PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D55

PROVIDER -
Brentwood Health Care Center
Sagamore Hills, Ohio

Provider No. 36-5746

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
AdminaStar Federal, Inc.

DATE OF HEARING-
December 2, 1997

Cost Reporting Period Ended -
December 31, 1990

CASE NO. 93-0846

INDEX

ISSUE:

Was the Intermediary's adjustment of the nursing cost proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Brentwood Health Care Center ("Provider") is a skilled nursing facility located in Sagamore Hills, Ohio. For calendar year ended December 31, 1990 ("1990") it provided daily nursing home care to 75 patients in 75 beds and rest home services to 25 patients in 25 beds. The 75 bed nursing home section had a distinct part or Medicare certified area ("SNF") composed of 17 beds. The balance of 58 nursing home beds were non-SNF beds. The Provider, which opened in March, 1989, offered three levels of care: (1) rest home for ambulatory patients who only require personal care services to help them in their daily living (no nursing care); (2) intermediate care for patients who require more nursing services and some skilled nursing services, but not enough to be classified as requiring fully skilled care, and (3) skilled nursing care which was rendered in an area certified as meeting Medicare requirements. The three levels were confined to three physically separate areas.

In 1992, Mutual of Omaha[1] ("Intermediary") audited the Provider's books and records and made adjustments to the Provider's cost report disallowing the Provider's system of recording nursing costs. The adjustment reclassified nursing labor, transferring $151,829 from SNF-Participating to SNF non-participating ($137,157) and to rest home ($14,672).[2] The adjusted amount for the SNF became $106,745, and the SNF non-participating unit became $744,689.[3] Adjustments were similarly made for both employee benefits and administrative and general expenses. The Intermediary's disallowance was based on its use of the average cost-per-diem method for allocating nursing costs as set forth in Provider Reimbursement Manual, HCFA Pub. 15-1 ("HCFA Pub. 15-1") § 2340.1(B). The Intermediary's adjustment resulted in a reduction in Medicare reimbursement of approximately $152,000.

The Provider appealed the Intermediary adjustments to the Provider Reimbursement Review Board ("Board"). The filing has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider is represented by Samuel Laderman, Esquire, of Samuel Laderman Co., L.P.A. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

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1 Mutual of Omaha was the Provider's original intermediary. AdminaStar Federal, Inc. later assumed responsibility for auditing the Provider's records.

2 See adjustment No. 6, lines 15, 16 and 62 of HCFA Form 2546-86.

3 See Intermediary Exhibit No. 1.

PROVIDER'S CONTENTIONS:

The Provider contends that the Medicare program prohibits cross subsidization between the Medicare program and non-Medicare payers. Section 1395x(v) of the Social Security Act states that the reasonable cost of any services shall be the cost actually incurred, excluding amounts not necessary to the efficient provision of health care. Such costs shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services. The Secretary is given considerable discretion in establishing these regulations. The regulation at 42 C.F.R. § 413.9(b) provides:

> [t]he regulations in this part take into account both direct and indirect cost of providers of services. The objective is that under the method of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program.

42 C.F.R. § 413.9(b). (Emphasis Added)

This provision clearly is meant to prevent the Medicare program from subsidizing non-Medicare related costs, but it equally clearly proscribes Medicare from being subsidized by non-Medicare sources.

The Provider argues that the average cost-per-diem method used by the Intermediary in this case results in cross-subsidization and should be avoided if possible. The average cost-per-diem method results in the conclusion that the cost of providing services to each patient is the same regardless of the actual services rendered to each patient and the level of care required for that patient. This is a direct contradiction to the statutory prohibition against cross-subsidization between the Medicare program and non-Medicare payers. Simply put, the Medicare program is to bear its own costs and is not to bear any of the costs incurred by non-Medicare patients. Similarly, non-Medicare patients are to bear their own costs and are not to bear any of the costs incurred by the non-Medicare patient. Skilled nursing care is more costly than non-skilled care. The Provider's witness testified clearly and without contradiction that the greater the level of acuity, the more care that is required.[4]

The Provider further argues that the Intermediary should not have used the average-per diem costs in 1990 where an alternative method is available. The nursing service accounting records for 1991 and 1992 were kept the same way in 1990.[5] These records were apparently acceptable to the Intermediary for 1991 and 1992 but were not acceptable to the Intermediary

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[4] Transcript ("Tr") at 52, 57 and 59.

[5] Tr. at 67 and 87.

in 1990.[6] In 1991 the nursing cost per patient day allowed by the Intermediary was $103.59.[7] In 1992, the nursing cost per patient day allowed by the Intermediary was $65.41.[8] In 1990, nursing cost per patient day determined by the Intermediary was $35.88 based upon using the average-cost-per-diem method. It is evident that the latter amount is not a true reflection of skilled cost in 1990.

The Provider argues that the excuse given for accepting the accounting records in 1991 and 1992, i.e., the Intermediary's limited time and/or budget constraints,[9] is ludicrous. Average-per-diem cost figures for 1991 and 1992 could have been produced in less than five minutes per cost report. The Intermediary witness' testimony that, after uncovering a major problem in 1990, the Intermediary elected to give the Provider "a pass" in the subsequent two years, is simply not credible.[10]

The Provider observes that the Intermediary may apportion nursing costs based on the facts in the case. HCFA does allow an exception to the method of allocating nursing service based upon an actual time basis or the average cost-per-diem method, as follows:

> [w]here a provider is able to furnish sufficient documentation to satisfy the intermediary that the patient population in the non-certified part of the facility includes a substantial number of domiciliary patients requiring little or no nursing care, the intermediary may grant an exception to the average cost per diem method and apportion costs on the basis of the facts in that case.

HCFA Pub. 15-1 § 2340.1.

The same would hold true where there are different and easily recognizable levels of care capable of being measured. Costs should be apportioned on the basis of the facts in this case. The Board, although not the Intermediary, has recognized this permissible alternative by accepting (1) case studies, (2) assignment sheets and (3) time studies in certain circumstances in other hearings involving different providers. Some examples are:

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6 Tr. at 67.

7 Tr. at 67 and Provider Exhibit J.

8 Tr. at 67 and Provider Exhibit K.

9 Tr. at 87.

10 Tr. at 88.

(1) Case Studies

University of Minnesota Hospitals and Clinic v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Minnesota, PRRB Hearing Dec. No. 91-D29, March 29, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,134.

(2) Assignment Sheets

Henrietta D. Goodall Hospital and Hillcrest SNF v. Blue Cross and Blue Shield Assoc./Blue Cross/Blue Shield of Maine, PRRB Hearing Dec. No. 83-D33, February 3, 1983, Medicare & Medicaid Guide (CCH) ¶ 32,436.

(3) Time Studies

Bridgeview Convalescent Center (Bridgeview, IL) v. Ætna Life Insurance Co., PRRB Hearing Dec. No. 89-D66, September 27, 1989, Medicare & Medicaid Guide (CCH) ¶ 38,216.

The Provider argues that the Minimum Data Set ("MDS") + case mix method should be used in this case to allocate nursing costs. That method was developed by HCFA and adopted by the State of Ohio. Rule No. 5101-3-41, 42, 43 and 44, Ohio Administrative Code. It provides an accurate, auditable, scientific and viable alternative method that would fit the circumstances in this and other cases. It measures the residents' need for care. It is based upon time studies made by HCFA and Ohio Department of Human Services for nursing labor. It is a system that takes into account the medical needs of the patient (resident characteristics) and the amount of time that the nursing staff will be required to treat those needs (the measured resource use). The nursing staff consists of registered nurses ("RNs") licensed practical nurses ("LPNs") and nurses aides ("NAs"). It does not include physical, speech and occupational therapies. It takes into account the fact that some residents are more costly to care for than others due to their different care needs. Some residents require skilled care (more and thus more costly care) and others require non-skilled care (less and less costly care). The MDS + method thus provides a way to measure the relationship of the needs (and thus the cost) of one level of care to another level of care; in short, the relative acuity levels between the skilled (participating) and less skilled (non-participating) areas.

The Provider contends that the MDS + summary method, although developed after 1990, could still be applied to 1990 data and would be a better indicator of 1990 levels of care. At the Provider, under this method, each and every patient admitted in 1990 was evaluated according to his (her) medical condition based on the patients record. This evaluation was done by a team composed of representatives of the nursing staff.[11] A questionnaire identified as MDS + for Nursing Home Assessments and Care Screening was filled out, and the data fed

[11] Tr. at 34-37.

into a computer. The software program, the resident assessment protocol software, is mandated and approved by the Ohio Department of Human Services. That software classifies the residents into seven groupings and each is assigned a scoring. The groupings are special rehab, extensive care, special care, clinically complex, impaired cognition, behavior problems, and reduced physical functions.[12] The scoring is highest in the special rehab and decreases in the groups that follow in a vertical order. The lowest scoring is in the reduced physical functions group.

The Provider argues that in applying this system to 1990 data, the nurses made the resident evaluation from the resident's own chart.[13] The only difference as to when this was done (in 1990 or 1996) is that no care plan was prepared in 1996.[14] There was no difference in the assessments as the nurses, having been with the home a long time, had known the patients.[15]

The Provider observes that the Medicare admissions, because of their relatively short stay, were representative of the entire Medicare population. The non-participating admissions (28 admissions equal 48% of the 58 available beds) were representative of the entire non-participating patients.[16] The comment by the Provider's witness[17] that patients may get worse as they get older,[18] is not relevant in this case because the non-participating patients, already in their beds as of January 1, 1990, had been admitted to the home during the second half of 1989 as the home had opened in 1989.

The Provider notes that the Intermediary attempted to make it appear that the data upon which the Provider based its ratio of acuity levels is flawed because dividing the number of admissions into the number of Medicare days yields an obviously incorrect number of days per patient. The Intermediary's mistake is its assumption that all patients in the home were assessed. However, the Provider's witnesses were quite clear that they had assessed only those who were admitted during 1990.[19]

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12 See Provider Exhibit G.

13 Tr. at 34.

14 Tr. at 37:2.

15 Tr. at 36.

16 Tr. at 79.

17 Id.

18 Tr. at 79.

19 Tr. at 35.

The Provider observes that all the patients admitted to the entire facility during 1990 were evaluated. The scoring for skilled care patients was 3.03810. The scoring for the intermediate care was 2.12460. The ratio of skilled cost to intermediate care was 1.43 (3.03810/2.12460 = 1.43). Using the adjusted per diem cost as established by the Intermediary, the nursing labor cost for the SNF is $51.31 per patient day ($35.88 x 1.43). Using the 2972 SNF days determined by the Intermediary times the daily rate of $51.31 yields total nursing care cost for 1990 of $152,493. Thus, the appropriate adjustment that should have been made by the Intermediary is as follows:

	As Reported	Adjustment	As Adjusted
SNF Participating	$258,574	($106,081)	$152,493
SNF Non Participating	$607,532	$ 91,409	$698,941
Rest Home plus rounding	-0-	$ 14,672	$ 14,672
Totals	$866,106	-0-	$866,106

Further adjustments should be made to increase: (1) employee benefits by $10,399 and (2) general and administrative expenses by $5,789.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that since the Provider did not furnish adequate time records to support its allocation of nursing costs, the Intermediary used the average cost per diem method of allocating nursing costs as required by HCFA Pub. 15-1 § 2340. The regulatory basis for it is 42 C.F.R. § 413.24 which requires a provider to maintain adequate cost data to support claimed cost. HCFA Pub. 15-1 § 2340 states that one of the prerequisites for an institution to have a portion of its facility participate as a SNF is that it must have the recordkeeping capability to insure that it can adequately furnish the financial and statistical data required to separately determine costs applicable to the portion of the facility participating as a SNF and to other parts of the facility. The provider must be able to satisfy the intermediary that the system employed for recording and accumulating the number of hours of nursing services is capable of audit and equitably allocates the nursing service costs for Medicare reimbursement purposes. In this case the Provider does not have the records necessary to allocate costs of nursing services.

The Intermediary observes that HCFA Pub. 15-1 § 2340 permits two methods for allocating nursing service to a distinct-part SNF:

> (1) Actual Time Basis: Under this method, a provider must use data from its own records: payroll record, assignment records, or other actual records. This section states

that the allocation should be equitable and based on records or notations made at the time services were rendered. This method does not give a provider the option of using state-wide or industry-wide statistics, or state minimum staffing requirements to allocate nursing service costs.

(2) Average Cost Per Diem Basis: This method is used when the Intermediary determines that adequate time records have not been maintained to support an equitable allocation of nursing costs.

HCFA Pub. 15-1 § 2340.

The above-section also provides an exception to the average cost per diem method if a provider furnishes sufficient documentation to show that the patient population in the noncertified part of the facility includes a substantial number of domiciliary patients requiring little or no nursing care. In these instances, the costs may be apportioned on the basis of the facts in that case. The Intermediary gave consideration to the fact that the patients in the other long term care area needed little nursing care in this case. RN and LPN salaries were not allocated to that area.

The Intermediary notes that the Board has heard this issue before. In general the Board and HCFA Administrator agree that the allocations must be equitable and must be based on records or notations made at the time the services were rendered. In the absence of adequate records, the average cost per diem method must be used. In Good Samaritan Health and Rehab Center (Antioch, Tenn.) v. Ætna Life Insurance Company, ("Good Samaritan") PRRB Dec. No. 96-D57, August 28, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,626 and Florida Living Care, Inc. Routine Service Expense Group v. Ætna Life Insurance Company, PRRB Dec. No. 94-D45, May 5, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,431, the Board found that the intermediary's adjustments were proper because the provider failed to meet the documentation requirements of 42 C.F.R. §§ 413.20 and 413.24. The Board stated in Good Samaritan, that under the provisions of HCFA Pub. 15-1, § 2340 the provider was required to have adequate recordkeeping capability to ensure that it can furnish financial and statistical data required to separately determine costs applicable to the portion of the facility participating as a SNF and to other parts of the facility. With respect to nursing services costs, the system employed for recording and accumulating the number of hours of nursing services must be capable of audit and must equitably allocate costs for Medicare reimbursement purposes. Where it is determined that adequate time records have not been maintained to support an equitable allocation of nursing costs, HCFA Pub. 15-1 § 2340.1 requires the intermediary to allocate nursing services costs based on an average cost per diem basis.

The Intermediary observes that in the instant case, the Provider did not submit any documentation to show actual time spent by the nurses in the certified and non-certified areas.

Therefore, the Intermediary properly used the average cost per them method of allocating cost of nursing services.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)	-	Reasonable Cost

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.9	-	Definitions
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding

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

§ 2340	-	Allocating Nursing Service Costs In Nursing Homes with Distinct-Part Skilled Nursing Facility
§ 2340.1	-	Methods of Allocating Nursing Service Costs for Cost Reporting Periods after 1972

4. Cases:

Bridgeview Convalescent Center (Bridgeview, IL) v. Ætna Life Insurance Co., PRRB Hearing Dec. No. 89-D66, September 27, 1989, Medicare & Medicaid Guide (CCH) ¶ 38,216.

Henrietta D. Goodall Hospital and Hillcrest SNF v. Blue Cross and Blue Shield Assoc./Blue Cross/Blue Shield of Maine, PRRB Hearing Dec. No. 83-D33, February 3, 1983, Medicare & Medicaid Guide (CCH) ¶ 32,436.

Good Samaritan Health and Rehab Center (Antioch, Tenn.) v. Ætna Life Insurance Company, PRRB Dec. No. 96-D57, August 28, 1996, Medicare & Medicaid Guide (CCH) ¶ 44,626.

Florida Living Care, Inc. Routine Service Expense Group v. Ætna Life Insurance Company, PRRB Dec. No. 94-D45, May 5, 1994, Medicare & Medicaid Guide (CCH) ¶ 42,431.

University of Minnesota Hospitals and Clinic v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Minnesota, PRRB Hearing Dec. No. 91-D29, March 29, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,134.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties' contentions and the Provider's post-hearing brief finds and concludes that the Intermediary properly applied the average per diem method of allocating nursing costs as prescribed by HCFA Pub. 15-1
§ 2340.1. That section allows two methods of allocating nursing service costs to a distinct-part SNF: (1) actual time basis and (2) the average cost per diem method. The actual time basis requires contemporaneous payroll, assignment or other appropriate records to distribute nursing costs. The Provider has not provided either the Intermediary or the Board appropriate time or personnel records. The Board notes that the MDS-plus system is a good tool in measuring the acuity of services rendered in various components of a facility that offers varying levels of service. However, this system does not replace the Provider Reimbursement Manual requirement for having actual time assignment or personnel records for allocating nursing service costs.

The Board also notes that the Provider attempted to use the MDS plus system retroactively. That is not permitted under the above program instruction. Further, the Provider's argument that the Intermediary's use of the average per diem method results in an inappropriate cross-subsidization of costs by Medicare is incorrect. The Board believes that the Medicare law and regulations are properly interpreted by the program instruction in HCFA Pub. 15-1 § 2340. The latter instruction allows an option for actual time when the provider keeps appropriate records. It only requires an averaging technique when actual time records are not kept or are inadequate. Thus, the manual gives the provider the opportunity to assign costs in a more direct manner if it believes that cross-subsidization exists. However, the manual puts the burden on the provider to establish and keep appropriate, contemporaneous records. The Provider has failed to do that in this case.

DECISION AND ORDER:

The Intermediary has properly used the average cost-per-diem method of allocating nursing costs in the Provider's distinct-part SNF. The Intermediary's adjustment is sustained.

Board Members Participating:

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

Date of Decision: May 21, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman