PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D64

PROVIDER -Mercy St. Teresa Center
Mariemont, Ohio

DATE OF HEARING-
February 10, 1998

Provider No. 36-5946

Cost Reporting Period Ended -
December 31, 1994

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
AdminiStar Federal

CASE NO. 96-0340

INDEX

ISSUE:

Was HCFA's denial of the Provider's request for an exemption from the routine cost limit ("RCL") as a new provider proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy St. Teresa Center ("Provider") is a not for profit long term care facility, located in Mariemont, Ohio. The Provider is comprised of eighty four licensed nursing home beds, fifty three rest home beds, and forty congregate living beds. Prior to November, 1993, the Provider was located in Silverton, Ohio ("Silverton"). Silverton was certified for Medicaid participation on November 20, 1984, but operated under numerous building waivers, due to the dilapidated condition of the physical plant. Silverton was never Medicare certified.

The Provider sought and received permission from the state agency to relocate the facility to Mariemont, Ohio. The Provider was given permission to acquire twelve approved but not yet built beds to be operated as a Medicare-certified Skilled Nursing Facility distinct part ("SNF"). Forty seven Nursing Facility ("NF") residents were transferred to the new facility. None was transferred to the SNF unit, which was certified and approved to admit residents as of January 17, 1994.[1] The first resident was admitted to the SNF on February 17, 1994.[2] Prior to January 17, 1994 neither facility was Medicare certified although both were Medicaid certified as a NF.

The Provider's as filed cost report for the period ended December 31, 1994 indicated that its routine costs exceeded the RCL. The Provider applied for and was granted an exception to the RCL pursuant to 42 C.F.R. § 413.30(f)(1) (atypical services)for the year ended December 31, 1994, resulting in payment of $276.43 per day for routine costs. However, $41.02 per day in routine costs in excess of the RCL remain unreimbursed. The Provider timely applied for an exemption to the RCL pursuant to 42 C.F.R. § 413.30(e)(2) as a new provider. By letter dated June 14, 1995, HCFA advised AdminiStar Federal ("Intermediary") that the Provider did not qualify for a new provider exemption.

The Provider timely appealed HCFA's denial to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and has met the jurisdictional requirements of those regulations. The estimated amount in dispute is approximately $115,000.

The Provider was represented at the hearing by David M. Levine, Esquire, of Benesch, Friedlander, Coplan and Aronoff, LLP and the Intermediary was represented by Bernard M.

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1 Transcript ("Tr.") at 27.

2 Tr. at 27.

Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it satisfied the criteria set forth in 42 C.F.R. § 413.30(e)(2), because it provided primarily "custodial care" and not primarily "Skilled Nursing Care" or rehabilitative services during the relevant period.

The Provider argues that the statutory definition of a SNF must be used in conjunction with 42 C.F.R. § 413.30(e)(2) to determine whether a provider "has operated as the type of provider (or the equivalent) for which it is certified for Medicare." In this case, the Provider is a Medicare-certified SNF. It is undisputed that the Provider did not operate as a SNF per se, during the look-back period, since it was first certified to participate in the Medicare program as a SNF on January 17, 1994. Therefore, the question to be resolved is whether the Provider operated as "the equivalent" of a SNF during the look-back period. The question turns on a correct application of the statutory definition of a SNF, verses the definition of a NF.

The Provider points out that the word "primarily" figures prominently in the definition of a SNF and a NF. Section 1819(g) of the Social Security Act states:

> In this title, the term: skilled nursing facility means an institution (or a distinct part of an institution) which--
>
> (1) is primarily engaged in providing to residents--
>
> (A) skilled nursing care and related services for residents who require medical or nursing care, or
>
> (B) rehabilitation services for the rehabilitation of the injured, disabled, or sick persons.

By contrast, the definition of a NF (Section 1919(g) of the Social Security Act) states:

> In this title, the term "nursing facility" means an institution (or a distinct part of an institution) which--
>
> (1) is primarily engaged in providing to residents--
>
> (A) skilled nursing care and related services for residents who require medical and nursing care,
>
> (B) rehabilitation services for the rehabilitation of the injured, disabled, or

sick person. or

(C) on a regular basis, health related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities. . . .

The Provider points out that the language in Section 1819(a)(1)(A) and (B) is identical to that in Section 1919(a)(1)(A) and (B). However, the language in Section 1919(a)(1)(C) is not found in the definition of a SNF under Section 1819(a) of the Act. The Provider argues that this clear definitional difference is, depending on the given facts, what may distinguish a NF from a SNF, The Provider argues, and the Intermediary's witness agreed,[3] that a facility may qualify as a NF under Section 1919(a)(1)(C), but not as a SNF or its equivalent, when it provides primarily the lowest level of care under Section 1919(a)(1)(C) (Custodial care). The Provider argues that under the unambiguous definitions in the Act, a NF and a SNF are not always equivalent types of providers, and the question of whether a facility meets the definition of a NF and a SNF, or merely falls under the definition of a NF but not a SNF is determined by the nature and the extent of the care and services the facility actually provided to residents. In this case the Provider argues that it was, and has met the definition of a NF during the three year look-back period, but did not operate as the equivalent of a SNF during that same period. In particular, the Provider demonstrated that it had provided primarily custodial care to its residents, and that the incidence of skilled nursing and/or rehabilitative services during the look-back period was very low.

The Provider points out that one of its witnesses testified that the Provider had occasionally provided some of the skilled nursing and rehabilitative services listed in 42 C.F.R. § 409.33(b) and (c), during the look-back period. Further, the OSCAR Report[4] indicates that such services were provided to residents on the dates of the Provider's annual certification surveys (August 8, 1990, July 26, 1991, July 17, 1992, and August 23, 1993) which surveys cover much of the look-back period. However, the Provider witness also testified that:

> The Silverton facility was not primarily engaged in providing skilled nursing services during the look-back period,[5]
>
> The Silverton facility was not primarily engaged in providing skilled rehab

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3 Tr. at 158.

4 Intermediary Exhibit 1-8.

5 Tr. at 85.

> services during the look-back period,[6]
>
> The Silverton facility was primarily engaged in providing on a regular basis health oriented care and services to individuals who, because of their mental or physical condition, required care and services above the level of room and board which can be made available to them only through institutional facilities during the look-back period.[7]

The Provider points out that HCFA has identified thirteen categories of skilled nursing and/or rehabilitative services in the OSCAR Report. The OSCAR report also shows that for each of the four annual surveys reported, the Provider had a total resident census of fifty one (in the NF beds). Accordingly, at each annual survey, a total of 663 skilled nursing and/or rehabilitative services could have been rendered to the NF resident population (13 possible services times 51 NF residents). If the Board were to accept the OSCAR Report as accurately reflecting the incidence of skilled nursing and rehabilitative services, then the results are as follows: compared to the number of skilled nursing/rehab services furnished to the possible number of skilled nursing rehab services for the first annual survey the percentage is 3.02, for the second the percentage is 7.94, for the third the percentage is 7.24 and for the fourth the percentage is 9.05.

The Provider points out that it demonstrated at the hearing that the services corresponding to the entries under the headings “bladder training” and “bowel training” did not constitute skilled nursing or rehabilitive services. By properly excluding those entries, the above mentioned percentages change to 3.02, 6.03, 3.47 and 4.22. The Provider also points out that the entries in the OSCAR Report under the heading “injections” improperly include intramuscular injections of vitamin B-12 and another vitamin supplement. These injections should also be excluded as not constituting skilled nursing or rehabilitative services. By adjusting the entries for the above mentioned items the percentages change to: 2.11, 5.13, 2.11, and 3.47.

The Provider also points out that the entry for the second survey, under the heading “special care rehab services” erroneously includes routine “range of motion” services provided by persons other than skilled nursing or rehabilitative personnel. That adjustment further changed the percentages to: 2.11, 2.26, 2.1l, and 3.47. Therefore, the Provider argues that given the extremely low incidence of services that would qualify as skilled nursing or rehabilitative services during the look-back period, the Provider furnished primarily “custodial care”, not primarily skilled nursing and/or rehabilitative services, and therefore was not operating as “the equivalent of a SNF.”

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6 Tr. at 85.

7 Tr. at 86.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that a new provider exemption would be granted to those providers of inpatient services that have operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present or previous ownership, for less than three full years in accordance with 42 C.F.R. § 413.30(e). In that regulation the phrase ". . .has operated as the type of provider. . ." refers to whether or not, prior to certification, the institution or institutional complex engaged in providing residents skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons identified in 42 C.F.R. § 409.33(b) and (c), and did not primarily care and treat residents with mental diseases. The definition of a SNF is statutory and can be found in Section 1819(a)(1) of the Social Security Act.

The Intermediary points out that the Omnibus Reconciliation Act of 1987 included the Nursing Home Reform provisions that regulate the certification of long-term care facilities under the Medicare and Medicaid programs. These provisions became effective for services rendered on or after October 1, 1990. The result is that both Medicare SNFs and Medicaid NFs are required to provide, directly or under arrangements, the same basic range of services described in Sections 1819(b)(4) and 1919(b)(x)(4) of the Social Security Act. This range of services includes those nursing services and specialized rehabilitative services needed to attain or maintain each resident's highest practicable level of physical, mental, and psychosocial well-being.

The Intermediary contends that the legislative history indicates that Congress' intent in adopting the Nursing Home Reform provisions was to "apply a single, uniform set of requirements to all nursing facilities participating in Medicaid, eliminating the current regulatory distinctions between skilled and intermediate nursing facilities. The Nursing Home Reform Law established a single standard of "skilled" care for all Medicare and Medicaid beneficiaries and forced facilities to provide "skilled" care as required by federal law and was in itself self-effectuating.

The Intermediary points out that in Gray Panthers Advocacy Committee et, al. v. Louis W. Sullivan, M.D. Secretary of Department of Health and Human Services, 936 F.2d 1284 (D.C. Cir. 1991), the court held that "the fact that the regulations (OBRA 1987) merely reiterate the statutory language precludes any serious argument that the regulation affects the agency or (regulated individuals) in such a way as to require notice and comment procedures pursuant to 5 U.S.C. § 553. . . because the Secretary determined that portions of the statute were self-effectuating." Id.

The Intermediary points out that in Newman v. Kelly, 849 F. Supp. 228 (1994) and Kansas Health Care Association Inc. v. Kansas Department of Social and Rehabilitation Services, 754 F. Supp 1502 (D. KS 1990), it was found that the statutory definitions clearly state that skilled care must be provided to all residents who require nursing care under either Medicare or

Medicaid reimbursement schemes. There is no indication in the definitions or statutory schemes that any distinction should be made on the basis of level of skilled care required by the resident who is eligible for Medicare or Medicaid reimbursement. Therefore, the Intermediary argues that the term "skilled nursing facility" is the substantial equivalent of the term "Nursing Facility".

The Intermediary points out that there has been no change in HCFA's longstanding policy on the new provider exemption since its inception on June 1, 1979. A new provider is defined in 42 C.F.R. § 413.30(e) as "a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under past and previous ownership, for less than three full years." This regulation is further interpreted in § 2604.1 of HCFA Pub. 15-1. For purposes of applying this regulation to SNF, the phrase "has operated as the type of provider. . ." refers to whether or not, prior to certification, the institution or institutional complex engaged in providing residents skilled nursing care and related services for residents who require medical and nursing care, or rehabilitative services for the rehabilitation of injured, disabled, or sick persons as defined at 42 C.F.R. §§ 409.33(b) and (c), and did not primarily care and treat residents with mental diseases. The definition of a SNF is statutory and can be found in Section 1819(a)(1) of the Social Security Act.

The Intermediary contends that HCFA has not applied an unpromulgated per se rule that any skilled nursing facility that was certified to participate in the Medicaid program on or after October 1, 1990, cannot receive a new provider exemption. The law is clear that an institution or institutional complex that has operated as a SNF or its equivalent in the three years prior to Medicare certification is ineligible for a new provider exemption.

The Intermediary asserts that a new provider exemption is based upon how the entire institution or institutional complex operated under both past and present ownership in the three years prior to Medicare certification. This is in compliance with HCFA Pub. 15-1 § 2604.1 and the Medicare regulation at 42 C.F.R. § 413.30(e),

The Intermediary argues that SNFs have historically exhibited a considerable degree of diversity in the types of services they furnish, not all of which meet the SNF level of care for purposes of Medicare coverage of extended services. Although a NF may not have furnished skilled care or rehabilitative care as frequently as a SNF providing those services on a continuous basis, the regulation at 42 C.F.R. § 413.30(e) makes no allowance for institutions providing a low volume of skilled nursing services prior to certification as a SNF. An institution having provided skilled nursing or rehabilitative services for three years prior to certification, regardless of the specific volume, is not entitled to the new provider exemption.

The Intermediary points out that when evaluating "equivalent status" to a NF, HCFA requests that the institution submit documentation indicating when they initially performed any of the skilled nursing and or rehabilitative services that appear in 42 C.F.R. § 409.33(b) and (c) on any patient in the institution, regardless of payor source. This is done to determine when the

institution first performed skilled nursing services and to determine the date the first patient required the services. This allows HCFA to determine the date the exemption period started. Where it is found that the facility did not perform any of the services in the three year period prior to the certification, it could be eligible for a new provider exemption.

The Intermediary points out that there is no requirement in the regulation that services that are considered "equivalent" must meet SNF coverage requirements. The Intermediary contends that demanding that "equivalent" services must meet Medicare coverage requirements is inconsistent with the statutory definition of a SNF, which merely requires that the facility provide skilled nursing and/or rehabilitative services.

The Intermediary argues that the Provider is incorrect in believing that an institution may qualify as a NF, but not as a SNF, by providing the lowest level of care (less than skilled nursing or rehabilitative services). A NF must be capable of providing, either directly or under arrangements, the same basic range of services described in Section 1819(b)(4) of the Social Security Act. This range of services includes those nursing services and specialized rehabilitative services needed to attain or maintain each resident's highest practicable level of physical, mental, and psychological well-being. Residents who require a ventilator, tracheotomy, I.V. therapy or tube feedings were and are expected to be admitted to any long term care facility, be it a SNF, NF, or SNF/NF, and receive the necessary care to achieve their highest practicable level of physical, mental and psychological well-being.

The Intermediary contends that the Provider furnished, either directly or under arrangements, skilled nursing care and rehabilitative services on January 14, 1984. The Provider also performed skilled nursing services since August 24, 1990. This information was documented on the Provider's self-reported resident census reports (HCFA Form 672) that are required during the survey and certification process.

The Intermediary argues that the decision of the Provider to increase the variety of skilled nursing services available to residents does not make it a new provider of skilled nursing and rehabilitative services. An exemption is granted based upon the functioning of the entire institution or institutional complex, in the three year period prior to certification for Medicare. This is inherent in the regulation itself. The level of care requirements necessary for Medicare coverage of extended care services are not a consideration in the determination of a new provider exemption. Therefore, the Provider is not eligible for a new provider exemption, because it has provided skilled nursing and rehabilitative services as defined by the Act and the regulations, and has been a NF for three or more years prior to its Medicare certification.

CITATION OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws

5 U.S.C. § 553 - Rule Making

Title XVIII of the Social Security Act:

§ 1819(g) et. seq. - Skilled Nursing Facility Defined

§ 1919(g) et. seq. - Nursing Facility Defined

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

§ 413.30 et. seq. - Limitations on Reasonable Cost-Exemptions

§ 409.33 et. seq. - Examples of Skilled Nursing and Rehabilitative Services

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

§ 2604.1 - Definitions - New Provider

4. Cases:

Gray Panthers Advocacy Committee et, al. v. Louis W. Sullivan, M.D. Secretary of Department of Health and Human Services, 936 F.2d 1284 (D.C. Cir. 1991).

Newman v. Kelly, 849 F Supp. 228 (1994).

Kansas Health Care Association Inc. v. Kansas Department of Social and Rehabilitation Services, 754 F. Supp. 1502 (D. KS 1990).

5. Other:

Omnibus Reconciliation Act of 1987

HCFA Form 672

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony at the hearing, and post hearing brief, finds and concludes that the Provider did furnish skilled nursing services during the three year period prior to certification and is, therefore, not entitled to an exemption from the Routine Cost Limit as a new Provider.

The Board finds that although the Provider did not furnish skilled and rehabilitative care as frequently as a skilled nursing facility, it did furnish a low volume of some skilled and

rehabilitative services. The regulation at 42 C.F.R. § 413.30(e)(2) makes no allowance for institutions providing a low volume of skilled nursing services prior to certification as a SNF. That regulation states in part:

> 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. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

Id.

Since the Provider did furnish some skilled and rehabilitative services for three years prior to certification, regardless of the specific volume, it is not entitled to the new provider exemption.

The Board notes that the Intermediary reviewed the Provider's documentation indicating when they initially performed any of the skilled nursing and or rehabilitative services that appear in 42 C.F.R. § 409.33(b). The Intermediary determined when the Provider first performed skilled nursing services and the date the first patient required such services. The review allowed the Intermediary to determine the date the exemption period started. The review indicated that the Provider did perform skilled services for the three years prior to certification and, therefore, the Provider is not entitled to a new provider exemption.

The Board finds that a nursing facility as described in Section 1819(b)(4) of the Social Security Act, must be capable of providing, either directly or under arrangements, a basic range of services. Both Medicare skilled nursing facilities and Medicaid nursing facilities are required to provide, directly or under arrangements, the same basic range of services as described in Section 1819(b)(4) and 1919(b)(x)(4) of the Social Security Act. This range of services includes those nursing services and specialized rehabilitative services needed to attain or maintain each resident's highest practicable level of physical, mental, and psychological well-being. The Board finds that the Provider performed, either directly or under arrangements, skilled nursing care since August 24, 1990. This information was documented on the provider's self-reported resident census reports (HCFA Form 672) .

DECISION AND ORDER:

The Provider is not entitled to a new provider exemption to the routine service cost limits in accordance with 42 C.F.R. § 413.30(e) or HCFA Pub. 15-1 § 2604.1. HCFA's denial of the Provider's request for an exemption is affirmed.

Board Members Participating:

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

Date of Decision: June 16, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman