

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D13

PROVIDER -
Englewood Community Hospital - SNF
Englewood, FL

DATE OF HEARING-
June 19, 1997

Provider No. 10-5883

Cost Reporting Period Ended -
December 31, 1995

vs.

INTERMEDIARY -Mutual of Omaha

CASE NO. 96-2058

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ISSUE:

Is the Provider exempt from the skilled nursing facility (“SNF”) routine cost limits as a “new provider?”

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:General Facts:

Englewood Community Hospital-SNF (“Provider”) is part of a 100 bed hospital located in Englewood, Florida. The 100 beds consist of 82 adult acute care beds (a Medicare agreement permits 15 beds to operate as swing-beds), 8 intensive care unit beds (“ICU”), and 10 SNF beds. The 10 SNF beds are certified as a "distinct part" of the hospital, i.e., a hospital based skilled nursing facility (“HB-SNF/DP”). The swing-beds were approved in April 1989, to provide extended care services, when appropriate. In April 1995, the Provider received from the Health Care Financing Administration (“HCFA”) a SNF certification for the 10 bed distinct part (“DP”) which also involved a separate Medicare provider number and agreement. The Provider's June 1995 exemption request from the SNF routine cost limits (“RCL”) as a new provider, under 42 C.F.R. § 413.30(e), was denied by HCFA in October 1995, because the Provider had furnished services [prior to its SNF certification] equivalent to Medicare SNF services in the swing-beds.

The Provider filed a timely appeal of HCFA's denial determination with the Provider Reimbursement Review Board (“Board”) pursuant to 42 C.F.R. §§ 413.30(c) and 1835-.1841 and has met the jurisdictional requirement of those regulations. The Medicare reimbursement effect in dispute is approximately \$411,700 for the fiscal year ended (“FYE”) December 31, 1995. The incurred Medicare program costs were approximately \$1,160,700 and the amount allowable after the RCL application was approximately \$749,000.

The Provider was represented by Jeffery T. Royer, Esquire, and Tamara L. Malkoff, Esquire, of Buckingham, Doolittle, & Burroughs, a Legal Professional Association. The Intermediary was represented by Marshal Treat, Mutual of Omaha Companies.

Stipulation of Facts:

The parties made the following stipulation of facts:

1. Provider is a 100 bed hospital, located in Englewood, Florida. The 100 beds consist of 82 adult care beds, 15 of which have swing-bed approval, 10 Skilled Nursing Facility beds (“SNF”), and 8 ICU beds.
2. From April 21, 1989 to the present, Provider operated and continues to operate 15 swing beds under a swing-bed agreement, No. 10-U267.

3. A swing-bed hospital is defined in 42 C.F.R. § 413.114 to mean a hospital participating in Medicare that has an approval from HCFA to provide extended care services as defined in 42 C.F.R. § 409.20 and meets the requirements specified in 42 C.F.R. § 482.66.
4. On June 10, 1993, Provider was granted a Certificate of Need (“CON”) to establish 10 new skilled nursing facility (“SNF”) beds, at a cost of approximately \$53,770.
5. In April 1995, Provider received approval for a Medicare Provider Number, No. 10-5883, for the 10 new SNF beds.
6. By letter dated June 19, 1995, Provider submitted a letter to Intermediary, requesting an exemption from the routine cost limits as set forth in 42 C.F.R. § 413.30. See Provider exhibit A, which is incorporated herein.
7. Intermediary reviewed the request in accordance with policy pertaining to a new provider exemption to the routine cost limit. By letter dated August 30, 1995, Intermediary agreed with Provider and recommended that the United States Department of Health and Human Services, Cost Control Policy Branch, Division of Payment & Reporting Policy, Bureau of Eligibility, Reimbursement Coverage, Health Care Financing Administration (“HCFA”) grant Provider an exemption to the routine cost limits. See Provider exhibit B for a copy of the August 30, 1995 letter which is incorporated herein.
8. Based upon a review of Provider's letter, dated June 9, 1995, requesting a routine cost exemption, Provider's SNF Exemption Questionnaire, Provider's Series Survey and Fiscal Intermediary's August 30, 1995 letter, the Director of the Office of Chronic Care and Insurance Policy, Bureau of Policy Development, HCFA, disagreed with Intermediary, and by letter dated October 31, 1995, denied Provider's request for an exemption from the routine cost limits. As explained in that letter, it was determined that the Provider provided skilled nursing services in the swing-beds prior to Provider's Medicare SNF certification, and that such services were equivalent to Medicare SNF services. See Provider exhibit C for a copy of the October 31, 1995 letter which is incorporated herein.
9. By letter dated November 15, 1995, Intermediary notified Provider of HCFA's determination that the facility was ineligible for an exemption to the routine cost limits. See Provider exhibit D for a copy of the November 15, 1995 letter which is incorporated herein.
10. Provider timely requested a hearing; and by letter dated April 26, 1996, the Provider requested an accelerated review. See Provider exhibit E which is incorporated herein.

11. On May 23, 1996, Intermediary received Provider's As-Submitted Cost Report for FYE 12-31-95, as part of Provider's healthcare complex. The routine cost limit for FYE 12-31-95 was determined to be \$138.25 per in-patient day. The SNF sub-provider's total in-patient operating costs, as determined with the routine cost limits as identified on supplemental worksheet D-1, Part III, were \$749,030 [See Provider exhibit F which is incorporated herein].
12. By invoking the exemption clause and recalculating the cost report, the costs were determined to be \$1,160,755. A copy of the recalculated worksheet D-1 with exemption is attached as Provider exhibit G, which is incorporated herein.
13. For the convenience of the PRRB, attached as Provider exhibit H and incorporated herein are the following relevant documents:
 - 42 C.F.R. §§ 413.114, 409.20, 482.66 (definition of swing-bed hospital with reference sections)
 - 42 C.F.R. § 413.30 (exemption from routine cost limits)
 - 42 C.F.R. §§ 482.1 et seq. (Medicare hospital participation requirements)
 - 42 C.F.R. §§ 483.5 et seq. (Medicare skilled nursing facility participation requirements)

Medicare Statutory and Regulatory Background:

The Medicare law established that health care providers furnishing services to Medicare patients are to be reimbursed the reasonable cost (“RC”) of providing such services. Title XVIII of the Social Security Act, section 1861(v)(1)(A), codified at 42 U.S.C. § 1395x(v)(1)(A), defines RC as “the costs actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. . . .” Id. This statutory provision also sets forth the provision that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs.

Congress authorized the Secretary of Health and Human Services (“Secretary”) to promulgate regulations to implement the RC statutory provision. The foregoing principles are further explained in the Medicare regulations in part at 42 C.F.R. §§ 413.9 and 413.53. The regulations also require providers to maintain “accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting under section 1815 of the Act” which is based on the provider's “financial and statistical records” 42 C.F.R. §§ 413.20(c)(1) and 413.24(a) respectively.

Congress later became concerned that providers of services had no incentive to limit their costs under the RC principles and amended the Medicare law, codified at 42 U.S.C. §

1395ww(a) - Limits on Operating Costs, authorizing the Secretary to promulgate regulations to establish prospectively, limits on the amount of costs recognized as reasonable in furnishing patient care. The Secretary implemented the cost limitation scheme, referred to as the routine cost limits (“RCL”), in the regulations at 42 C.F.R. § 413.30 - Limits on Cost Reimbursement. Sub-section (a)(1) sets forth the authority and scope, that HCFA may establish limits on provider costs recognized as reasonable in determining Medicare program payments. Sub-section (a)(2) generally states that a provider's costs may not exceed those estimated by HCFA to be necessary for the efficient delivery of needed health services which are applicable to both direct and indirect costs of items or services. The regulation also sets forth the procedure for providers to make requests and make appeals [Id. at Sub-section (c)]; and the circumstances and criteria that HCFA may grant exemptions, exceptions, and adjustments to the limits as may be appropriate to consider the special needs of particular providers [Id. at Sub-sections (e)-(h)].

The regulation permits an exemption from the RCL for a new provider which states:

(e) Exemptions.

* * *

(2) New provider. The provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

42 C.F.R. § 413.30(e)(2).

PROVIDER’S CONTENTIONS:

The Provider contends that it is exempt from the SNF RCL because it qualifies as a new provider under the Medicare regulations at 42 C.F.R. § 413.30(e). In support of that contention the Provider makes the following assertions:

1. Prior to its Medicare certification as a SNF in April 1995, it was not a SNF provider or an equivalent provider as required by the regulations at 42 C.F.R. § 413.30(e).

The regulation defines a new provider as:

(2) New provider. The provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

42 C.F.R. § 413.30(e)(2) (emphasis added).

The Provider states the sole question in this case is whether the Provider "has operated as the type of provider (or equivalent) for less than three years." The Provider asserts it has only operated as a SNF-type provider since April 1995, which is less than three years.

2. The Provider's swing-bed agreement was not equal to a SNF provider approval in value, force or meaning.

The term "equivalent" is not defined in the Medicare regulations; but it is defined in The American Heritage Dictionary of the English Language, Third Edition, 1992, at page 622 as:

- 1.a. Equal, as in value, force or meaning.
 - b. Having similar or identical effects.
2. Being essentially equal, all things considered; a wish that was equivalent to a command.
3. Mathematics . . .

The process of obtaining the SNF status and providing the required SNF services were very different in scope, level of intensity, and cost as compared to the swing-bed situation. To become a SNF, the Provider had to obtain a CON, perform extensive renovations, purchase equipment, create a new and dedicated physical space with a dedicated nursing staff which had to be educated and trained, and a host of other undertakings to meet the physical and administrative requirements of the SNF conditions of participation. The cost of providing extended care services to the swing-bed patients were essentially incremental in nature, i.e., some dietary and supply costs, because the same beds and nursing staff were used.

3. The conditions of participation ("CP") for a swing-bed agreement were not as comprehensive as the CP for a SNF certification. The Provider asserts there were close to 200 data tag numbers of CPs for SNFs compared to only 69 CP requirements for swing-beds.
4. The type of patient served in SNFs was different from swing-bed in several respects. Swing-bed patients have a much shorter stay, about 5 days, compared to a long term stay in a SNF. SNFs have greater requirements to maintain the patient's physical, mental, and psychosocial well-being during this longer term.

5. The definition of a SNF in the SNF manual specifically excludes a hospital with swing-beds at § 201 of HCFA Pub. 12.¹ This definition states in part:

the term SNF does not include swing-bed hospitals authorized to provide and be reimbursed for SNF level services.

HCFA Pub. 12 § 201 (emphasis added).

6. The reimbursement for services rendered in swing-beds and SNFs was different. Hospitals with swing-beds were reimbursed based on the provisions of 42 C.F.R. § 413.114 while SNFs were reimbursed on a normal RC basis.
7. HCFA's denial inappropriately relies on the term "equivalent services" rather than "equivalent provider" as stated in the regulation.

HCFA and the Intermediary have relied on cases and regulations that were distinguishable; distinguishable in that the regulations for other types of providers have been amended to clarify the terminology to mean "equivalent services," but not the SNF regulations. For example, the regulation relied upon in the two cases² cited by the Intermediary was 42 C.F.R. § 405.460(f)(7) [redesignated as § 413.30(f)]. This regulation pertained to home health agencies and was modified in 1984 to clarify that a new home health agency is one that "has provided. . . services equivalent to those that would have been covered if the agency had a Medicare provider agreement in effect." The regulation was amended to reflect the operative factor to be "equivalent services."

The Provider also states that in 42 C.F.R. § 413.40(f), which pertains to hospitals, the operative term for a new hospital is the "type of hospital inpatient services."

The SNF regulation at 42 C.F.R. § 413.30, even after its amendment in October 1995, still states "type of provider (or equivalent)." The Provider states that since the

¹ Provider's Posthearing Brief, Exhibit B.

² See Staff Builders Home Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Maryland, PRRB Dec. No. 86-D91, June 27, 1986, Medicare & Medicaid Guide (CCH) ¶ 35,846; rev'd HCFA Admr. Dec., August 27, 1986, Medicare & Medicaid Guide (CCH) ¶ 35,961; Staff Builders Home Health Care, Inc. v. Bowen, U.S. District Court for the District of Maryland, No. R-86-3317, Apr. 13, 1988. Medicare & Medicaid Guide (CCH) ¶ 37,133.

See Homemakers North Shore, Inc. v. Bowen, 832 F.2d 408, (7th Cir. 1987).

language of the regulation did not change to focus on equivalent services, then the intent of the regulation is whether the “provider operated as the type of provider or equivalent,” not whether it provided equivalent services.

8. The intent of the “new provider exemption” permits providers to recoup the higher costs typically associated with a new provider, e.g., start-up costs and low occupancy, while a patient population is being developed.

The Provider asserts it experienced significant start-up costs. The renovation and equipment costs of about \$213,200 is subject to the depreciation rules; significant costs were incurred to meet the conditions of participation, higher operating costs for additional staff such as an activities coordinator and a dedicated nursing service, supplies, and the administrative time for training as well as developing and maintaining patient medical records, etc. The Provider states it only had 68% occupancy in its first year, which is typical for new providers.

The Provider concludes that it has met the regulatory requirements of a new provider, and it is entitled to recoup the amount exceeded by the RCL, i.e., approximately \$411,725.

INTERMEDIARY’S CONTENTIONS:

The Intermediary makes the following contentions in support of the determination that the Provider does not meet the RCL exception requirements of a new provider under the regulations:

1. The Intermediary agrees with HCFA's determination that the Provider was disqualified from eligibility for an exemption as a “new provider” from the RCL because, prior to its SNF certification, skilled nursing services were furnished by the Provider for more than three years (April 1989 to April 1995) based upon an approved swing-bed agreement with the hospital.

The Intermediary agrees with the Provider that the controlling regulation for a SNF is 42 C.F.R.

§ 413.30(e)(2) which defines a new provider as:

(2) New provider. The provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

42 C.F.R. § 413.30(e)(2) (emphasis added).

In this case, the Provider furnished skilled nursing services for more than three years (April 1989 to April 1995) pursuant to an approved swing-bed agreement before it became a certified SNF.

2. The Intermediary contends that in determining eligibility for a new provider exemption, HCFA's policy was to determine whether the Provider operated or rendered services which were equivalent to those services furnished by a SNF. In this case, the type of skilled level of care rendered to an inpatient under the Medicare swing-bed agreement was equivalent to the type and level of care provided in a SNF.

The equivalency of services test was not arbitrary, capricious, nor an abuse of discretion. The HCFA Administrator and the courts have used this test. See Staff Builders and Homemakers North Shore.

3. The Intermediary states the level of care of the services rendered in both the SNF and swing-bed were equivalent. The services rendered in a swing-bed as well as a SNF bed are identified concurrently in the regulations at 42 C.F.R. § 409.20, "Coverage of services." This sections states:

(a) Included services. Subject to the conditions and limitations set forth in this subpart and subpart D of this part, "posthospital SNF care" means the following services furnished to an inpatient of a participating SNF or a hospital that has a swing-bed approval.

- (1) Nursing care provided by or under the supervision or a registered professional nurse;
- (2) Bed and board in connection with the furnishing of that nursing care;
- (3) Physical, occupational, or speech therapy;
- (4) Medical social services;
- (5) Drugs, biologicals, supplies, appliances, and equipment;
- (6) Certain medical services provided by an intern or resident-in-training;
- (7) Certain other diagnostic or therapeutic services; and
- (8) Other services that are necessary to the health of the patients and are generally provided by SNF's.

* * *

(c) Terminology. In §§ 409.22 through 409.30--

- (1) The terms "SNF" and "swing-bed hospital" are used when the context applies to the particular facility.
- (2) The term "facility" is used to mean both SNF's and swing-bed hospitals.

(3) The term “swing-bed hospital” includes an RPCCH with swing-bed approval under Subpart F of part 485 of this chapter.

42 C.F.R. § 409.20

4. The Intermediary states that because of the swing-bed certification agreement, the Provider already met most of the requirements of a SNF. The Intermediary acknowledges that the Provider incurred about \$213,200 of renovation costs in physically converting ten resident rooms to SNF rooms and adding an activity room, nursing station, tub room, and a separate entrance. However, these costs were depreciable “capital” costs, and were excluded from the calculation and application of the RCLs.

The Intermediary asserts the Provider has failed to explain or support the alleged incurred costs, and has not established any relationship to the RCL calculation. The Intermediary states the Provider has merely stated its total reported costs for the FYE December 31, 1995 was \$1,160,700 and only \$749,000 after the RCL application, yielding an amount in dispute of about \$411,700. There has been no identification or explanation of these costs. The Intermediary states the Provider has not indicated whether any of these costs could meet the definition of “start-up” costs which could provide a benefit. The Provider Reimbursement Manual defines start-up costs as:

Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit or expansion thereof to the time the first patient, whether Medicare or non-Medicare, is admitted for treatment

Start-up costs include, for example, administrative and nursing salaries, heat, gas, and electric, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incident to the start-up period.

HCFA Pub. 15-1 § 2132.

The Intermediary notes that since this appeal was filed before the FY ended, there has been no settlement or issuance of a final notice of program reimbursement.

5. The Intermediary also states the Provider failed to file for an exception to the RCL limits as urged in the HCFA denial letter of October 31, 1995 when it did not meet the “new provider” exemption requirements.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:1. Law - 42 U.S.C.:

- § 1395x(v)(1)(A) - Reasonable Cost
- § 1395ww(a) - Limits on Operating Costs

2. Regulations - 42 C.F.R. 405, Subpart D:405 - Subpart R:

- § 405.1801 et. seq. - Provider Reimbursement Determinations and Appeals

409 - Subpart C:

- § 409.20 - Posthospital SNF Care. Coverage of Services
- § 409.30 - Requirements for Coverage of Posthospital SNF Care. Basic Requirements

413 - Subparts A, B, and C:

- § 413.9 - Cost Reimbursement - General
- § 413.30 - Limitations on Reimbursable Costs
- § 413.30(e) - Exemptions
- § 413.30(f) - Exceptions
- § 413.114 - Payment for Posthospital SNF Care Furnished by a Swing-bed Hospital

Subchapter E--Standards and Certification:Part 482--Conditions of Participation for Hospitals:

- § 482 et.seq. - Conditions of Participation for Hospitals

§ 482.66 - Special Requirements for Hospital Providers of Long-term Services (“swing-beds”)

Part 483 -- Requirements for States and Long Term Care Facilities:

§ 483 et. seq. - Requirements for States and Long Term Care Facilities

§ 483.5 - Definitions

Subpart F--Conditions of Participation: Rural Primary Care Hospitals (RPCHs):

§ 485.645 - Special Requirements for RPCH Providers of Long Term-Care Services (“swing-beds”)

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

§ 2132 - Start-up Costs

Skilled Nursing Facility Manual (HCFA Pub. 12):

§ 201 - Skilled Nursing Facility (SNF) Defined

4. Cases:

Staff Builders Home Health Care, Inc. v. Blue Cross and Blue Shield Association/Blue Cross of Maryland, PRRB Dec. No. 86-D91, June 27, 1986, Medicare & Medicaid Guide (CCH) ¶ 35,846; rev'd HCFA Admr. Dec., August 27, 1986, Medicare & Medicaid Guide (CCH) ¶ 35,961; Staff Builders Home Health Care, Inc. v. Bowen, U.S. District Court for the District of Maryland, No. R-86-3317, Apr. 13, 1988. Medicare & Medicaid Guide (CCH) ¶ 37,133.

Homemakers North Shore, Inc. v. Bowen, 832 F.2d 408, (7th Cir. 1987).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and posthearing briefs, finds and concludes that the Provider is not entitled to an exemption from the routine cost limits as a "new provider."

The Board finds that the primary controlling authorities in this case are 42 U.S.C. § 1395(v)(1)(A), Reasonable Cost and § 1395ww(a), Limits on Operating Costs. 42 C.F.R. § 413.30 et seq. sets forth the Medicare regulatory provisions concerning the "Limitations on Reimbursable Costs." The Provider claims an exemption under this regulation as a new provider which states:

(2) New Provider. The provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

42 C.F.R. § 413.30(e)(2)

The Board finds that there is insufficient evidence in the record to substantiate the Provider's contention that it was not a SNF provider or an equivalent provider prior to its Medicare SNF certification in April 1995. The Board finds that the Provider has not made any clear and evidentiary demonstration of its allegations. For example, the Provider alleged that the conditions of participation for a SNF were more numerous than those for swing-beds. The Board finds that the Provider merely highlighted that there were "200 data tag numbers identifying participation requirements for SNFs [but] only 69 data tag numbers identifying participation requirements for swing-beds."³ The Board finds there was no identification or comparison of these requirements to demonstrate the perceived "intended differences" between the services provided in swing-beds versus SNF beds. The Board notes that many of the conditions of participation for a hospital, set forth in 42 C.F.R. § 482 et seq., duplicate and even exceed the SNF conditions of participation in 42 C.F.R. § 483 et seq. Additionally, the Board notes that the essential elements and requirements for SNF services are required to be provided in swing-beds as stated in 42 C.F.R. § 482.66.

Although the Board agrees conceptually with the Provider that there is a basic environmental difference between swing-beds and a SNF, that in itself was not conclusive evidence of qualifying as a new provider. For example, the approval process for a SNF, compared to swing-beds, was much more comprehensive and completely different. As in this case, the Provider not only undertook the CON process, but it also incurred significant capital costs to comply with the physical requirements for a SNF, e.g., a dedicated physical area with an independent nursing station, etc. However, as the Provider acknowledged, these incurred

³ Provider's Posthearing Brief at p. 7.

capital costs were excluded from the RCL, and the depreciation thereon is reimbursed separately in full.

The Board disagrees with the Provider's assertion that the difference in reimbursement for services rendered in swing-beds and a SNF facility shows it was not the equivalent of a SNF. The Board finds that the Secretary was authorized to develop methods of reimbursement to implement and insure that only reasonable costs were paid; and that the difference was possibly an accommodation to swing-bed hospitals to avoid maintaining the necessary financial and record keeping requirements.

The Provider cites the definition of a SNF as stated in HCFA's SNF manual to show it was not a SNF provider. This definition states in part:

201. SKILLED NURSING FACILITY DEFINED.

the term SNF does not include swing-bed hospitals authorized to provide and be reimbursed for SNF level services. Swing bed hospitals must meet many of the same requirements that apply to SNFs.

HCFA Pub. 12 § 201 (emphasis added).

The Board acknowledges that this definition was for a "Skilled Nursing Facility", and it clearly shows Medicare does not consider swing-beds as a SNF facility. This is axiomatic since, as already noted, swing-beds have not had a SNF facility certification approval. On the other hand, the definition shows that SNF-level services were to be rendered in the swing-beds together with a statement that swing-beds must meet many of the same requirements that apply to SNFs. Thus, in obtaining the swing-bed agreement the Provider had to demonstrate it was capable of rendering SNF level services.

In addition, the Board notes that the regulation addressing the coverage of posthospital SNF care states:

"posthospital SNF care" means the following services furnished to an inpatient of a participating SNF or a hospital that has a swing-bed approval.

42 C.F.R. § 409.20.

While claiming the new provider exemption, the Provider's primary argument focused solely on the regulatory language of "type of provider" and emphatically rejected the Intermediary's argument of "equivalent services" as being an improper determining criterion. The Board notes the Provider has interwoven the "equivalency of services" argument while attempting to show it was not a SNF type provider or the equivalent. The Board finds the Provider's assertion that the type of services rendered in the swing-beds were not equal to nor could it be

compared to the scope, level, or intensity of the type of services required by a SNF provider, was not proven. The Board finds that the Provider did not offer any evidence to demonstrate the precise differences or comparisons of these SNF-level services. The Board finds the Provider's bare allegation that the nursing care provided to a swing-bed patient was the same as acute care [rather than SNF level] because the patient continued to stay in the same bed with the same acute care nursing staff, shows the patient was, at least, receiving a higher level of care than SNF care by definition. The Board notes the core requirements for SNF level services were also required to be provided for swing-beds as stated in 42 C.F.R. § 482.66.

The Board notes that it would be theoretically possible for the services rendered in a swing-bed, depending upon the specific facility, to be either the same or different from SNF services, but there was no evidence presented on this aspect.

The Board notes the Provider has not identified or compared the differences in the level of services rendered between swing-beds and SNFs; nor has the Provider identified how, why, or in what manner the excess costs over the RCL were attributable to the SNF services rendered in the first year.

The Board notes that there has been no final settlement on the year in question, and that there is still an opportunity for the Provider to seek an exception to the RCL as stated in the HCFA denial letter.

DECISION AND ORDER:

The Provider is not entitled to an exemption from the routine cost limits as a “new provider.” The HCFA denial letter is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Teresa B. Devine
Henry C. Wessman, Esquire

FOR THE BOARD:

Irvin W. Kues
Chairman

CONCURRING OPINION of Board Member Henry C. Wessman, Esquire

I wish to emphasize the fact that anyone who believes a "swing-bed" environment is equivalent to a "skilled nursing facility" milieu is not living in the real world of present-day socio-health care delivery. Unfortunately, the Provider, in this case, did not present evidence to sharply demonstrate that difference to the point of qualifying as a "new provider"; and, thus, I must concur with my colleagues in upholding the denial of the "new provider" exemption.

Henry C. Wessman, Esquire