PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D46

PROVIDER -
Stouder Memorial Hospital Subacute Unit
Troy, Ohio

vs.

Provider No. 36-6007

INTERMEDIARY -
Administar Federal and Anthem Insurance Companies/Blue Cross and Blue Shield Association

DATE OF HEARING-
December 14, 1999

Cost Reporting Period Ended -
December 31, 1995

CASE NO. 97-2385

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ISSUE:

Is the Provider entitled to an exemption from the routine cost limits as a new provider under 42 C.F.R. ' 413.30(e)?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Stouder Memorial Hospital (ASMH@) is a 138-bed community hospital located in the city of Troy and county of Miami, Ohio. SMH decided to develop a hospital-based skilled nursing unit in the early 1990s. At the time, the State of Ohio had imposed a moratorium on the addition of any new nursing home beds.[1] Therefore, SMH decided to acquire existing nursing home beds and relocate them to their facility. SMH identified the Johnson Nursing Home (AJNH@) as a potential seller of nursing home beds.[2] JNH became a participating provider in the Medicaid program in 1972, but never participated in the Medicare program.[3] In 1983, JNH withdrew from participation in the Medicaid program and admitted only private pay patients from that point forward until it closed in August, 1994.[4] In January, 1994, SMH filed its application for CON approval to relocate the JNH beds and it was approved by letter dated December 14, 1994.[5] SMH=s distinct-part skilled nursing unit is the subject of this appeal (AProvider@).

On May 5, 1995, the Provider received nursing home licensure for its 18-bed distinct part unit from the Ohio Department of Health.[6] The Provider admitted its first patient shortly thereafter,[7] and was ultimately certified for participation in the Medicare program on May 19, 1995.[8] The Provider=s first fiscal year was from May 19, 1995 through December 31, 1995. By written request to Administar of

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[1] Tr. at 55.

[2] Tr. at 21.

[3] Id.

[4] Id

[5] Intermediary Exhibit 14.

[6] Provider Exhibit 3.

[7] Tr. at 31.

[8] Provider Exhibit 4.

Ohio, the fiscal intermediary for Ohio (AIntermediary@), the Provider formally requested an exemption from the routine cost limits as a Anew provider@ pursuant to 42 C.F.R. ' 413.30(e).

The Provider provided information requested by the Intermediary to process its request for exemption including a five-page questionnaire relating to the background and services provided at JNH.[9] The questionnaire included a AProvider Services Survey@ which lists ten services that are considered to be Askilled@ nursing or rehabilitative services and asks when and if they were provided at JNH, all of which were answered in the negative.[10] The information was provided by the prior owner of JNH. Indeed, Provider was given no records or documentation from the prior owner of the JNH that would enable a further response to the questionnaire. The Provider confirmed this with the Intermediary by letter dated October 22, 1996.[11] The Provider also submitted the same questionnaire for its newly-opened unit.[12]

The Provider's exemption request was forwarded by the Intermediary to the Health Care Financing Administration (AHCFA@), apparently without any recommendation from the Intermediary.[13] In addition, HCFA reviewed and considered two surveys of JNH conducted by the Ohio Department of Health, one on August 25, 1992, and one on August 12 and 13, 1993.[14] HCFA also reviewed and considered the Provider's certificate of need application, and certain requested patient admission and discharge information from JNH, which was submitted to the Intermediary on August 1, 1996.[15] The above information constituted the factual information considered by HCFA in rendering its decision.[16]

By letter dated November 25, 1996, HCFA denied the Provider's exemption request.[17] The letter cited three reasons for the denial, only one of which is in dispute. It states that:

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[9] Provider Exhibit 1.

[10] Id.

[11] Provider Exhibit 2.

[12] Provider Exhibit 3.

[13] Tr. at 166.

[14] Provider Exhibits 11A and 12A

[15] Intermediary Exhibits 12 and 20.

[16] Tr. at 165-168.

[17] Intermediary Exhibit 34.

> Johnson Nursing Home operated as a[n] ICF from 1972 to 1983. In 1983 the facility withdrew from the Medicaid program and admitted only private pay patients until the date of closure in August of 1994. Surveys conducted in 1992 and 1993 by the Ohio Department of Health show that skilled nursing and rehabilitative services were provided by Johnson Nursing Home for three or more years prior to its closure in August of 1994. These services included, but were not exclusive of, caring for patients with complex medical conditions such as diabetes and conditions requiring gait training as well as the treatment of pressure ulcers. Therefore, Johnson Nursing Home is an equivalent provider of skilled nursing or rehabilitative services.[18]

While the Provider was not granted approval for an exemption, it was permitted to apply for an exception to the routine cost limits (ARCLs@) as provided in 42 C.F.R. ' 413.30(f). The Provider also applied for and received approval for exceptions in fiscal years 1995 and 1996.[19] The exception approvals did not cover all of Provider's costs in these years, which costs have already been audited for reasonableness.[20] Even with approval of the exception, the Provider experienced $601,872.80 in unreimbursed Medicare costs for fiscal year 1995; additional amounts can be calculated for subsequent years.[21]

The Provider appealed HCFA=s denial to the Provider Reimbursement Review Board (ABoard@) pursuant to 42 C.F.R. '' 405.1835-.1841, and has met the jurisdictional requirements of those regulations.

The Provider was represented by James F. Flynn, Esquire, of Bricker and Eckler, LLP. The Intermediary was represented by James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that in establishing the Medicare program, Congress determined that health care providers furnishing services to Medicare patients are to be reimbursed the reasonable cost of providing such services. 42 U.S.C. ' 1395x(v). AReasonable costs@ are defined in pertinent part as

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[18] Id. at 3.

[19] Intermediary Exhibits 31 and 32.

[20] Tr. at 80.

[21] Tr. at 65-66.

Athe 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 Y@ 42 U.S.C. ' 1395x(v)(1)(A).

Congress thereby authorized the Secretary of Health and Human Services (ASecretary@) to promulgate regulations to implement the reasonable cost statutory provision. The foregoing principles are further explained in the Medicare regulations at 42 C.F.R. '' 413.5 and 413.9. Congress authorized the Secretary to promulgate regulations to prospectively establish limits on the amount of costs recognized as reasonable in furnishing patient care. The Secretary implemented a method to limit costs, commonly referred to as the RCLs, in the regulations contained at 42 C.F.R. ' 413.30.

The Provider asserts that from the time it was first certified for Medicare participation, it experienced costs which far exceeded the RCLs. Accordingly, the Provider applied for an exemption under the regulation which provides as follows:

> (e) **Exemptions.** Exemptions from the limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that 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.

42 C.F.R. ' 413.30(e).

The Provider notes that Athe intent of the new provider exemption is to allow a provider to recoup the higher costs normally resulting from low occupancy rates and start-up costs during the time it takes to build its patient population.@ See Maryland General Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Maryland, PRRB Case No. 99-D69, September 20, 1999, Medicare and Medicaid Guide (CCH) & 80334, rev=d, HCFA Administrator, November 22, 1999, Medicare and Medicaid Guide (CCH) &80,406.

The Provider contends that it meets both the letter and intent of the new provider exemption. HCFA denied the Provider's exemption request because it found JNH to be an equivalent provider of skilled nursing or rehabilitative services. In both the denial letter and testimony before the Board, HCFA confirmed that the sole bases for this finding are the two Ohio Department of Health survey reports.[22] Thus, the issue before the Board is whether JNH provided skilled nursing or rehabilitative services during the pertinent time periods.

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[22] Provider Exhibits 11A and 12A and Tr. at 165-166 and 193.

The Provider contends the record before the Board is devoid of any support for HCFA's finding that JNH provided skilled nursing services. The Provider contends that HCFA=s findings of skilled nursing care are based on assumptions, presumptions or suppositions which are not supported by the record. To the contrary, the Provider presented a vast amount of evidence about JNH, its patient population, the capabilities of its staff and the types of services available and provided. Each of the descriptions of JNH consistently depict a non-institutional facility that provided the equivalent of a supervised home setting. The Provider witness that visited JNH provided the following description.

> Well, my first visit to Johnson Nursing Home I was surprised. I wasn't really expecting to see a house. It was an old brick home that had been obviously added on to over the years. And I entered through the kitchen, which is where the back door was. And there were residents milling around in the kitchen. And it's just your typical old home where the rooms are attached to each other. And it didn't give me the feel of a nursing home. It was more what we would describe today as assisted living. That's what it appeared like to me. More like kind of a sorority/fraternity house atmosphere.[23]

The Provider also presented testimony from a physician who regularly had patients and visited JNH monthly in the late 1980s and early 1990s. His first-hand description of the facility was as follows.

> The best way I can describe Johnson Nursing Home is that it reminded me of my grandmother's house when I went to visit. **Y** Going into the kitchen, they had a gas stove as you would see in a house, and with large kettles of food usually cooking. Usually, some of the patients would be sitting at the kitchen table that was identical to a kitchen table that probably any of us would have in our house, and more probably appropriate of what I remember in my grandmother's house.
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> The rest of the rooms were make-do rooms. As you've seen on the blueprints, they had I think from two to maybe four or five patients within a room. There were not dividers that were typically in place on an ongoing basis. And there was a slight amount of room in between the beds.[24]

The physician witness also confirmed that JNH was the only long-term care facility in Miami

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[23] Tr. at 22-23.

[24] Tr. at 92-93.

County that operated out of a converted home.[25] The Provider presented descriptions of the facility,[26] a floor plan and photos of the JNH building and certain of the rooms also exist in the record.[27]

The primary factual dispute between the Provider and the Intermediary pertains to what services were provided at JNH, particularly during the period between May, 1992 (three years prior to Provider's unit being certified) and August, 1994, when JNH closed. The Provider presented testimony of a physician familiar with JNH and its patients. The physician lived in Miami County virtually his whole life and practiced as a family practice physician for 15 years from 1981 to 1996.[28] He saw patients at JNH starting in the mid-1980s and continuing into the 1990s.[29] He also served as JNH's medical director from approximately 1989 to 1991.[30]

The Provider indicated that the Intermediary witness was a Health Insurance Specialist with HCFA's Division of Institutional Post-Acute Care with limited experience with HCFA and no health-related education or experience, except for working as a nursing assistant in a Pennsylvania nursing home from 1988 to 1989.[31] The Intermediary witness, who was responsible for reviewing and recommending the decision on Provider's exemption request,[32] indicated that her testimony concerning the services provided at JNH was based on the two survey reports obtained from the Ohio Department of Health licensure files.[33] She had never been to JNH.

The physician witness described the patient population at JNH as follows:

> There were no patients that had serious, significant illnesses there that required intensive treatment as in comparison to the other nursing facilities that I was alluding to, who did provide those

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25 Tr. at 94-95.

26 See Provider Exhibit 13 at 12-15.

27 Provider Exhibits 13, at 32 and 33; 14 and 15, first three pages of addendum.

28 Tr. at 87-88.

29 Tr. at 89.

30 Tr. at 90.

31 Tr. at 141 and 175.

32 Tr. at 141-142.

33 Tr. at 166-168.

> services for patients.[34]

In fact, if asked by a patient or family about JNH, the physician testified:

> I think I tried to make sure that they knew what the alternatives were for them. **Y** I think that, if they were looking for a family atmosphere, if they were looking at something that more resembled [a] home than a hospital, then Johnson's was a reasonable alternative. I think it was also described that along with that homey atmosphere there were not all [of] the other things that were available at other facilities.[35]

The Provider pointed out that persons providing services to JNH patients were predominantly nurse aides (also sometimes referred to as nursing assistants). A nurse aide is not a licensed professional but rather a Anon-trained person that is hired and trained on the job@ and who typically is in a pay range which is Acomparable to many of the fast food places.@[36] The Intermediary witness acknowledged that a nurse aide was not trained or capable of providing any service which would be considered Askilled.@

There also is no dispute that JNH provided absolutely no rehabilitative services, including such things as physical therapy, speech therapy or occupational therapy.[37] There was no space to provide any type of therapy services within the JNH facility.[38] The Provider's physician witness testified that if a patient needed physical therapy, he or she would be transferred to another facility.[39]

The record evidence identifies only two licensed professionals as providing any services at JNH. The physician witness testified about one full-time nurse who was Aeither an R.N. or an LPN@ who Awas there Monday through Friday during the daytime hours.@[40] The second person identified was the wife owner of JNH who was believed to be an R.N., but whose role was limited to Apitch in

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34 Tr. 96-97.

35 Tr. at 110-111.

36 Tr. at 98-99.

37 Tr. at 99-100.

38 Id.

39 Id.

40 Tr. at 97.

when [the full-time nurse] was sick or out and provide some backup services@ as the husband owner also did occasionally.[41] The only reference to a Anurse@ in the two Ohio Department of Health surveys was the lack of a nurse on duty at required times.[42]

In sum, the physician witness described the staff as Anice people, good people, [who] cared for the people very well.@[43] He also stated that:

> their skill level was low. And I think, that as a physician, I could not depend on their abilities to assess the changes in patients. They might be able to tell me they don't look just quite right, or they now have a temperature of 103, but some of the critical thinking skills that go into skilled nursing, that make it a reimbursable service that someone=s put a value on were not there at this facility.[44]

In determining whether skilled nursing services were provided at JNH, the parties agree that 42 C.F.R. ' 409.33, entitled, AExamples of skilled nursing and rehabilitation service,@ should serve as the basis for any such determination.[45] It should be noted that this regulation was amended effective July 1, 1998.[46] Both sub-sections that the Intermediary relied upon heavily in this case were deleted by the amendments. The July 1, 1998 amendment deleted the first section of the old rule entitled AServices that could qualify as either skilled nursing or skilled rehabilitation services.@ Two sub-sections contained in the deleted section were sub-sections entitled AOverall management and evaluation of care plan@ and AObservation and assessment of the patient's changing condition.@ Thus, the Secretary no longer considers these services to be Aexamples of skilled nursing and rehabilitation services.@ Accordingly, the Intermediary=s reliance upon the old version of the rule in these proceedings is improper.

Even assuming that the Board should apply the old version of the rule to the facts of this case, the Provider contends that finding skilled nursing services requires more than matching up words in the regulations with words in the Ohio Department of Health survey reports. For example, the Intermediary=s witness pointed to references in the survey reports to a Aplan of care.@ Contrary to

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41 Id.

42 See Provider Exhibit 12A at 5.

43 Tr. at 114.

44 Id.

45 See Provider Exhibit 10.

46 Id.

the Intermediary's use of this term, the regulation qualifies this term with attributes such as the required involvement of licensed personnel and an intent to promote recovery. The regulation states:

> (1) Overall management and evaluation of care plan. The development, management, and evaluation of a patient care plan based on the physician's orders constitute skilled services when, because of the patient's physical or mental condition, those activities require the involvement of technical or professional personnel in order to meet the patient=s needs, promote recovery, and ensure medical safety. . . . Although any of the required services could be performed by a properly instructed person, such a person would not have the ability to understand the relationship between the services and evaluate the ultimate effect of one service on the other. . . . Therefore, if the patient=s overall condition would support a finding that recovery and safety can be assured only if the total care is planned, managed and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided.

42 C.F.R. ' 409.33(a)(1).

The Provider points out that the regulation requires a careful analysis of situations involving the management of a care plan before skilled nursing services can be inferred. The Provider contends that HCFA inferred skilled nursing services were provided merely by the appearance of the words Aplan of care@ in the survey reports. However, the additional attributes described above do not appear in and cannot be inferred from the survey reports.

The Provider's physician witness testified about his actual knowledge and experience at JNH. He testified that JNH kept charts on patients but had no care plans.[47] The charts, he indicated, recorded Aphysician orders, progress notes and other notations made by staff, which mainly dealt with periodic vital signs and occasional comments@ about major events.[48] When asked about the development of care plans for a particular patient, the physician witness indicated that:

> [i]t very much again I think depends on the patient, the family and what the goals were in trying to provide that care. I think that looking at it from a solely academic standpoint very much so. I think that probably we would all agree with that. But, the realities are that those patients in this facility did not always want agressive

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[47] Tr. at 95

[48] Id.

> treatment, did not want things very much necessitate a care plan to be both developed and very closely followed, monitored or altered as either progress or lack of progress occurred. [49]

Further, when asked what a plan of care might involve for this same patient, the physician described activities which JNH did not have the capability of providing, such as the services of a dietician.[50] In fact, the physician indicated that the diabetic patient would require close monitoring of the diet. The Provider notes that the Ohio Department of Health survey report indicates that JNH staff altered caloric intake by Acutting back a little.@[51]

The Provider points out that HCFA's denial letter cited the provision of Agait training@ as evidence that JNH provided skilled nursing services. This appears to be based on a nursing note cited in one survey that Athe resident ambulated per self, that the gait was unsteady, and the resident would need assist.@[52] The Provider contends that this reference only indicates that the resident needed assistance with ambulation but does not indicate that professional gait training occurred. The physician witness confirmed this, stating that he had never known gait training to ever have occurred at JNH, nor would JNH staff have the capability of providing that service, nor would there be any place for any such training to occur at JNH.[53] The Provider contends there is absolutely no support in the record for this HCFA finding.

HCFA also pointed to references in the survey reports to "pressure ulcers" as examples of skilled nursing services provided at JNH. Once again, Provider contends that HCFA is doing little more than matching words. Reference to the treatment of skin sores actually exists at two places in the regulation (the contents are the same for both the old and current rule). Under AServices that qualify as skilled nursing services,@ the following description is given: ATreatment of extensive decubitus ulcers or other widespread skin disorder.@ 42 C.F.R. '409.33(a)(6) (current rule) Another reference exists under the definition of Apersonal care services.@

> (c) Personal care services. Personal care services which do not require the skills of qualified technical or professional personnel are not skilled services except under the circumstances specified in '409.32(b). Personal care services include, but are not limited to, the following:

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49 Tr. at 120.

50 Tr. at 126.

51 See Provider Exhibit 11A and Tr. at 112-113.

52 Provider Exhibit 12A at 2

53 Tr. at 101.

> . . .
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> (5) Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

42 C.F.R. '409.339(c) (current rule).

Provider contends the interpretation of the HCFA representative that Aevery@ pressure ulcer requires skilled nursing services is not supported by the rule.[54] The Provider's physician witness gave a detailed description of pressure ulcers, their degrees, and how they can be treated.[55] By definition, a pressure ulcer is merely a breakdown of the skin; however, this can progress to varying degrees of severity. The physician witness confirmed that not all pressure ulcers were treated with skilled nursing services; in fact, he recounted patients who had Aterrible ulcerations@ treated at home without going to a skilled nursing facility and without home health.[56]

The Intermediary has pointed to two references in the survey reports which discuss pressure sores. The first entry cited by the Intermediary is as follows.

> On June 25, 1992, it was noted in the nurses notes that a resident had a reddened area on the left ankle. The area measured one and one-half centimeters with an open center and a reddened area on the left side of the left foot measuring one and one-half centimeters. A treatment was initiated using standing orders. The physician was not called until June 30, 1992.[57]

The physician witness reviewed this entry and interpreted it as follows:

> I do know that it was not unusual for some physicians to have orders to start applying antibiotic, topical antibiotic ointments to changes in a skin area that there was a concern by the physician that could further break down and develop into an ulceration. And I think that

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54 Tr. at 187.

55 Tr. at 106-108.

56 Tr. at 108.

57 Provider Exhibit 11A at 2.

> this area describes an area that was open. And I would assume that the physician had orders that, if any of those were seen, to start treating with a topical medication.[58]

In fact, the physician indicated that he used standing orders just as he described them. The physician testified that he did not construe this entry, nor the entry regarding a coccyx pressure sore, to indicate that skilled nursing services were provided.[59] Indeed, Provider contends that a reddened area just over one centimeter in diameter does not constitute an Aextensive decubitus ulcer@ as defined in 42 C.F.R. ' 409.33(b)(6). Rather, the application of ointments to such sores would be more consistent with the Aapplication of creams@ under the definition of Apersonal care services.@ 42 C.F.R. ' 409.33(c)(5).

The Provider contends that the evidence in the record, when considered in its entirety, fails to substantiate and clearly demonstrate that skilled nursing services were provided at JNH. In fact, such evidence supports the opposite conclusion. The testimony of the physician indicates, from his personal experience, that he was never aware of any service provided at JNH which would constitute skilled nursing services as defined by the regulation. Moreover, the physician witness testified, from his personal experience, that the staff at JNH lacked the skills and experience to provide skilled nursing services as defined by the regulation. In fact, Provider contends that the Ohio Department of Health surveys actually illustrate the inability of JNH to provide such services.[60]

The Intermediary=s lone witness testified to many of the same clinical situations as did the Provider's physician witness but Arespectfully disagreed@ with all of his findings.[61] The Provider contends the physician=s testimony is entitled to considerably more weight and credibility as such testimony is actually based on his own personal knowledge and experiences and the documentation contained in the record. On the other hand, the Intermediary=s witness made large assumptions and readily admitted reading into and beyond the contents of the survey reports. Consider the following exchange:

> A.: [The physician=s] diagnoses most likely were in the [patient=s] medical record, which would have been done by a physician. However, the patient's changing condition occurs in the facility and then the registered nurse or the

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58 Tr. at 106.

59 Provider Exhibit 12-A at 6 and Tr. at 108-109.

60 See Provider Position Paper at 16 to 19.

61 Tr. at 178.

LPN would be required to monitor that and notice different changes in his condition, which would lead them to determining whether or not he had pneumonia.

Q.: And what here [in the survey report] indicates that they were evaluating a change? I just see that there was one blood pressure report. Is that what you're talking about?

A.: No. I don=t believe they necessarily documented everything that they did, which is a common practice.

Q.: Oh, so you're assuming that things went on that aren't documented ?

A.: Oh, absolutely.

Q.: Okay, and that helped form the basis for your decision here ?

A.: Yeah.[62]

In fact, many of this witness=' conclusions went beyond any words contained in the survey reports. The Provider contends that administrative agencies should not be permitted to make decisions in this manner.

The HCFA representative raised a new issue in her testimony relating to the effect of state licensure rules on these proceedings. Because this testimony was new and based on evidence not in the record, the parties have filed a Joint Stipulation Regarding Supplemental Authority.[63] The following discussion assumes the Board accepts such exhibit into evidence.

The HCFA representative offered testimony suggesting that Ohio licensure laws supported HCFA=s conclusion in this case. All of her conclusions regarding Ohio licensure laws were based on statutory sections she reviewed the week before the hearing ,[64] and were not part of HCFA=s initial review of the Provider=s exemption request.[65] Moreover, her review was limited to statutes and did not consider any of Ohio's administrative rules which also provide regulation of nursing home licensure in Ohio.[66] Although all of the statutes apparently reviewed by this witness are

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62 Tr. at 182-183.

63 See Provider Exhibit 48.

64 Tr. at 176.

65 See Provider Exhibit 48

66 Id.

included in the stipulation, the parties have stipulated as to those parts she relied upon for her testimony regarding skilled nursing services. The Provider contends this witness= testimony relating to Ohio licensure laws should be afforded little if any weight or credibility.

The HCFA representative suggested in her testimony that by virtue of licensure with the State of Ohio, JNH was required to provide skilled nursing services.[67] This is a complete misinterpretation of Ohio law. Ohio Revised Code (AR.C.@) ' 3721.01(A)(6) (emphasis added) defines a Anursing home@ as follows:

> ANursing home@ means a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require skilled nursing care and of individuals who require personal care services but not skilled nursing care. A nursing home is licensed to provide personal care services and skilled nursing care.

Id.

Thus, although a nursing home license allows a nursing home to provide skilled nursing care, it is not required to do so by virtue of its license. Moreover, the HCFA representative apparently ignored the statutory section which defines the conditions for issuance of a license.[68] This statute contains absolutely no reference to skilled nursing services or the requirement that such services must be provided. Thus, there is no basis to conclude that state licensure laws required JNH to provide skilled nursing services. At most, it can be concluded that JNH's license authorized it to provide skilled nursing services, but this alone does not substantiate the finding needed to support HCFA's decision in this case **C** that JNH actually did provide such services.

The HCFA representative also cited to the Ohio licensure laws to support her belief that all nursing homes in Ohio were required to have a Aplan of care@ for every resident,[69] but this citation was not included in the Joint Stipulation. In fact, none of the four sections cited as the bases for the witness= testimony contain any reference to a plan of care. The witness also mentioned laws governing residents= rights as the basis for her conclusions. The state statute at R.C. ' 3721.13 (not cited in the Joint Stipulation) represents the section governing residents= rights but still contains no requirements of a plan of care. The closest possible reference that Provider can ascertain is to subsection R.C. ' 721.13(A)(8) of that statute, which states as follows:

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[67] Tr. at 191.

[68] See R.C. ' 3721.07, Conditions for Issuance of a License, Provider Exhibit 48.

[69] See Tr. at 184 referring to R.C. '3721.121 - Criminal Record Check, Disqualification from Employment, Provider Exhibit 48.

> (8) The right to participate in decisions that affect the resident's life, including the right to communicate with the physician and employees of the home in planning the resident's treatment or care and to obtain from the attending physician complete and current information concerning medical condition, prognosis, and treatment plan, in terms the resident can reasonably be expected to understand; the right of access to all information in his medical record; and the right to give or withhold informed consent for treatment after the consequences of that choice have been carefully explained. When the attending physician finds that it is not medically advisable to give the information to the resident, the information shall be made available to the resident's sponsor on the resident's behalf, if the sponsor has a legal interest or is authorized by the resident to receive the information. The home is not liable for a violation of this division if the violation is found to be the result of an act or omission on the part of a physician selected by the resident who is not otherwise affiliated with the home.

Id.

The Provider contends it is a stretch to interpret the right to participate in his or her own medical decisions as a requirement of a plan of care.

In summary, the Provider contends that the Intermediary=s findings that skilled nursing care was rendered at JNH are not supported by conclusive evidence in the record.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends the Provider does not qualify for a new provider exemption from the RCLs under the terms of 42 C.F.R. ' 413.30(e). The regulation makes the new provider exemption available to a Aprovider of inpatient services that has operated as the type of provider (or the equivalent) or which it is certified for Medicare, under present or previous ownership, for less than three full years.@ Id.

The Intermediary argues that the phrase A. . . has operated as the type of provider. . .@ refers to whether or not, prior to certification, the institution engaged in providing skilled nursing care and related services to residents who required medical or nursing care, or rehabilitation services for the rehabilitation of injured and disabled, or sick persons= as identified in 42 C.F.R. ' 409.33(b) and (c) and did not primarily care and treat residents with mental illness. This definition of a skilled nursing facility is statutory and can be found in ' 1819(a)(1) of the Social Security Act, 42 U.S.C. ' 1395 i-3(a).

The Intermediary applied the terms of 42 C.F.R. ' 413.30(e) by first recognizing that the Provider

seeking relief was a skilled nursing facility. The Intermediary next determined the length of operation of the Provider under present and past ownership. Pursuant to HCFA Pub. 15-1 ' 2533.1(E), the sale of some or all of a providers assets used to render patient care would be considered a change of ownership. Therefore, the JNH=s sale of licensed beds to the Provider constituted a change of ownership. As a result, the Intermediary looked to see whether JNH, under present or prior ownership had operated for less than three years and whether it had provided skilled nursing services. Because JNH had operated for more than three years prior to the certification as a Medicare skilled nursing facility, the Intermediary looked at the operation of JNH to see if it provided skilled nursing services as defined at 42 C.F.R. ' 409.33 (a), (b) and (c).

To determine whether or not JNH rendered skilled nursing services prior to its Medicare certification, the Intermediary reviewed state licensure survey reports. Those reports indicated the staff of JNH had skilled nursing personnel, and that they were performing services such as: development, management and evaluation of patient care plans; observation and assessment of a patient=s changing medical condition; application of dressings involving prescription drugs; and treatment of decubitus ulcers.[70] All of those activities are considered skilled nursing services under 42 C.F.R. ' 409.33. The survey records indicate JNH treated patients with: grand mal seizures; pneumonia; chronic obstructive pulmonary disease and coronary insufficiency; diabetes and leg amputation; and pressure ulcers. The Intermediary=s witness testified that these are conditions, which obviously require skilled nursing evaluation, monitoring, and intervention. Therefore, prior to its certification as a Medicare skilled nursing facility, the Provider was operating as the same type of provider. Although JNH may not have provided skilled nursing services as frequently as a skilled nursing facility, the regulation at 42 C.F.R. ' 413.30 makes no allowance for institutions providing a low volume of skilled nursing services prior to certification as a skilled nursing facility.[71] The fact that skilled nursing services were performed, regardless of the volume, is determinative as to whether or not the exemption is available. As a result, the Provider is not entitled to a new provider exemption, as it is not a new provider under the terms of the regulations.

The Intermediary points out that the Board has confronted the same issue in Milwaukee Subacute and Rehabilitation Center v.United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, Medicare and Medicaid Guide (CCH) & 46,224, HCFA Administrator, declined review, June 8, 1998; Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/Administar Federal, PRRB Dec. No. 98-D64, February 10, 1998, Medicare and Medicaid Guide (CCH) & 80,006, HCFA Administrator, declined review, August 7, 1998, aff=d No. C-1-98-547 (S.D. Ohio W.D. June 16, 1999) (AMercy St. Teresa Center@) and South Shore Transitional Care Center v. Blue Cross and Blue Shield Association/ C&S Administrative Services, PRRB Dec. No. 99-D38, April 21, 1999 Medicare and Medicaid Guide (CCH) &80,182, HCFA Administrator, declined review, June 21, 1999. In all of these decisions, the Board affirmed HCFA=s application of 42 C.F.R. ' 413.30 in determining that a new provider exemption was not appropriate.

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[70] Tr. at 156-161.

[71] Tr. at 162.

Further, the decision in Mercy St. Teresa Center, supra, was affirmed by the U.S. District Court. In that decision, the district court found that the provider, prior to its certification as a Medicare skilled nursing facility, had provided some skilled nursing services and was therefore providing equivalent services prior to certification. The court then upheld the Board=s determination that Mercy St. Teresa Center, supra, was not a new provider under 42 C.F.R. ' 413.30 and was not entitled to a new provider exemption.

CITATIONS OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

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

' 1395i-3(a)	-	Definition of Skilled Nursing Facility
' 1395x(v) et seq.	-	Reasonable Costs

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

'' 405.1835-.1841	-	Right to Board Hearing - Time, Place, Form and Content of Request or Board Hearing
' 409.33 et seq.	-	Examples of skilled nursing and rehabilitation services.

(Both pre and post July 1, 1998)

' 413.5	-	Cost Reimbursement: General
' 413.9	-	Cost Related to Patient Care
' 413.30 et seq.	-	Limitations on Reimbursable Costs

3. Provider Reimbursement Review Manual - HCFA Pub. 15-1:

' 2533.1(E)	-	Change in Ownership

4. Case Law:

Maryland General Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Maryland, PRRB Case No. 99-D69, September 20, 1999, Medicare and Medicaid Guide (CCH) & 80334, rev=d, HCFA Administrator, November 22, 1999, Medicare and Medicaid Guide (CCH) & 80,406.

Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/Administar Federal, PRRB Dec. No. 98-D64, February 10, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,006, HCFA Administrator, declined review, August 7, 1998, aff=d No. C-1-98-547 (S.D. Ohio W.D. June 16, 1999).

Milwaukee Subacute and Rehabilitation Center v.United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,224, HCFA Administrator, declined review, June 8, 1998.

South Shore Transitional Care Center v. Blue Cross and Blue Shield Association/ C&S Administrative Services, PRRB Dec. No. 99-D38, April 21, 1999 Medicare and Medicaid Guide (CCH) ¶80,182, HCFA Administrator, declined review, June 21, 1999.

4. Other:

Ohio Revised Code § 3721.01(A)(6) - Definitions and Classifications; Restrictions on Facilities; Nursing Home.

Ohio Revised Code § 3721.07 - Condition for Issuance of a license

Ohio Revised Code § 3721.13 - Rights of Residents of a Home

Ohio Revised Code § 3721.121 - Criminal Records Check; Disqualification from Employment

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The majority of the Board (Amajority@), after consideration of the facts, parties= contentions, evidence presented, testimony elicited at the hearing finds, and post hearing briefs, finds and concludes as follows:

The majority notes that the Intermediary witness indicated that JNH was a private facility, not participating in the Medicare program and having stopped participation in the Medicaid program in 1982, and thus the usual source of information relied upon by HCFA for these determinations, the OSCAR reports was not present.[72] Instead, HCFA obtained the 1992 and 1993 Ohio Department of Health licensure reports.[73] The Intermediary witness indicated that no medical records were submitted for residents of JNH and therefore were not used in making its

[72] Tr. at 153.

[73] Id.

determination.[74] The purpose of the State of Ohio survey reports was to document violations of licensure requirements.[75] HCFA=s determination was based on examination of the description of deficiencies in which it identified language which it interpreted to be evidence of the provision of skilled nursing services.[76]

The majority notes that the background of the Intermediary witness includes no clinical education and a limited exposure to clinical care of nursing home patients as a nursing assistant for a two year period.[77] In addition, the Intermediary indicated that no one on the initial review team had any clinical background.[78] The Intermediary witness indicated that a HCFA physician did review the State of Ohio survey reports prior to the hearing and concurred with the finding, but that no written record was made regarding that conclusion.[79] The Provider presented testimony from a physician with practice experience at the facility who indicated that skilled nursing services were not provided and that capabilities needed to provide some skilled nursing services were not available at JNH.[80] The majority notes that every example of skilled nursing care cited by the Intermediary was addressed by the Provider.[81] In general, the Provider pointed out that the Intermediary could not conclude that skilled nursing services had been delivered based on the information in the State of Ohio survey reports alone and that one could just as easily conclude that only custodial care had been rendered.

The majority reviewed the evidence in the record cited by the Intermediary as proof of skilled nursing services being delivered at JNH. The majority agrees with the Provider that the evidence in the licensure reports is not by itself conclusive that skilled nursing care had been delivered. The Intermediary cited the phrase Aplan of care@ and assumes, without any medical record verification, that the skilled nursing care requirements of management and evaluation of care plans at 42 C.F.R. ' 409.33(a)(1) have been met. The majority notes that the Provider witness, with experience practicing at JNH, testified that it kept charts but no care plans for residents.[82] The Intermediary

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74 Tr. at 154.

75 Id.

76 Tr. at 155

77 Tr. at 141.

78 Tr. at 171.

79 Tr. at 172 -173.

80 Tr. at 86 - 138.

81 See Provider Post Hearing Brief.

82 Tr. at 95

witness cited as evidence of skilled nursing care JNH=s management of a diabetic patient. The Provider witness testified that the JNH did not have the capability to carry out a plan of care for a diabetic.[83] The Intermediary witness also indicated that there was skilled nursing care because there had been treatment of a decubitus ulcer.[84] The Provider witness testified that not all pressure ulcer care required skilled nursing care and that the pressure ulcer cited in the licensure did not constitute an Aextensive decubitus ulcer@ as defined in the regulations at 42 C.F.R. ' 409.33(b)(6) and that care was more likely to have been application of ointments to sore consistent with Apersonal care services A under 42 C.F.R. ' 409.33(c)(5). The Intermediary also cited Agait training@ as a skilled nursing service.[85]. The Provider witness noted that there is no evidence that gait training was provided and that the JNH could not provide such a service.[86]

The majority also considered evidence and testimony about the physical plan of JNH, being a converted farm house, and low level of training of its employees, which further supports the conclusion that JNH was providing residential or custodial care versus skilled nursing care.[87]

The majority notes that the Intermediary witness also argued that the facility by virtue of its licensure by the State of Ohio was required to provide skilled nursing care. The parties submitted a more complete set of statutes and administrative regulations applicable to facilities licensed in the State of Ohio.[88] The majority reviewed the state law and finds that it allows a licensed nursing home to provide skilled nursing care but does not require that it do so. See R.C. ' 3721.01(A)(6). In addition, the majority points out that the facility was never certified for Medicare and no longer participated in Medicaid after 1982 and therefore did not have to comply with the necessity to provide skilled care imposed by those programs.

In summary, the majority finds that the HCFA determination that skilled nursing services were rendered at the facility during the 3-year look back period is not supported by the evidence in the record. Th majority finds that the specific examples relied upon by the Intermediary could be interpreted as either skilled nursing care or custodial care. The majority finds evidence that the facility did not provide skilled nursing care and transferred patients in need of skilled nursing care to other facilities.[89] The majority also finds that Ohio state law did not require the facility to provide

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[83] Tr. at 126.

[84] Tr. at 161.

[85] Intermediary Exhibit 34 at 2.

[86] Tr. at 101.

[87] See Provider Exhibits 13 and 14 and Tr. at 90-99.

[88] See Provide Exhibit 48.

[89] Tr. at 99-100.

skilled nursing care. It is evident from the regulation that providers are afforded relief for excessive start-up costs to provide skilled nursing services for the first time. See 42 C.F.R. ' 413.30(e). The majority finds that there is no conclusive evidence that JNH operated as the type of provider for which it is certified for Medicare.

DECISION:

The majority finds no definitive evidence to support HCFA=s determination that skilled nursing services were provided during the 3-year look back period. HCFA's denial of the Provider's request for an exemption to the RCLs as a new provider under 42 C.F.R. ' 413.30(e) was improper.

Board Members Participating:

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

FOR THE BOARD:

Irvin W. Kues
Chairman

Stouder Memorial Hospital Subacute Unit

I respectfully dissent.

The plain meaning of 42 C.F.R. ' 413.30(e) is found within its four corners: an exemption to the limitations on costs recognized as reasonable in furnishing the efficient delivery of needed health services may be granted to a facility which qualifies as a Anew provider@. A Anew provider@ is A. . . .a provider of inpatient services that 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.@ Id.

Ohio statute, under which the facilities in question in this case were licensed, defines Anursing home@ (as in Johnson Nursing Home, from whom Stouder Memorial purchased licensed nursing home beds) as A . . . a home used for the reception and care of individuals who by reason of illness or physical or mental impairment require skilled nursing care and of individuals who require personal care services but not skilled nursing care. A nursing home is licensed to provide personal care services and skilled nursing care.@ (Emphasis added) Ohio Rev. Code Ann. ' XXXVII Chapter 3721.01(A)(6) Definitions and Classifications; Restrictions on Facilities . As a Anursing home@, Johnson Nursing Home, the progenitor of the Stouder Subacute Unit, was thus licensed to provide skilled care.

The record demonstrates (Provider Position Paper, Exhibits 11-A, 12-A) that Johnson had the 1) qualified personnel, 2) patient type, and 3) services offered that are recognized by the State of Ohio as Askilled services@ (Ohio Rev. Code Chapter 3721.01et seq). The issue here is not the quantity, or even the quality of those services offered by Johnson, de minimis as each may be, if they were offered at all, ' 413.30(c) precludes the purchaser of those >licensed@ beds from seeking a new provider cost limit exemption.

Provider Exhibits 11-A and 12-A, while intended, I suspect, to infer the paucity of skilled levels of care, and patients who need that level at Johnson, do, in fact, show evidence of Askillness@, in the professional judgment of the personnel (nurses notes of 8/1/93 indicate that medication was withheld from patient, based on adverse reaction of patient to Prozac, Provider Exhibit 12 - A at 2; nurses notes of 6/25/92 indicate treatment initiated using standing orders, Provider Exhibit 11-A at 2); in the type of patient (decubiti, hypertension, chronic obstructive pulmonary disease, organic brain syndrome, patient=s admitted directly from a hospital, 7/16/93 notes, Provider Exhibit 12-A), and in the services provided (treatment to a coccyx pressure sore, Provider Exhibit 12-A at 6; antibiotic therapy, Provider Exhibit 11-A at 2; medication management, Provider Exhibit 12-A at 2; plan of care, Provider Exhibit 12-A at 4).

Again, quantity is not the issue in ' 413.30(e), as alluded to by the Majority, nor is quality, as inferred by the Provider: Atype of provider (or the equivalent) . . .under present and previous ownership, for less than three full years@ are the benchmarks. In this case, both benchmarks are evident in the licensure level, the personnel, the patient type, and the services of Johnson Nursing Home. In reality, had they not been, the beds would have been of no value to Stouder. In order to avoid the Anew bed@ moratorium in Ohio, by their very definition, the beds to be purchased, and thus to be immediately available to Stouder Subacute, had to evidence those characteristics of a Askilled nursing@ bed.

In my opinion, the comments by the Provider and the Majority that Ohio Nursing Home licensure didn=t require the facility to provide skilled levels of care amounts to nothing more than a red herring; its the ability to provide skilled levels - the license to do so, that gave the Johnson beds economic value to Stouder Subacute. That license allowed Stouder to move immediately into

the subacute business, to avoid substantial Certificate of Need (CON) start-up costs, and to circumvent the societal consensus and legal mandates in Ohio that restricted Anew@ nursing home beds via the moratorium. Stouder also, incidentally, should have been aware of the regulatory and economic risks of such a venture. Extending this logic, I personally believe that the issue in this case falls under the rubric of the prohibition against cross-subsidization found at 42 U.S.C.A. ' 1395x(v)(1)(A), thus bringing into question whether or not these costs are Areasonable,@ and whether or not an exemption from such costs would inappropriately burden the Medicare fisc. Stare decisis, both at the level of the PRRB (See Intermediary Position Paper, Exhibits 23, 24, 25, 26 & 28), and within the U.S. District Court for the State of Ohio (Mercy St. Teresa Center v. Department of Health and Human Services, No. C-1-98-547 (Southern District, Western Division, Ohio, June 17, 1999)) supports the decision of HCFA to deny Stouder=s exemption request.

Finally, the wording of 42 C.F.R. ' 413.30 (c) appears quite clear: AA Provider may request a reclassification, exception, or exemption . . .@ (Id. emphasis added). Not Aand@, but Aor@ - denoting one or the other. In my humble opinion, no single facility should be allowed more than one remedy, one bite, of the U.S. taxpayer financed Medicare exception/exemption apple. Stouder sought, and received, an exception (Intermediary Position Paper at 21) to the routine service cost limits. One bite is enough. HCFA=s new provider cost exemption denial should be upheld.

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Henry C. Wessman, Esq.