke's Methodist Hospital v. Blue Cross and Blue Shield Association*, PRRB Dec. No. 2000-D11.

<sup>16</sup> A study conducted by Abt Associates, Inc., found that hospital-based SNFs have significantly higher per-patient costs than freestanding SNFs after controlling for various factors, but could not explain why. See Abt Associates, Inc., *Why Are Hospital-Based Nursing Homes So Expensive? The Relative Importance of Acuity and Treatment Setting*, Health Services and Evaluation (HSRE) Working Paper No. 3 (Cambridge, Massachusetts: February 2001). Available online at <http://www.abtassociates.com/Reports/HSRE-W3-HBDDMC.pdf>. Another study, which compared hospital-based and freestanding SNF costs when controlled for case-mix and staffing patterns, found that less than one-half of the cost differences could be attributed to those factors. See *Cost and case-mix difference between hospital-based and freestanding nursing homes*, by Margaret B. Sulvetta and John Holahan, *Health Care Financing Review*, Spring 1986, Volume 7, Number 3, p. 83. A study conducted by the General Accounting Office on the Medicare Exception Process in

In establishing the hospital-based SNF cost limit at the freestanding SNF limit plus 50 percent of the difference between the freestanding limit and the 112 percent of the mean hospital-based SNF routine service costs, Congress accepted the findings of this report. Congress thus mandated that the 50 percent difference in costs related to inefficiency, facility characteristics, and overhead allocations<sup>17</sup> were not reasonable costs and should not be reimbursed. This results in the reimbursement gap disputed by the Provider that is comprised of an amount that CMS recognizes as unreasonable and, thus, not allowable.

In addition to establishing dual limits for hospital-based and freestanding SNFs, DEFRA (1984), in subsection (b) of §1888, mandated that an additional amount be added to the hospital-based SNF limit to account for cost differences between hospital-based and freestanding SNFs that are attributable to excess overhead allocations resulting from Medicare reimbursement principles. However, this subsection was subsequently changed, pursuant to § 13503(a) of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66) (OBRA '93). Congress instead mandated that the Secretary **not** recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities limits attributable to excess overhead allocations.<sup>18</sup> This change further shows that Congress intended that the hospital-based SNF inefficiencies should never be recognized as reasonable and, likewise, should not be paid pursuant to the exception methodology. If CMS were to allow exceptions for hospital-based SNFs for costs that fell within the “gap” between the hospital-based SNF routine cost limit and 112 percent of the peer group mean, it would be paying those very costs which are not recognized as reasonable and which Congress has specifically instructed it not to pay.

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SNFs found no substantive differences between the characteristics of, and services received by Medicare patients residing in SNFs which had been granted exceptions for atypical services and those in SNFs that did not receive exceptions. As others have noted, “If hospital-based facilities do not serve the more disabled patients or provide higher quality care, then the cost differential is not justified and should not be recognized by Medicare.” *See Prospective payment for Medicare skilled nursing facilities: Background and issues*, by George Schieber, Joshua Wiener, Korbin Liu, and Pamela Doty, Health Care Financing Review, Fall 1986, Volume 8, Number 1, p. 83.

<sup>17</sup> An add-on for the overhead allocation was mandated by Congress under DEFRA, but was subsequently disallowed in the Omnibus Budget Reconciliation Act of 1993.

<sup>18</sup> *See* Conference Agreement noting “Additional payments for excess overhead costs allocated to hospital-based facilities are eliminated, effective for cost reporting periods beginning on or after October 1, 1993.” 139 Cong Rec H 5792 (Aug. 4, 1993).

Notably, Congress has never mandated the recognition of the cost differences between hospital-based and freestanding SNFs that are attributed to inefficiencies and facility characteristics.

The Secretary was also given broad discretion to authorize adjustments to the cost limits under DEFRA provisions. Section 1888(c) provided:

The 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.

In accordance with this section, the regulation at 42 C.F.R. §413.30(f) provides for exceptions as follows:

*Exceptions:* Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(5) 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.]<sup>19</sup>

Pertinent to this case, §413.30(f)(1) specifically provides for an exception 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 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 on the efficient delivery of needed health care.

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<sup>19</sup> See also 44 Fed. Reg. 31804 (June 1, 1979), adopting language at 42 C.F.R. §405.460(f) stating that: “An adjustment will be made only to the extent the costs are *reasonable*, attributable to circumstances specified, separately identified by the Provider, and verified by the Intermediary.” [Emphasis added].

This regulation creates a two-prong test, requiring that any exception request be examined to determine the reasonableness of the amount that a provider's actual costs exceed the applicable cost limits, and determine the atypicality of the costs by using a peer group comparison, i.e., the 112 percent threshold. A hospital-based SNF's costs are thus compared to the costs of a typical facility (112 percent of the peer group mean) in order to determine if its costs are actually atypical.

Although this peer group comparison exceeds the RCLs established for hospital-based SNFs, it is a practical standard for measuring the atypical nature of a provider's services. It is also the same test used to determine the amount of an exception for a freestanding SNF, and is a standard based entirely upon data from similarly-situated hospitals.

Consistent with the statute and regulations, CMS set forth the general provisions concerning payment rates for certain SNFs in Chapter 25 of the PRM. However, Chapter 25 of the PRM did not address the methodology used to determine exception requests. In July 1994, in order to provide the public with current information on the SNF cost limits under §1888 of the Act, CMS issued Transmittal No. 378.<sup>20</sup> Transmittal No. 378 explained that new manual sections, at §2530, *et seq.*, were being issued to "provide detailed instructions for skilled nursing facilities (SNFs) to help them prepare and submit requests for exceptions to the inpatient routine service cost limits."

Section 2534.5, as adopted in Transmittal No. 378, "Determination of Reasonable Costs in Excess of Cost Limit or 112 Percent of Mean Cost," explains the process and methodology for determining an exception request based on atypical services. In determining reasonable costs, a provider's costs are first subject to a test for low occupancy and then are compared to per diem costs of a peer group of similarly classified providers. Section 2534.5B of the PRM explains the methodology CMS developed to quantify the peer group comparison that is part of the test for reasonableness:

*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

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<sup>20</sup> Transmittal No. 378 also rendered §§2520-2527.4 of the PRM, adopted in July 1975, under Transmittal No. 129, as obsolete.

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...

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 at 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 annual 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 to the amount of the exception or a denial of the exception.

Contrary to the Board's findings, the Administrator finds that the exception guidelines in Chapter 25 of the PRM are reasonable and appropriate, as they closely adhere to the requirements of §1888(a) of the Act and are within the scope of the Secretary's discretionary authority under §1888(c) of the Act to make adjustments in the SNF RCLs, and under the implementing regulations at §413.30(f)(1)(i). The Administrator rejects the Board's view that § 1888(a) of the Act and the implementing regulation at 42 C.F.R. § 413.30 entitle all SNFs to be paid the full amount by which their costs exceed the applicable RCL.<sup>21</sup> The Administrator finds

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<sup>21</sup> The Board had previously reached the opposite conclusion in several other cases on this issue. *See Mercy Medical Skilled Nursing Facility*, PRRB Dec. No. 1999-D61; *Riverview Medical Center Skilled Nursing Facility*, PRRB Dec. No. 1999-D67; *St. Luke's Methodist Hospital- SNF*, PRRB Dec. No. 2000-D11; *New England Rehabilitation Hospital*, PRRB Dec. No. 2000-D53; *Fort Bend Community Hospital-SNF*, PRRB Dec. No. 2000-D86; *San Joaquin Community Hospital-SNF*,

that the policy interpretation in §2543.5B, requiring the hospital-based SNF costs to be compared to 112 percent of the group's mean per diem costs, is an appropriate method of applying the reasonable cost requirements that have existed in the regulation since at least 1979.

Furthermore, the Administrator finds use of the methodology set forth in §2534.5 of the PRM in no way alters, or revises, Medicare policy as set forth in the regulations at §413.30(f)(1)(i) but is one method of applying that policy. Indeed, §2534.5 did not affect a change in CMS policy. Although Congress changed the RCLs for hospital-based SNFs in 1984, the published cost limits since 1980<sup>22</sup> reflect that CMS had previously used a methodology under which the SNFs' per diem costs were compared to a percentage of the peer group mean diem cost.<sup>23</sup>

Notably, §2534.5 refers to the "cost limit", rather than to 112 percent of a SNF's peer group mean per diem cost, only where the terms are interchangeable, i.e., where the cost limit is equal to 112 percent of the SNF's peer group mean cost. For periods prior to the effective date of the hospital-based SNF RCL under DEFRA, July 1, 1984, the term, "112 percent of the peer group mean per diem cost" was synonymous with the term, "cost limit," for both freestanding SNFs and hospital-based SNFs. After June 1984, the freestanding SNF RCL remained at 112 percent of the peer group mean per diem cost. However, as explained above, Congress changed the amount of the hospital-based SNF RCL. Thus, §2534.5 uses the term of cost limit to refer to 112 percent of the freestanding SNF mean per diem cost, but cannot use the same term for the hospital-based SNFs. Section 2534.5 simply recognizes that, after July 1, 1984, the term of cost limit can no longer be used interchangeably with the

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PRRB Dec. No. 2001-D17; *Centennial Medical Center-SNF*, PRRB Dec. No. 2001-D54; *Colleton Regional Hospital-SNF*, PRRB Dec. No. 2002-D8; *Alameda Hospital SNF*, PRRB Dec. No. 2002-D46; *Providence Hospital-Central SNF*, PRRB Dec. No. 2002-D50.

<sup>22</sup> 45 Fed. Reg. 41,292 (1980) ("We are proposing that the limits be set at 112 percent of each group's mean cost. We believe that the 12 percent allowance above mean cost is a reasonable margin factor in view of the refinements made in the method used to establish the limits."); 45 Fed. Reg. 58,699 (1980) ("[I]imits set at 112 percent of the average per diem labor-related and nonlabor costs of each comparison group." *Id.*) 46 Fed. Reg. 48,026 (1981); 51 Fed. Reg. 11,234 (1986).

<sup>23</sup> *See, e.g.*, 44 Fed. Reg. 51,542, 51,544 (Aug. 31, 1979) ("We believe the use of a limit based on the average to be superior to a percentile limit. The average is a good measure of the cost incurred in the efficient delivery of services by peer providers.... Since these are the first limits we have established for SNFs, the methodology used does not account for any conceivable variable which could affect SNF costs. As we gain information and experience, the methodology will be refined.")

term of 112 percent of the peer group mean per diem cost for hospital-based SNFs. In short, although the statutory cost limit for hospital-based SNFs was changed under DEFRA, that change did not impact CMS' peer group methodology.

The Administrator also disagrees with the Board's finding that the methodology for determining an exception for atypical services of a hospital-based SNF using the uniform peer group comparison, as set forth in §2534.5 of the PRM, constituted a change in policy requiring notice and comment rule-making under 5 U.S.C. §552. CMS has consistently compared SNF costs to their comparison group in applying the cost limits. The Administrator finds that the methodology at issue does not involve application of a "substantive" rule requiring publication of notice and comment under the APA. The Secretary has broad authority to promulgate regulations under §§1861(v)(1)(A) and 1888 of the Act. Relevant to this case, the Secretary has promulgated a regulation at 42 C.F.R. §413.30(f)(1) establishing a specific exception from the RCLs based on atypical services. The Secretary does not have an obligation to promulgate regulations that specifically address every conceivable situation in the process of determining reasonable costs.<sup>24</sup> Rather, the Intermediary is required to make a determination on the exception request, applying the existing reasonable cost statute, controlling regulations, and any further guidance that CMS has issued. Notably, the regulation instructing the payment of reasonable cost only where an exception is granted has been in place since 1979. The methodology set forth in §2534.5 of the PRM is a proper interpretation of the statute and the Secretary's rules allowing an exception to the limits on reasonable costs based on atypical services.<sup>25</sup> The methodology also is specifically in accordance with the directive of Congress in OBRA '93 to not recognize as reasonable certain differences in hospital-based and freestanding SNFs caused by inefficiencies.<sup>26</sup>

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<sup>24</sup> See *Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87, 96(1995) (The Supreme Court also explained that, "[t]he APA does not require that all the specific applications of a rule evolve by further more, precise rules rather than by adjudication,"); *Chrysler Corp. v. Brown*, 441 U.S. 281, 302, n. 31 (1979) ("An interpretive rule is issued by the agency to advise the public of the agency's construction of the statutes and the rules which it administers," quoting the Attorney General's Manual on the Administrative Procedure Act," 30 at n.3 (1947).).

<sup>25</sup> Similarly, the Intermediary's application of the methodology set forth at §2534.5 of the PRM does not constitute a substantive rule, and is consistent with the reasonable cost rules in effect for the cost years at issue. Moreover, the nature of reasonable cost reimbursement requires the determination of allowable costs after the close of the cost reporting period. Application of any reasonable cost comparison determination would constitute a retroactive rulemaking under the Provider's definition of that term.

<sup>26</sup> See §1888(b) of the Act.

Furthermore, CMS used this method, even before it was set forth in the PRM in July, 1994. On November 16, 1992, HCFA responded to a provider's exception request for its August 31, 1989 cost reporting period by comparing its cost to its peer group mean costs, and granting only a partial exception. This same provider, a hospital-based SNF, had been granted similar partial exceptions for its 1985, 1986, 1987, and 1998 cost reporting periods.<sup>27</sup> On February 23, 1993, HCFA denied another provider's 1985 cost year exception request because the costs did not exceed the peer group per diem cost. HCFA explained<sup>28</sup>:

The peer group developed by HCFA for evaluating exceptions to the cost limits 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 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. As a result, a hospital-based SNF is only eligible for an exception for atypical services for the amount that its actual costs exceeds 112 percent of the mean costs of hospital-based SNFs and not by the amount that its actual costs exceeds its cost limit.

Further, even if HCFA Transmittal No. 378 constituted a new methodology to determine the reasonable cost that could be allowed under the exception process, such a methodology was based upon new facts demonstrating that certain hospital-based SNF costs above the limit were *per se* unreasonable. As distinguished from the court's holding in *Alaska Professional Hunters Ass'n*,<sup>29</sup> the Court of Appeals in the District of Columbia in *Hudson v. FAA*,<sup>30</sup> rejected the argument that an agency had impermissibly changed its interpretation of the regulation. In that case, the court found the agency was entitled to apply the regulation to a new understanding of the facts without violating the principles set forth in *Alaska Professional Hunters Ass'n* or *Paralyzed Veterans of America*.<sup>31</sup> In this instance, the Secretary's application of the longstanding reasonable cost criteria reflects the factual findings that hospital-based SNFs systemically have unnecessarily high costs due to inefficiencies. These unreasonable costs are reflected in the 50 percent difference between the hospital-based SNF cost limit and the 112 percent peer group mean per diem cost for hospital-

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<sup>27</sup> *North Coast Rehabilitation Center*, PRRB. Dec. No. 1999-D22 (June 23, 1998), p. 2-3.

<sup>28</sup> *New England Rehabilitation Hospital*, PRRB Dec. No. 2000-D53 (April 13, 2000), p. 4.

<sup>29</sup> 117 F.3d 579.

<sup>30</sup> 192 F.3d 1031 (D.C. Cir. 1999).

<sup>31</sup> 177 F.3d 1030.

based SNFs.<sup>32</sup> Thus, the Secretary's alleged new methodology was implemented as a result of a new understanding of the cost inefficiencies affecting hospital-based SNFs.

Accordingly, after review of the record and applicable law, the Administrator finds that the methodology set forth in §2534.5 of the PRM is consistent with the plain meaning of §§1861(v) and 1888(a)-(c) of the Act, the legislative intent, and the regulations at 42 C.F.R. §413.30. The Intermediary properly applied the methodology at §2534.5 of the PRM in partially denying the Providers' requests for an exception to the RCL.

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<sup>32</sup> In addition, the exceptions for the routine cost limits have been in place since 1979 (*See, e.g.*, 44 Fed. Reg. 31, 802 (1979)) and initially covered a broad spectrum of providers and were not specific to SNFs. Thus, the wide prescription in the regulation that all costs allowed pursuant to the granting of an exception must be reasonable is consistent with the various types of providers to which the cost limits were applied.

**DECISION**

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION  
OF THE SECRETARY OF HEALTH AND HUMAN SERVICES.**

Date: 7/9/13

/s/  
Marilynn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services