PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D81

PROVIDER -
Rocky Mountain Care Routine Cost Limit Group-Transmittal No. 378 Application,
Salt Lake City, Utah

Provider No. Various (See Appendix A)

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Regence Blue Cross Blue Shield of Utah/
Blue Cross and Blue Shield of Wyoming

DATE OF HEARING-
October 8, 1999

Cost Reporting Period Ended -
Various (See Appendix A)

CASE NO. 96-2281G

INDEX

ISSUE:

Whether HCFA=s methodology of determining the amount of the exception from the routine cost limits for freestanding skilled nursing facilities as set forth in HCFA Pub. 15-1, ' 2534.5, Transmittal No. 378, is correct?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Rocky Mountain Care (ARMC@) is a health care management company located in Salt Lake City, Utah. It manages five nursing homes and each of the homes has a certified distinct part ("CDP") where skilled nursing care is rendered. The CDPs are classified as skilled nursing facilities ("SNFs") for Medicare purposes. The nursing homes are located in and around Greater Salt Lake City-Ogden, Utah and the Northwestern corner of Utah. Collectively, the nursing homes are referred to as the AProviders@.

Each of these Providers filed an exception request to the Routine Cost Limits (ARCLs@) for various fiscal years.[1] The Providers also filed exception requests for the 1995, 1996, 1997 fiscal years and, in the case of RMC/Evanston, the March 31, 1996, March 31, 1997 and March 31, 1998 fiscal years. The local Intermediaries, Regence Blue Cross Blue Shield of Utah and Blue Cross and Blue Shield of Wyoming reviewed those exception requests before forwarding them to the Health Care Financing Administration. (AHCFA@). Most of the requests were partially granted. However, the Providers received less than they otherwise would have primarily because of the HCFA=s interpretation of Transmittal No. 378 to the Provider Reimbursement Manual (APRM@).

There are three subissues to this appeal: (1) the low occupancy issue, (2) atypical services limitation by the Intermediary and (3) the use of the actual Afrozen@ routine cost limit. For the fiscal years ended 1991-1994, the first issue has a $45,339 Medicare impact, the second issue has a $21,786 impact, and the third issue has a $37,449 impact.[2] For the fiscal years ended 1995-1997, the impact of the low occupancy limitation was $120,268.[3] The impact of the atypical limitation is $197,865, and the frozen RCL limitation does not have an impact for the latter group.[4]

The Providers= appeals meet the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841. The Providers= are represented by Charles MacKelvie, Esquire, of MacKelvie & Associates, P.C. The

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1 See Providers= Exhibits 18-37.

2 See Provider Exhibit No. 4.

3 See Provider Exhibit No. 5.

4 Id.

Intermediaries are represented by James R. Grimes, Esquire, of Blue Cross and Blue Shield Association.

PROVIDERS= CONTENTIONS:

Low Occupancy Issue

The Providers= contend that each of the Providers had occupancy levels in its entire facility in excess of 75% for each of the fiscal years[5] except for RMC- Evanston in fiscal year 1992 which had a facility occupancy level of 67.08%. Pursuant to the Intermediary=s reading of Transmittal No. 378 to the PRM, in HCFA=s opinion an interpretation of regulation ' 413.30 (f)(1), the Intermediary reduced the exception amount stated as a cost per diem because the occupancy level in the Medicare certified distinct parts of each of the five Providers was less than 75%. In Transmittal No. 378, HCFA had set the minimum occupancy level for skilled nursing facilities at 75 percent. The Providers argue that HCFA=s use of low occupancy rates is arbitrary and capricious. Moreover, this HCFA restriction to the Routine Cost Limits exception process is procedurally invalid. The Administrative Procedure Act (AAPA@), 5 U.S.C. ' 553, requires that all rules that have a Asubstantial impact on the regulated@ are to be published in accordance with certain notice and comment procedures. See, Pickens v. United States Board of Parole, 507 F. 2d 1107 (D.C. Cir 1974). Therefore, if a provider=s costs were within the aggregate limits as these five Providers= costs were, HCFA does not have the right to deny reimbursement for low occupancy.

The Providers note that the regulation at 42 C.F.R. ' 413.30 (f)(1) places the burden of proving a right to an exception on a provider. The burden involves proving that specifically identified costs are reasonable and attributable to the circumstances specified. Nothing in the regulation expressly allows HCFA to withhold relief for reasons such as low occupancy.

The Providers observe that the Intermediaries= witness stated that HCFA draws its authority for the 75 percent occupancy limitation from legislative history, which indicates that Congress wanted the Secretary of Health and Human Services to avoid paying for costs associated with inefficient operations. The Intermediaries argue that the low occupancy limitation was implicit in 42 C.F.R. ' 413.30 (f). However, if the low occupancy standard were implicit in the regulations, then there would be no need for the Secretary to explicitly establish a low occupancy standard in 42 C.F.R. ' 413.30 (f)(3)(iii) Providers In Areas With Fluctuating Populations, unless the Secretary=s intent was to establish such standard for such aforesaid Providers. The language in (iii) indicates, A[t]he provider meets occupancy standards established by the Secretary.@ Id. By adding this language to Subsection (f)(3), and thus to be applicable to providers in areas with fluctuating populations, low occupancy standards are not implicit in 42 C.F.R. ' 413.30 (f)(1). The Intermediaries argument defies statutory construction and

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[5] See Providers= Exhibit 51.

should be ignored. Thus, regardless of whether overall Transmittal No. 378 was properly adopted or not, the specific section setting the occupancy levels is not founded on the regulations and, accordingly, the low occupancy section should have been adopted via the APA procedures.

The Providers argue that because the Secretary did not establish explicit limits on occupancy levels in the certified distinct parts of the skilled nursing facilities as a whole, the United States Congress choose to create a limit on aggregate routine costs. Further, the Providers contend that the occupancy level refers to the entire facility, not just occupancy in the CDPs. The Intermediaries argue that the low occupancy figure (75%) in Transmittal No. 378 applies only to occupancy in the certified distinct part, not to the entire facility, based on HCFA=s reviewing the cost reports for all Medicare certified skilled nursing facilities for two fiscal years, 1988 and 1989, before establishing the four national peer groups of Medicare SNFs discussed in Transmittal No. 378. According to HCFA=s own data, there were approximately 12,585 nursing homes participating in the Medicare Program in 1993.[6] Assuming the same number of nursing homes participated in the Medicare Program when HCFA did its study, and assuming it took ten minutes to review each cost report, it would have taken a HCFA employee more than four years to complete a peer group analysis of every Medicare participating nursing home in 1988 and 1989. That testimony defies credulity and should not be believed.

The Providers argue that HCFA literature, which was offered into evidence,[7] further throws doubt on the HCFA witness= testimony. According to those exhibits, only 74.2% of the 16,989 nursing homes in the United States are Medicare certified as SNFs. While the occupancy rate in the 16,989 nursing facilities nationwide was 90.3%, Utah had an occupancy rate in its nursing facilities of only 82%. Moreover, nursing home beds per 1000 of population in Utah declined by 23% since 1978. Medicare certified only 61% of the total SNFs in Utah and only 33.45% of its beds. As HCFA itself concedes, if the bed supply is limited, nursing homes will first satisfy private patient demand, and many public patients will have difficulty gaining access to Medicare beds. The Medicare occupancy rate of SNF beds in Utah was considerably below 75%.

The Providers note that previous case law, which has been decided first by the PRRB, also indicates that the occupancy level referred to is the occupancy level in the entire facility, not just the Medicare certified portion of the home. For example, in Larkin v. Shalala (Mass) [sic], CCH Medicare and Medicaid Guide @ paragraph 80,415 [sic], the intermediary determined that there was a 42% occupancy rate. In order for that intermediary to determine the occupancy rate, it would have to add 58 noncertified beds in its calculation of the total beds, not just the distinct part beds. In Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, HCFA Adm. Dec. 95-D52, October 18, 1995, Medicare and Medicaid Guide (ACCH@) &43,722, the HCFA

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6 See Health Care Financing Review, 1995.

7 See Providers Exhibits 53 and 54.

Administrator indicated that the occupancy standard was not intended to be an absolute but would be reevaluated when the provider offered support for generally lower occupancy. More importantly, the HCFA Administrator indicated the occupancy limitation discussed in Transmittal No. 378 applied to the whole institution, not just in the distinct part embodied within the provider=s brain trauma unit.

The Providers further argue that the Intermediaries classified certain costs as fixed when they are actually variable. This is contrary to the Medicare cost reimbursement principles. The Intermediaries classified the director of nurses salary and other costs as fixed when, under generally accepted accounting principles and Medicare cost allocation procedures, such costs are variable. Transmittal No. 378 indicated that for 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.[8] Yet, the Intermediaries required the Providers to treat these costs in their Medicare cost reports as variable, using variable statistics to allocate these costs. In a letter from the Intermediary[9], it opines that costs of several cost centers, i.e., laundry, housekeeping and dietary, are fixed, even though the Medicare cost report treats such costs as variable. Moreover, in the same letter, the Intermediary indicates that the director of nurses and other nurses salaries and benefits are fixed. Again, this is inconsistent with the cost report requirements. If the Intermediary were correct in stating that the costs of the director of nurses were fixed costs of the CDP, then 100% of these costs should be allocated to the CDP.

The Providers observe that at the hearing the Intermediaries= witness, Mr. Menning, gave testimony about how he had set up the four national peer groups surrounding the Medicare Routine Cost Limits.[10] He was asked whether that information could be obtained under the Freedom of Information Act (AFOIA@), to which he answered yes.[11] Relying on that response, the firm of MacKelvie & Associates, P.C. sent Mr. Menning a FOIA request on November 23, 1999, asking for his data base on the four peer groupings and information concerning the low occupancy criteria of Transmittal No. 378. Despite the FOIA mandate that FOIA requests must be responded to within 10 days, Mr. Menning has not answered that request despite the civil penalties attached to the request. This lack of response can be interpreted to mean that HCFA no longer has the background data that Mr. Menning testified to, or alternatively, that Mr. Menning=s testimony was hyperbolic. Either way, the Board should give no weight to his testimony based on the flaws pointed out above.

The Providers observe that in a recent California case, Glendale Adventist Medical Center v. Director

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[8] See Provider Exhibit 48-10.

[9] See Provider Exhibit 55-12.

[10] Transcript (ATr.@) at 69.

[11] Tr. at 79.

of State Department of Health Services, No. B116998, slip op (Cal. Ct. App. Sept. 28, 1999) (AGlendale Adventist@), the California appeals court held that great weight should be given to that plaintiff=s expert testimony, especially because the plaintiff did not have access to the internal data of other hospitals in its peer group. It, therefore, could not have been expected to present empirical comparisons based on the internal operating data of the hospitals in its peer group. Thus, the appeals court reversed the case finding for the plaintiff. In our case, since Mr. Menning did not provide the requested data he testified about, the Board should give great weight to the Providers witness= testimony and give no weight to Mr. Menning=s testimony.

Atypical Cost Limit Issue:

The Providers contend that, in reviewing the exception requests, the Intermediaries should have required the Providers to reclassify holiday and vacation pay from fringe benefits to the direct cost centers in order to have an Aapples to apples@ comparison of the Providers= costs to their peer group=s costs. Since the Intermediaries and not the Providers had the peer group information, the Glendale Adventist case, cited above, supports this position. The Providers reclassified holiday, vacation and sick leave to the direct cost centers in accordance with HCFA Pub. 15-1 ' 2534.10A, Transmittal No. 378. Such a reclassification is in conformity with the recent memorandum from the Director, Division of Acute Care, Center for Health Plans and Providers, regarding the revised cost reporting instruction for Worksheet S-3, Parts II and III for hospitals. In that memorandum a hospital is to enter from Worksheet A the wages and salaries paid to hospital employees, increased by amounts paid for vacation, holiday, sick, paid-time-off, severance and bonus pay. This reclassification has a reimbursement impact of $172,591.[12]

The Providers note that with respect to the remaining differences,[13] these result from the Intermediaries improperly classifying variable costs as fixed costs as discussed above. In the Providers= prior appeal, the Board did not rule that the costs herein referred to should be treated as fixed costs. Quite to the contrary, treating these costs as fixed is contradictatory to the Medicare reimbursement principles and cost reporting requirements.

Frozen Cost Limit Issue:

The Providers argue that the routine cost limit should have been calculated as if no freeze was imposed. The Deficit Reduction Act of 1984 (ADEFRA@) established the current routine service cost limits applicable to SNF=s. See 42 U.S.C. ' 1395yy. The statute provides that the reimbursement limits for cost reporting periods beginning on or after July 1, 1984, for urban and rural SNF=s, respectively, are

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[12] See Providers= Post Hearing Exhibit B.

[13] See Providers= Post Hearing Exhibit A.

equal to 112 percent of the mean per diem routine service costs of freestanding SNFs (AFS-SNFs@) located in those areas. The limits for urban and rural SNF's however, are equal to the sum of the corresponding limit for FS-SNFs plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital based SNFs (AHB-SNFs@), in the urban and rural localities, respectively, exceed the FS-SNF limit. Congress expected the Secretary to provide a process by which providers could request and receive an Aexception@ from the limits in certain circumstances. In the legislative history to DEFRA, Congress stated that cost differences between hospital-based and free-standing facilities attributable to excess overhead allocations resulting from Medicare reimbursement principles would be recognized as an Aadd-on@ to the limit. Adjustments would be made to take into account differences in wage levels prevailing in a facility's area. Exceptions to the limit could be granted based upon case mix or circumstances beyond the control of the facility be it either a freestanding or hospital-based facility. House Conference Report to P.L. 98-369, 1884, See also, St. Francis Health Care Center v. Community Mutual Ins. Co,. PRRB Hearing, Dec. No. 97-D38, March 24, 1997, CCH & 45,159.

The Providers argue that Transmittal No. 378 effectively substitutes 112 percent of the mean per diem cost for the phrase Aapplicable limit@ in 42 C.F.R. ' 413.30. The very purpose of the exception process is to deal with situations where a provider has excess costs due to atypical services. The only rational interpretation of the regulation is that the cost limit is intended to set a presumptive level of reasonableness for typical services and not the cost of atypical services. In the legislative history to P.L. 98-369, Congress stated that in addition to the prescribed adjustments based on hospital overhead allocations and wage level differences, exceptions could be granted based upon case mix or circumstances beyond the control of the facility be it either a free standing or hospital-based facility. In the instant case, the Providers' requests for exception should not have been denied.

The Providers observe that HCFA's comparison confuses the concept of atypical cost with the concept of Athe cost of atypical services@ and produces unsound results. The distinction between Aatypical costs@ and the cost for atypical services was clarified in Regents of the University of California, on Behalf of Davis Medical Center v. Schweiker, Civ Div, No. S-80-961 MLS (E.D. Cal), aff=d 756 F.2d 1387 (9th Cir. 1985). The decision states:

> UCDMC sought reimbursement for Aatypical routine nursing costs@ in the amount of $33.37. The Intermediary=s award apparently excluded $17.76 as a claim for typical services at atypical cost. . .
>
> It is the Secretary=s position that the exception contained in 20 C.F.R. ' 405. 460 (f)(2) is designated only to cover the delivery of atypical services.

Id.

The methodology contained in Transmittal No. 378, which froze the routine cost limit calculation, is invalid because it represents a change in policy rather than an interpretation of an existing regulation in violation of the APA.

The Providers contend that they are entitled to be paid the entire amount of their costs in excess of the cost limits based upon the plain language of 42 C.F.R. ' 413.30(f), the applicable regulation. The cost limits established there by Congress are the gauge for evaluating the routine service costs of a SNF and represent the upper most per diem amount a SNF can be reimbursed absent an exception. If an exception is granted, a provider is to be paid each and every dollar that its costs exceed the limit.

INTERMEDIARIES= CONTENTIONS:

The Intermediaries contend that '' 1861 (v)(1)(A) and 1888 of the Social Security Act, as implemented in 42 C.F.R. ' 413.30, authorize the Secretary to establish limits on providers= costs recognized as reasonable in determining payments. The Secretary may adjust a provider=s routine cost limit to reflect additional costs for atypical items identified in 42 CFR '' 413.30 (f) and HCFA Pub. 15-1, ' 2534.10. This adjustment is made only to the extent costs are reasonable, attributable to the circumstances specified and verified by the Intermediary. An exception request may be made for each cost reporting period in which the provider believes an exception is due. The Secretary is not mandated to make an exception but can and will make exceptions when it is appropriate. These exceptions are proper to comply with the Nursing Home Reform and Occupational and Safety Act requirements. Changes in the limits are published in the Federal Register. The current law, in 1996, froze cost reports starting on or after October 1, 1993 and before October 1, 1995.[14]

The Intermediaries observe that the Providers believe that Transmittal No. 378 is an improper interpretation of Medicare Law. They take issue with the restrictions and limitations they feel are required by these regulations. The Intermediaries are required to follow all laws, regulations, and procedures for each exception request. After an intermediary's review, HCFA is the one who accepts or rejects the request. One issue raised by the Providers is whether the provisions of Transmittal No. 378 are subject to the provisions of the APA. The Providers contend that Transmittal No. 378 is an improper interpretation of 42 C.F.R. ' 413.30(f). The Providers go on to state that Transmittal No. 378 was implemented without complying with the notice and hearing provisions of the law, and is, therefore, invalid. The Intermediaries= position is that Transmittal No. 378 is a valid interpretation of the regulations, and the validity of HCFA=s authority to issue such an interpretation is supported by the determination of the United States Supreme Court in the case of Guernsey v. Shalala, 115 S. Ct. 1232, 1238 (1995). In that ruling the Court held that it was appropriate for the Secretary to issue a guideline or interpretive rule. The Court goes on to state that interpretive rules do not require notice and

[14] F/R 1/6/94, (59FR762).

comment period although they also do not have the force and effect of law and are not accorded that weight in the adjudicatory process. APA rulemaking would be required if the interpretation represented a new position that is inconsistent with any of the Secretary's existing regulations.

Regarding the low occupancy adjustment, the Intermediaries note that the Providers object to the low occupancy adjustment which is required by HCFA Pub. 15-1, ' 2534.5A. The HCFA Publication states that 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, a threshold occupancy rate of 75 percent 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.

The Intermediaries note that in the case of Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Michigan, PRRB Dec. No. 95-D52, August 22, 1995, CCH &43,590 the Board determined that the 75% low occupancy limitation was improper, and the provider was entitled to a full exception to the routine cost limits. The HCFA administrator, in modifying that decision, ruled that the occupancy standard represents HCFA=s longstanding interpretation of the governing reasonable cost statutes and regulations and has been used to evaluate skilled nursing facility cost limit exceptions since the beginning of the exception process. The statute establishes that in determining the reasonable costs, Medicare shall not pay the excess costs generated by inefficiencies in provider operations, including idle capacity. 42 C.F.R. ' 413.30(f), which governs all exceptions to the routine cost limits, provides that the limits may be adjusted upwards, and that adjustments shall be permitted only to the extent the costs are reasonable, attributable to the circumstances specified, and are separately identified by the Provider. Further, 42 C.F.R. ' 413.30(f)(1) states that in obtaining an exception for atypical services, a provider must show, among other things, that the atypical items and services that it furnishes are necessary in the efficient delivery of needed health care. Accordingly, responding to Congressional concern that the Medicare program not pay for excess costs incurred as the result of low occupancy, reflected in ' 1861(v)(1)(A) of the Social Security Act and the legislative history of the 1972 amendments, the Secretary provided the governing regulation for evaluating exception requests under efficiency standards, including limiting Medicare payment for idle capacity.

Regarding the freeze on the Routine Cost Limits, the Intermediaries note that the Providers argued against HCFA's application of the freeze on the Routine Cost Limits. Although the Providers were granted exceptions to the Routine Cost Limits, the Providers= argument is based on the fact that the exception amount was reduced due to the application of the frozen limit. The Providers contend that the freeze is arbitrary. The Intermediaries counter that they have relied on Omnibus Reconciliation Act (AOBRA 1993") as support for the application of the freeze on the Routine Cost Limits. According to OBRA 1993, the freeze on the Routine Costs Limits applies to all cost reporting periods beginning on

or before October 1, 1995.

The Intermediaries note that the Providers were all given the opportunity to obtain exceptions to their routine costs by submitting documentation to HCFA following HCFA Pub. 15-1 ' 2530, and the regulations outlined by the Secretary of the U.S. Department of Health and Human Services. Some of these submissions were accepted as proper and an exception to the Routine Cost Limits was granted. Some of the submissions were denied and more documentation was requested. In some of these cases, the new documentation was submitted and most of the exceptions were granted.

The Intermediaries observe that ' 1888 of the Social Security Act established the cost limits for skilled nursing facilities by classification. These were set up for urban or rural, freestanding or hospital-based. The cost limit for a freestanding skilled nursing facility is 112 percent of the mean per diem routine service cost for freestanding skilled nursing facilities in either urban or rural areas. The statute goes on to grant the Secretary of Health and Human Services authority to establish and make adjustments to the cost limits to the extent that the Secretary deems appropriate. Pursuant to that authority, the Secretary promulgated the regulations at 42 C.F.R. ' 413.30, which set out in very broad terms the method under which adjustments to the cost limits can be made for exception requests, including requests in situations where a provider incurs excess cost due to the provision of atypical services. Under the latter, the regulations provide that the adjustments will only be made to the extent that a provider can establish that there is an atypical item of service, the cost of the atypical item is reasonable, the costs are attributable to that item of service, and the cost is verifiable.

The Intermediaries observe that the Providers= counsel has pointed out and cited in his position paper, the case of St. Francis Health Care Center v. Shalala, No. 3:97 CV 7559, June 13, 1998 (N.D. Ohio 1998) (ASt. Francis@). The U.S. District Court for the Northern District of Ohio found that under the APA, notice and comment are not necessary when an agency issues interpretive rules. Chapter 25 of HCFA Pub. 15-1, as contained in Transmittal No. 378, is an interpretive rather than a substantive rule. The court found that it is a valid interpretation of the statute and the regulation was therefore not subject to the APA notice and comment provisions. St. Francis did not deal with years that were subject to the OBRA freeze. That decision was talking about the application of actual costs under their limits when they are being affected by the freeze. However, the reasoning in the St. Francis case has been adopted by this Board in at least two recent decisions, the Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Co., PRRB Decision 99-D61, Aug. 20, 1999, CCH & 80,320 and the Riverview Medical Center SNF. v. Mutual of Omaha Insurance Co, PRRB Dec. 99-D67, Sep. 2, 1999, CCH & 80,331.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

' 1861(v)(1)(A)	-	Reasonable Cost
' 1888	-	Payment To Skilled Nursing Facilities for Routine Service Costs

Law - 5 U.S.C.:

' 553	-	Administrative Procedure Act

Law - 42 U.S.C.:

' 1395yy	-	Payment To Skilled Nursing Facilities For Routine Service Costs

Law - Miscellaneous:

OBRA 93	-	Omnibus Budget Reconciliation Act of 1993
P.L. 98-369	-	Public Law 98-369
DEFRA	-	Deficit Reduction Act of 1984

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

'' 405.1835-.1841	-	Board Jurisdiction
' 413.30	-	Limitations On Reasonable Costs
' 413.30(f)	-	Exceptions
' 413.30(f)(1)	-	Atypical Services
' 413.30(f)(3)(iii)	-	Providers In Areas With Fluctuating Populations

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

Chapter 25	-	Limitation On Coverage Of Costs

		Under Medicare and Notice Of Schedule Of Limits On Provider Costs
Transmittal No. 378	-	Exception Request Requirements
' 2530	-	Inpatient Routine Service Cost Limits For Skilled Nursing Facilities
' 2534.5	-	Determination of Reasonable Costs In Excess of Cost Limit Or 1/2 Of Mean Cost
' 2534.5A	-	Low Occupancy
'2534.10 et seq.	-	Atypical Services Or Items

4. Cases:

Pickens v. United States Board of Parole, 507 F. 2d 1107 (D.C. Cir. 1974).

Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Michigan, PRRB Dec. No. 95-D52, August 22, 1995, CCH & 43,590.

Southfield Rehabilitation Center v. Blue Cross and Blue Shield Association/Blue Cross of Michigan, HCFA Adm. Dec 95-D52, October 18, 1995, Medicare and Medicaid Guide (ACCH@) &43,722.

Glendale Adventist Medical Center v. Director of State Department of Health Services, No. B116998, slip op (Cal. Ct. App. Sept. 28, 1999).

St. Francis Health Care Center v. Community Mutual Inc. Co., PRRB Hearing Dec. 97-D38, March 24, 1997, CCH & 45,159.

St. Francis Health Care Center v. Shalala, No. 3:97 CV 7559, June 13, 1998 (N.D. Ohio 1998).

Regents of the University of California, on Behalf of Davis Medical Center v. Schweiker, Civ Div, No. S-80-961 MLS (E.D. Cal), aff-d 756 F. 2d 1387 (9th Cir. 1985).

Guernsey v. Shalala, 115 S. Ct. 1232 (1995).

Mercy Medical Skilled Nursing Facility v. Mutual of Omaha Insurance Co., PRRB Dec. 99-D61, Aug. 20, 1999, CCH & 80,320.

Riverview Medical Center SNF. v. Mutual of Omaha Insurance Co., PRRB Dec. 99-D67, Sep. 2, 1999, CCH & 80,331.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties= contentions, evidence submitted and the Providers= post-hearing brief finds and concludes the following. The Board finds that the real issue in this case contains three subparts: low occupancy, fixed versus variable costs in measuring the atypical costs, and the Afrozen@ cost limit. Regarding the low occupancy subissue, the Board finds that the parties are concerned as to whether the low occupancy level of 75% used to reallocate fixed costs applies to the certified distinct part or to the entire facility. In examining the regulations and program instructions, specifically Transmittal No. 378 to the Provider Reimbursement Manual, the Board concludes that the Medicare instruction deals with the certified unit only. The parties are also concerned with the propriety of Transmittal No. 378 and whether it is subject to the review and comment requirements of the APA. The Board concludes that the above transmittal is a clarification and interpretation of existing rules and regulations. As such, it is not subject to APA procedures. HCFA properly issued the program instruction, and it is a reasonable interpretation of existing law and regulations.

Subissue number two deals with the director of nursing and holiday, vacation and sick leave costs and whether these costs should be fixed or variable costs. As addressed above, the Board found Transmittal No. 378 to be an appropriate interpretation of existing regulations. Since the transmittal treats the director of nursing costs as a fixed costs, the Board concurs with this interpretation. Regarding the holiday, vacation and sick leave issue, the Board finds that such costs should have been treated as variable costs in light of the requirements of Transmittal No. 378. However, the Providers did not make such an adjustment in filing their exception requests. Further, they did not develop appropriate documentation to support the actual reallocation of such costs to variable costs as part of their briefing and oral arguments. Therefore, the Board cannot provide the relief that the Providers are requesting.

Regarding the Intermediaries= application of the Afreeze@ of the Medicare cost limit, the Board finds and

concludes that OBRA 93 authorized the application of the Afreeze@, and the Intermediaries properly applied it.

DECISION AND ORDER:

The Intermediaries properly: (1) applied Transmittal No. 378 low occupancy requirements to the certified distinct part of the Providers= facilities (2) treated the director of nursing costs as fixed costs in calculating atypical services costs, and (3) applied the Afreeze@ requirements of OBRA 93. The Intermediaries adjustments are affirmed.

BOARD MEMBERS PARTICIPATING

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: September 07, 2000

For The Board

Irvin W. Kues
Chairman