PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D22

PROVIDER -
North Coast Rehabilitation Center
Santa Rosa, California

Provider No. 05-5837

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association
(formally Aetna)

DATE OF HEARING-
June 23, 1998

Cost Reporting Period Ended -
August 31, 1989

CASE NO. 93-1886

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ISSUE:

Is the Provider entitled to the full exception request, which it sought from HCFA?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

During the cost reporting period at issue, fiscal year ending August 31, 1989, North Coast Rehabilitation Center ("Provider"), located in Santa Rosa, California, owned and operated a 32 bed hospital-based Skilled Nursing Facility ("SNF"). Services provided to Medicare beneficiaries treated in the SNF unit were subject to limitations on reimbursable costs, commonly referred to as the Routine Cost Limit ("RCL"). For several years preceding the fiscal year in question, the Provider's routine service costs exceeded the RCL.[1]

Aetna Life Insurance Company ("Intermediary")[2] produced a finalized Medicare cost report and issued a Notice of Amount of Program Reimbursement ("NPR") on September 23, 1991 which was received by the Provider on September 24, 1991. The RCL was erroneously calculated at $121.94 per patient day and subsequently changed to the correct RCL of $126.78.[3] In the partial exceptions granted by FYE 1987 and FYE 1988, HCFA had determined that the Provider was also entitled to additional reimbursement for the malpractice insurance apportionment to the skilled nursing unit. The Provider also requested this from the Intermediary in its letter regarding the incorrect RCL rate.[4]

On October 18, 1991, the Provider submitted a timely request to the Intermediary for an exception from the hospital-based skilled nursing RCL for FYE August 31, 1989 pursuant to 42 C.F.R. § 413.30(f)(i).[5]

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[1] The Provider submitted exception requests for fiscal years ending August 31, 1985, August 31, 1986, August 31, 1987, and August 31, 1988. The Health Care Financing Administration ("HCFA") did not grant a full exception for any of these fiscal periods. Only partial exceptions were granted.

[2] The current Intermediary is Blue Cross and Blue Shield Association.

[3] Provider Exhibit 6, pg 1.

[4] Id.

[5] Provider Exhibit 7.

The Intermediary reviewed the request for exception and transmitted its recommendations to HCFA on March 24, 1992.[6] The Intermediary endorsed an exception for atypical nursing services costs, associated employee benefits and administrative and general costs, nursing administration costs, and atypical costs relating to medical records and social services. However, the Intermediary recommended that exceptions be denied for dietary, laundry and linen costs.

On November 16, 1992, HCFA responded to the request the Intermediary submitted on behalf of the Provider.[7] HCFA specifically found that the Provider had exceeded the RCL due, in part, to the fact that it experienced a low occupancy level for the fiscal period at issue. The Provider's occupancy level was 73.9 percent, and it was HCFA's position that in order for it to evaluate exception requests, a provider must have a minimum level of efficient utilization. Consequently, HCFA adjusted the Provider's costs to the 75 percent utilization level. The impact reduced the Provider's per diem cost from $184.98 to $183.85.[8]

To determine whether the Provider would then qualify for a exception, HCFA compared components of the revised costs (based on 75 percent utilization) to the Provider's peer mean group cost which totaled $162.89.[9] As in previous years, HCFA's response was only a partial approval of the exception. The amounts granted were $21.64 for Atypical Nursing Services, $3.69 for Medical Records and $4.92 for Social Services. The total amount granted was $30.25.[10] HCFA, however, denied exceptions for the Provider's claimed nursing administration, cafeteria, dietary, and laundry and linen. HCFA explained that although the per diem costs for these services exceeded the costs of a comparable peer group, the Provider had not submitted sufficient documentation to support the excess costs, and accordingly, its request for an exception for these costs was denied.

The Intermediary reopened the Medicare cost report to adjust the RCL to include the $30.25 amount granted by HCFA. The Intermediary sent a Notice Of Corrected Program Reimbursement on February 1, 1993 notifying the Provider of the changes.[11]

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6 Provider Exhibit 8.

7 Provider Exhibit 10.

8 Provider Exhibit 10, pg. 6; Provider Exhibit 2, pg. 4, col. D.

9 Provider Exhibit 10, Exhibit C-2, col. C.

10 Id. at pg. 6.

11 Provider Exhibit 12, pg. 13.

Since the original filing, the Medicare Cost report for FYE 1989 has undergone a series of reopenings. The latest was sent by the Intermediary on August 14, 1995. (Exhibit 13).

On July 27, 1993, the Provider appealed HCFA's determination to the Provider Reimbursement Review Board ("Board"), and has met all the jurisdictional requirements of 42 C.F.R. § 405.1835-.1841.[12] The approximate amount of Medicare reimbursement in controversy is $195, 298.[13]

The Provider is represented by Jerry Strum of Jerry Strum and Associates. The Intermediary's representative is Bernard Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

It is the Provider's position that the central issue related to this appeal is whether the Intermediary and HCFA imposed conditions which are not contained in the regulations at 42 C.F.R. §413.30 to determine the Provider's additional reimbursement. The Provider contends that HCFA must follow the rules and regulations in determining whether or not a Provider is entitled to an exception. The Provider refers to section 413.30 (f) which states in part:

> Exceptions. Limits established under this section may be adjusted upward for a provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section.. . . . An adjustment is made only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.
>
> (1) Atypical services. The provider can show that:
>
> (i) The actual cost of items or services furnished by a provider exceeds the applicable limit because such items or services are atypical in nature and scope, compared to the items or services generally furnished by providers similarly classified; and
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> (ii) The atypical items or services are furnished because of the special needs of the patients treated and are necessary in the efficient delivery of needed health care.

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[12] Provider Exhibit 12, pg. 1.

[13] Provider Exhibit 1, pg. 7.

42 C.F.R. § 413.30 (f).

The Provider contends the facts in this case are clear. HCFA recognized that the Provider furnished atypical services as evidenced by the recognition of a partial exception for nursing services.[14] The Provider points out that in order to quality for a full exception, the regulations as stated require the provider to show its costs are reasonable, attributable to the circumstances specified, separately identified and verified by the Intermediary. The Provider contends that in its exception request, all costs were separately identified by the Provider as required. The Provider submitted the request to the Intermediary who verified the costs as evidenced by the Intermediary's submission of the request to HCFA.[15] The Provider argues that it followed all the rules for a full exception and there were no comments from the Intermediary or HCFA regarding the scope or adequacy of its data.

However, the Provider contends that HCFA circumvented the regulations to avoid granting the Provider an exception. To do so, the Provider asserts that HCFA fabricated language beyond the scope of the language contained in 42 C.F.R. §413.30(f). The Provider notes that HCFA's determination states:

> We recognize that a provider's classification of indirect costs may not be consistent with the proportions prescribed by the peer group. Therefore, we evaluate the total of all indirect cost centers to determine the efficiency of a provider's operation. For an exception to be granted for any indirect cost center, the provider must meet the requirements of 42 CFR 413.30(f) by satisfying the following conditions:
>
> 1. Any exception for indirect costs is limited to the amount by which the sum of costs in excess of the peer group exceeds the sum of costs below the peer group.
>
> 2. All direct costs in excess of the peer group are properly justified, and
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> 3. The provider's actual cost in each cost center for which an exception is requested exceeds the peer group in column C on the enclosed exhibit C.

Provider Exhibit 10.

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[14] Provider Exhibit P-10 at 2-3.

[15] Provider Exhibit P-8.

The Provider is asking the Board to determine if HCFA has the authority to subject the Provider to language, conditions and standards which have not been promulgated in the regulations.

The Provider also takes exception to HCFA's adjustment for occupancy in making its final determination. In its determination, HCFA cites the Report of the Senate Finance Committee accompanying Public Law 92-603 as its justification for imposing a 75 percent occupancy standard prior to evaluating an exception request. The Provider's occupancy during the appeal year was 73.9 percent. The effect of increasing the Provider's occupancy to the 75 percent standard was to decrease its routine cost per day from $184.99 to $183.85.[16] The Provider contends this occupancy standard has never been promulgated as a regulation.

The Provider asserts that it is the responsibility of the Intermediary, during the time of audit, to determine if a provider is operating efficiently. There have never been any findings by the Intermediary that the Provider was not operating efficiently. The Provider contends that the nursing hour distribution, which was submitted with its exception request, clearly shows that nursing hours vary with census. Additionally, the Provider contends that its lower than average length of stay requires standby capacity which is not experienced by skilled nursing providers who are not furnishing atypical services. The Provider asserts that its shorter length of stay will generate pockets of low occupancy.

The Provider also rejects HCFA's determination that it is not entitled to an exception amount for atypical nursing administration costs.[17] It is the Provider's contention that if HCFA recognizes that the Provider is entitled to additional reimbursement because of atypical nursing hours, then it should logically follow that the Provider is entitled to additional nursing administration expense since these expenses are apportioned on the basis of direct nursing hours.[18] The Provider maintains that it has more nursing FTEs than are built into the limit, and as a result, its costs are significantly higher.[19]

The Provider contends that there is no dispute that it was furnishing atypical services during the period at issue. This was evidenced by HCFA's granting of partial exceptions for nursing services, medical records and social services. It is the Provider's position, however, that the

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16 Provider Exhibit P-10, Exhibit A.

17 Provider Exhibit P-10 at 4. The Intermediary had recommended to HCFA that the Provider be granted an exception for nursing administration. See Provider Exhibit P-8, Pg. 3.

18 Tr. at 59.

19 Tr. at 71.

methodology used by HCFA to grant the Provider partial exceptions precludes cost recovery even in those areas where HCFA recognizes atypical services were furnished.

The Provider refers to Section 2319 of the Deficit Reduction Act of 1984, enacted on July 18, 1984. This Act provided new authority to adopt separate limits for hospital-based skilled nursing facilities (SNFs) and freestanding SNFs. For cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984, this section also provided that the cost limits for routine services for urban and rural hospital-based SNFs must be set at 112 percent of the mean for the respective routine costs for urban and rural hospital based skilled nursing facilities.

The single set of limits was published in the Federal Register (47 Fed. Reg. 42894) on September 26, 1982 as required by P. L. 97-284. The cost limits for inpatient routine skilled nursing services were calculated at 112 percent of the mean of the routine costs for freestanding and hospital-based SNFs (that is urban and rural). For each group, the routine cost components were divided between labor-related costs and nonlabor costs in the urban and rural categories.

The Provider notes that the Federal Register notice published Tuesday, April 1, 1986, (51 Fed. Reg. 11234) included provisions for cost reporting periods beginning on or after July 1, 1984. For urban freestanding skilled nursing facilities, the limit already established would continue. This limit was set at the average cost for routine services in urban freestanding SNFs times 112 percent. This continued as the routine cost limit for urban freestanding skilled nursing providers ("Freestanding RCL").

The Provider points out that the April 1, 1986 notice included substantial changes in how hospital-based skilled nursing providers would be reimbursed for routine services. For the cost reporting periods beginning on or after October 1, 1982 and before July 1, 1984, the routine cost limit for urban hospital-based SNFs had been set at 112 percent of the average (mean) cost for urban hospital-based SNFs.

Unlike the Freestanding RCL, this number does not become the RCL for hospital-based skilled nursing providers. The limits for urban and rural hospital based SNFs however, are equal to the sum of the corresponding limit for freestanding SNFs plus 50 percent of the difference between the freestanding limit and 112 percent of the mean hospital based inpatient routine costs for hospital based SNFs, in the urban and rural localities, respectively.

The Provider contends that when HCFA considers the merits of an exception from the RCL, it compares the Provider's components of cost (adjusted to 75 percent utilization) to the components of the "limit" that was calculated using the 112 percent of the peer mean group and not the RCL as defined in the regulations. The Provider contends that using the HCFA methodology, even when HCFA recognizes atypical services, it can never recover the portion

of its cost that is above the true RCL and below the 112 percent limit which HCFA uses in determining exceptions.

As an example, the Provider notes that the HCFA methodology granted an additional $4.92 per patient day for Social Services (Provider Exhibit P-10, pg. 6, col. E). This was based on the HCFA Peer Group mean cost of $3.70 per patient day (Provider Exhibit P-10, pg. 11, col. C) compared to the Provider's actual cost (based on a 75 percent utilization) of $8.62 per patient day (Provider Exhibit P-10, pg. 11, col. D) However, the Provider has demonstrated the cost component for Social Services which is included in the RCL is only $2.88 per patient day (Provider Exhibit P-2, page 3). Therefore, the Provider is denied the difference between $3.70 per patient day and $2.88 per patient day, or $.82 per patient day because HCFA's Peer Group average is before the fifty percent reduction. Similarly, the HCFA methodology granted an additional $3.69 for Medical Records. This was based on the HCFA Peer Group mean cost of $2.72 compared to the Providers actual cost of $6.41. Again, the Provider has demonstrated the cost component for Social Services which is included in the RCL is $2.12, a difference of $.60, based on a similar comparison.

The Provider also makes the point that the exceptions granted should be even greater since HCFA reduced the Provider's true costs when it utilized the 75 percent utilization standard.

As part of the exception request, the Provider also requested additional reimbursement for dietary costs citing compliance with the "New National Nursing Home Reform Law", P.L. 100-203, Omnibus Reconciliation Act of 1987. The Provider cited the additional dietary assessments required by the shorter length of stay of the Provider's patients.[20] The Provider notes that these assessments are conducted both on admission and discharge, which produces atypical labor.
HCFA denied the Provider's request for additional dietary costs stating that the type of food and nutrition services the Provider provides are not atypical. It was HCFA's position that the fact that a short average length of stay requires a registered dietitian to do more work is not, in and of itself, justification for an exception. HCFA noted that the additional costs related to atypical services must be explicitly demonstrated and quantified. The Provider, however, contends it is justified in receiving additional reimbursement of $5.79 per day which is the difference between the Provider specific RCL and the Provider's actual cost for these services.[21]

HCFA also denied the Provider's request for atypical laundry and linen services. The Provider asserts that HCFA used data from a 1977 National Nursing Home Survey, and that HCFA has adopted incontinence as a standard for review with no regulatory authority. The Provider notes that this study is now almost 20 years old. HCFA is testing the exception

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[20] Tr. at 38-39.

[21] Provider Exhibit P-2, Pg.4.

request against a peer group used to develop the July 1, 1984 cost limits. The Provider contends that the 1977 National Nursing Home Survey cannot have any bearing on the statistics experienced by providers in 1984.

The Provider submitted selected portions of this Survey (Provider Exhibit P-15). The first page of the document clarifies the data is not a survey of hospital-based skilled nursing facilities: "The data presented in this report are based on the 1977 National Nursing Home Survey, conducted by the Division of Health Care Statistics of the National Center for Health Statistics. The survey was conducted from May to December 1977 in a sample of nursing homes in the conterminous United States. The survey covered all types of nursing homes, including nursing care homes, personal care homes with nursing, personal care homes, and domiciliary care homes." The Provider contends that the only acceptable standard which could be developed for the peer group is pounds of laundry. The Provider asserts that the Secretary has failed to compile these data and promulgate them into regulations and that HCFA cannot hide behind a 1977 National Nursing Home Survey to cover this failure.

The Provider also points out that in July 1994, HCFA published new Intermediary instructions for review of skilled nursing exception requests (Transmittal No. 378, July 1994). The Provider contends that HCFA appears to have relaxed the incontinent requirement. The Provider Reimbursement Manual, Part 1, §2534.10(F) reads:

> F. Atypical Laundry Cost. An exception may be granted if the provider can demonstrate (1) a higher than average number of incontinent patients; computed as the provider's laundry per diem cost in excess of the peer group laundry per diem cost, or (2) the rendering of rehabilitation care with a high percentage of patients discharged home which necessitates utilization of personal clothes that are cleaned by the provider. The exception is computed as the lesser of the percentage of Medicare patients receiving rehabilitation and utilizing personal clothing times the provider's laundry per diem cost or the provider's laundry per diem cost in excess of the peer group laundry per diem costs."

Id.

It is the Provider's position that it is clear that HCFA does not in fact, have reliable, verifiable standards adopted against which to measure atypical laundry and linen services, and these standards have not been promulgated in the regulations. The Provider contends that the study was not a study of laundry expenses in hospital based SNFs, but a study of other types of providers, most notably domiciliary care homes.[22] The Provider argued at the hearing that because of its extremely short length of stay, a complete change over in linens occurred more

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[22] Transcript ("Tr") at 70.

frequently than in other SNFs.[23] The Provider also argued that because of the type of patients it services, there was a need for isolation gowns which were twice the cost of normal gowns.[24] The Provider also testified regarding its specialized bathroom training procedures and how these would be more costly than other SNFs.[25]

In addition, the Provider argues that the standards with which HCFA denied its request in the laundry area did not come from data in the 67 urban facilities which HCFA asserts that are in its peer group.[26] Based on HCFA's calculations, the Provider's laundry and linen costs exceeded HCFA's Peer Group by $.90 per patient day. (Provider Exhibit P-1, pg. 11) Based on the Provider's calculations, the Provider's costs exceeded HCFA's Peer Group by $2.15. (Provider Exhibit P-2, pg. 3) The Provider is therefore requesting the Board to grant its exception request of $2.15 per day.

In the original request, the Provider had also requested additional reimbursement for General and Administrative expenses citing the accumulated costs associated with atypical nursing salaries and other expenses as well as marginal accounting costs related to the short length of stay. With the exception of $3.76 per patient day which was granted for the nursing salary differential only, HCFA has ignored this component of the request. The Provider's calculations indicate the Provider was over the cost of the HCFA Peer Group by $9.88 per patient day.

In summary, the Provider requests the Board to overturn HCFA's decision and grant it a full exception.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it reviewed the information supplied by the Provider and forwarded it to HCFA in accordance with Medicare regulations and program instructions. Further, that HCFA, rather than the Intermediary, is the deciding entity with respect to RCL exception applications. Because HCFA's determination is in accord with Medicare law, regulations and manual instructions, it should be upheld.

The Intermediary believes the central issue in this case is an attack by the Provider on HCFA's regulations and the methodology used to determine cost under the exceptions, a methodology that has been sustained with essentially similar issues brought by the Provider in

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[23] Tr. at 28.

[24] Id.

[25] Tr. at 36-37.

[26] Tr. at 75.

the two previous years.[27] The Intermediary contends that the earlier cases were decided correctly.

The Intermediary contends that since there has been nothing materially different presented in the Provider's exception request, HCFA's decision on limited relief on specific subjects should stand.
The Intermediary believes the amounts determined by HCFA are consistent with the law, regulations, and manual provisions that implement the routine cost exception calculations.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law:

42 U.S.C. § 1395yy et seq.	-	Payment to Skilled Nursing Facilities for Routine Service Costs

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

§§405.1835-.1841	-	Board Jurisdiction
§413.30 et seq.	-	Limitations on Reasonable Costs

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

§ 2530 et seq.	-	Inpatient Routine Service
(As requested by Transmittal No. 378, July, 1994)		Cost Limits for Skilled Nursing Facilites
§2534	-	Request for Exception to SNF Cost Limits

4. Other:

47 Fed. Reg. 42894 (September 26, 1982).

51 Fed. Reg. 11234 (April 1, 1986).

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[27] Tr. at 12.

Deficit Reduction Act of 1984 § 2319.

Senate Finance Committee Report accompanying Pub. Law 92-603.

New National Nursing Home Reform Law, Pub. Law 100-203.

1977 National Nursing Home Survey

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND DISCUSSION:

The Board majority, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and the Provider's post hearing brief finds and concludes as follows:

The Provider requested an exception to the SNF RCL for its fiscal year ending August 31, 1989, pursuant to the regulations at 42 C.F.R. § 413.30(f). Before HCFA made a determination that the costs incurred in excess of the Provider's cost limits were due to atypical services, it reviewed the Provider's cost report to ensure that the excess costs were not the result of inefficiencies in operation or excess staffing. HCFA found that the Provider's occupancy level (73.9 percent) was below an average it considered reasonable and consequently adjusted the Provider's costs to the 75 percent level. The adjustment reduced the Provider's per diem cost from $184.98 to $183.85.[28]

After the occupancy adjustment, HCFA, utilizing a uniform peer group to evaluate and quantify the Provider's costs, granted part of the exception sought and denied relief for excess nursing administration costs, dietary costs, laundry and linen costs, and a portion of the administrative and general costs which the Provider contends were associated with atypical nursing hours.[29] With respect to the denial for atypical nursing administration costs, HCFA found that the Provider had not submitted enough documentation to demonstrate the cause for these higher costs as they relate to patient care. For the atypical dietary costs claimed, HCFA found that the nutritional services furnished by the Provider were not atypical and that the claimed excess costs were not explicitly demonstrated and quantified.[30] HCFA also granted the Provider a portion of the general and administrative costs tied to atypical nursing hours.[31] HCFA indicated that the balance of these administrative and general costs must be

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[28] Compare Provider Exhibit 2, pg. 3, col. D. to Provider Exhibit 2, pg. 4, col. D.

[29] Provider Exhibit 10.

[30] Id. at 4.

[31] Id. at Exhibit B line 10.

specifically identified and justified as they relate to atypical patient care. Last, HCFA denied an exception for laundry and linen costs based on a lack of documentation to justify those costs over those of the peer group, particularly because a greater utilization of services does not automatically translate into atypicality. [32]

It is the Provider's position that the central issue related to this appeal is whether the Intermediary and HCFA imposed conditions which are not contained in the regulations at 42 C.F.R. §413.30 to determine the Provider's additional reimbursement. In particular, the Provider challenges HCFA's determination on two bases. First, the Provider takes exception to HCFA's adjustment for occupancy in making its final determination. The Provider contends that this occupancy standard has never been promulgated into the regulations. And second, the Provider contends that when HCFA considers the merits of an exception from the RCL, it compares the Provider's components of cost (adjusted to 75 percent utilization) to the components of the "limit" that was calculated using the 112 percent of the peer mean group, and not the RCL as defined in the regulations. The Provider contends that by using the HCFA methodology, even when HCFA recognizes atypical services, it can never recover the portion of its cost that is above the true RCL and below the 112 percent limit which HCFA uses in determining exceptions.

The Board majority concludes that except for the denial of dietary costs, HCFA's determination of the Provider's request for an exception to the SNF RCL was proper and in accordance with Medicare regulation. HCFA establishes the cost limits pursuant to regulation utilizing a number of factors. 42 C.F.R. § 413.30(b). Specifically, HCFA uses data obtained by classifying providers according to the type of services furnished, geographical area, size, nature and mix of services rendered, and patient case mix. In addition, "[e]stimates of costs necessary for the efficient delivery of health services . . . based on costs reports or other data providing indicators of current costs are also considered." Id. Adjustment to the limits is made only to the extent that the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary. Id. at subsection (f). Therefore, in order for the Provider here to receive an exception based on atypicality, each routine service cost must be specifically described and identified in terms of its atypicality, compared to other similarly situated providers, and then quantified. Id. at subsections (1) (i) and (ii).

The Board first addresses the Provider's challenge to HCFA's adjustment for low occupancy. Before considering exceptions for individual cost components, HCFA adjusted the Provider's occupancy from 73.9 percent to 75 percent. The Board finds that HCFA has relied on a Congressional report (Report of the Senate Finance Committee accompanying Public Law 92-603) in which low occupancy is specifically mentioned as an area in which HCFA should

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[32] Id. at 5.

consider when establishing cost limits.[33] The Board notes that the average national occupancy level for skilled nursing facilities was over 90 percent,[34] therefore, HCFA's adjustment increasing the Provider's level to 75 percent did not appear to be unreasonable. In addition, the Board notes that HCFA recognized that the 75 percent level is not an absolute occupancy standard and offered to reevaluate its adjustment if the Provider could offer additional support for its lower occupancy.[35] The Board also points to HCFA Pub. 15-1 § 2534.5A which states in part:

> [l]ow occupancy 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.. . . Accordingly, the 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 perdiem costs, by cost center, are adjusted to reflect its perdiem equivalent at the 75 percent occupancy rate.

Id.

Based on the above, the Board finds that contrary to the Provider's argument, HCFA was not restricted from using the 75 percent occupancy rate. The Board finds there is nothing in the record to indicate that the Provider provided sufficient additional support for HCFA to reevaluate its adjustment.

The Provider also challenges HCFA's use of the 112 percent of the peer mean group rate as a "limit" and not the RCL as the "limit" as defined in the regulations. The Board majority finds that Section (c) of the Statute gives HCFA great flexibility in setting limits. The Board majority refers to 42 U.S.C. § 1395yy (c) which states:

> [t]he Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate, based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

Id.

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[33] Provider Exhibit 10 at 2.

[34] Id., see also HCFA Pub. 15-1 § 2534.5A.

[35] Provider Exhibit 10 at 2.

Although the Board majority finds that the above statute gives HCFA broad discretion to authorize adjustments to the cost limits, the Board majority notes that this statute also requires the Secretary to establish limits. The Board majority finds that there is nothing in evidence that this was done or that providers were given notice of the limits.

The Board majority also finds that the regulation affords HCFA a two prong test in which it can compare costs and types of services. 42 C.F.R.§ 413.30(f)(1). The Board majority also notes that HCFA's methodology of using of 112 percent of the hospital based peer mean group when reviewing exception requests is supported in the Program instructions. HCFA Pub. 15-1 § 2534.5B. Therefore, based on the above analysis of the statute, regulation and program instruction, the Board majority concludes it was not unreasonable for HCFA to use the 112 percent of the hospital based peer mean group when reviewing exception requests.

Next, the Board addressed the individual component costs at issue, specifically the Provider's entitlement to exceptions for nursing administration, dietary, laundry and linen costs, and additional general and administrative costs which the Provider contends were associated with atypical nursing hours. With respect to nursing administration costs, the Board rejects the Provider's argument that because HCFA recognizes that the Provider is entitled to additional reimbursement because of atypical nursing hours, then it should follow logically that the Provider is entitled to additional nursing administration expense. The Board finds that HCFA's reason for denying these costs was a lack of supporting documentation on the Provider's part. The Board also finds that HCFA informed the Provider that it could submit additional documentation describing the causes for higher costs as they relate to patient care. The Board concludes that there is no evidence in the record to indicate that satisfactory documentation was ever presented to HCFA.

With respect to dietary costs, the Board finds that testimony at the hearing associated with Board member questions, supports the Provider's claim.[36] First, the Provider substantiated the atypical nature of the diet required for the patients at its facility compared with the diet provided in a traditional SNF. The testimony given at the hearing evidenced a number of factors that distinguished the Provider's dietary services from those of traditional SNFs. Further, because the primary focus of the Provider was to provide rehabilitative services to stroke, brain injury, and amputee patient populations, it was required to furnish dysphagia and total peritoneal nutrition kind of diets.[37] The high protein and nutritional caloric nature of the diets was necessary to supply the patient the energy level for the participation in intense rehabilitative programs.[38] Accordingly, the Board concludes that HCFA's denial of an exception for the Provider's dietary costs should be reversed.

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[36] Tr. at 28-33, 37-39.

[37] Tr. at 29-30.

[38] Tr. at 30.

With respect to the Provider's claim for laundry and linen costs, the Board concurs with HCFA's determination. The Provider failed to substantiate that its excess costs over the peer group per diem were associated with the special needs of its patients and are necessary in the efficient delivery of needed health care. The Provider claims the incurred costs are due to a greater utilization, but fails to specify the cause for the increased utilization and the additional costs. The Board agrees with HCFA that a greater utilization of laundry services in the SNF portion relative to other units within the hospital complex is not justification for an exception for these cost centers. The Board also notes HCFA's offer that if the Provider could show that its percentage of incontinent patients exceeds the average percentage of incontinent patients, an exception may have been justified. The Board finds nothing in the record that the Provider provided this documentation to HCFA.

Finally, with respect to the Provider's claim for additional administrative and general costs which the Provider contends were associated with atypical nursing hours, the Board finds that the Provider failed to provide HCFA with enough documentation to support a full exception in this area. The Board notes that HCFA did in fact grant the Provider a partial exception for "other expenses" relates to atypical nursing services. In particular, HCFA granted the Provider an additional $3.76 for administrative and general costs and $.27 for employee health and welfare costs associated with atypical nursing. The Board affirms HCFA's position that additional expenses in this category must be specifically identified and justified as they relate to atypical patient care. Without this additional documentation, the Board agrees with HCFA that no additional exception amount would be granted.

DECISION AND ORDER:

The Board finds that the Provider is entitled to an exception for its excess dietary costs. HCFA's determination with respect to the Provider's dietary costs is reversed. The Board finds that the methodology used by HCFA to assess the Provider's low occupancy was in accordance with the statute, regulation, and program instructions, and was therefore proper. The Board majority finds that it was appropriate for HCFA to use 112 percent of the hospital based peer mean group when reviewing exception requests. The Board finds that there is insufficient documentation in the record to support the Provider's claim for additional nursing administration, laundry and linen, and general and administrative costs. HCFA's determination in these areas is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq. (Dissenting in part)
Charles R. Barker

Date of Decision: February 18, 1999

For The Board

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover Jr.

I respectfully dissent:

The Provider contends that it is entitled to be paid the entire amount of its costs in excess of the cost limit.

In part, 42 U.S.C. § 1395yy(a)(3) states:

> With respect to hospital based skilled nursing facilities located in urban areas, the limit shall be equal to the sum of the limit for free standing skilled nursing facilities located in urban areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital based skilled nursing facilities located in urban areas exceed the limit for free standing skilled nursing facilities located in urban areas.

42 U.S.C. § 1395yy(a)(3)

The plain language of the statute establishes the cost limits for hospital based skilled nursing facilities located in urban areas.

The implementing regulation 42 CFR § 413.30(a)(2) states in part:

> HCFA may establish estimated cost limits....

This regulation appears to be, in my opinion, contrary and in conflict with the statute since the regulation grants to HCFA that which has heretofore been established.

The Board majority finds that section C of the statute gives HCFA great flexibility in setting limits. The Board majority refers to 42 U.S.C. § 1395yy which states:

> [t]he Secretary may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary deems appropriate based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.

It is my opinion that this section is limiting rather than discretionary since only two types of adjustments are permitted, adjustments based upon case mix or circumstance beyond the control of the facility.

It is noted that in the St. Francis Health Care Center v. Community Mutual Insurance Company, PRRB Dec. No. 97-D38, dated March 24, 1997, the Board found for the provider using in part the following:

> [t]he Board finds that the Provider's requests should not have been denied. HCFA's comparison of the Provider's routine service cost per diem to the 112 percent level is inconsistent with both the statute and regulation. In addition, HCFA's comparison confuses the concept of "atypical costs" with the concept of "the cost of atypical services," and produces results that are seemingly unsound.
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> Contrary to HCFA's exception methodology, which fails to reimburse HB-SNFs for routine service costs that exceed the limit but are less than the 112 percent level (the gap), the Board finds that 42 U.S.C. § 1395yy entitles SNFs, either freestanding or hospital-based, to be paid the full amount by which their costs exceed the applicable cost limit. In part, 42 U.S.C. § 1395yy(a) states:

> [t]he Secretary, in determining the amount of the payments which my be made under this title with respect to routine service costs of extended care services shall not recognize as reasonable. . . per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section . . .

42 U.S.C. § 1395yy(a).

The Board also finds there is no authoritative basis supporting HCFA's reliance upon the 112 percent peer group per diem to determine the amount of a HB-SNF exception. As discussed above, reliance upon the 112 percent level effectively increases the amount or level a provider's cost must exceed before it may be granted an exception. The Board finds it inappropriate for HCFA to establish and rely upon an amount greater than the limit established by Congress as it would find it inappropriate for HCFA to introduce a methodology that would effectively reduce the limits set by Congress.

The Board notes that 42 C.F.R. § 413.30 provides HCFA with the general authority to establish cost limits. In part, the regulation states "HCFA may establish limits on provider costs recognized as reasonable in determining program payments. . . . Id. The regulation goes on to state that "HCFA may establish estimated cost limits for direct overall costs or for costs of specific items or services. . . . Id. However, the Board finds that the cost limits applicable to SNFs are not presented in the regulations or in HCFA's manual instructions; Congress has superseded HCFA's authority to establish cost limits with respect to SNFs by statutorily mandating them.

St. Francis PRRB Dec. No. 97-D38.

I concur with the findings and conclusion of the Board in the St. Francis case.

It is my opinion that the methodology used by HCFA to determine the amount of the exception from the routine service cost limits for hospital based skilled nursing facilities is not proper and the denial by HCFA of the Provider's request for full exception to the routine service cost limits should be reversed.

Martin W. Hoover, Jr