PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D8

PROVIDER -Larkin Chase Nursing and
Restorative Center
Bowie, Maryland

DATE OF HEARING-
June 10, 1998

Provider No. 21-5264

Cost Reporting Period Ended -
December 31, 1994

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

CASE NO. 96-0640

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ISSUES:

1. Was HCFA's denial of the Provider's request for an exemption from the skilled nursing facility routine cost service limitation, as a new provider, proper?

2. Was the Intermediary's denial of the Provider's request for an exception to the skilled nursing routine service cost limitations, based upon atypical services, without an occupancy adjustment, proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Larkin Chase Nursing and Restorative Center ("Larkin Chase") or ("Provider") is a 120 bed comprehensive care facility that was built in 1994 in Bowie, Maryland pursuant to a Certificate of Need ("CON") originally issued by the Maryland Health Resources Planning Commission to the Bowie Center Limited Partnership.[1] The facility opened April 29, 1994 and became Medicare certified May 2, 1994.[2]

The CON that was ultimately awarded for the construction of Larkin Chase evolved from a complex series of events involving several different entities and projects. In 1988, the Bowie Center Limited Partnership sought CON approval to build an 85 bed facility in Glenn Dale, Maryland to be known as the Oakwood Life Center. Around the same time, Dimensions Healthcare ("Dimensions") gained CON approval to replace 27 existing comprehensive beds and add 18 new comprehensive beds at its Madison Manor nursing facility in Hyattsville, Maryland. Also, in 1988 Dimensions filed for a second CON to expand another nursing home it owned, Gladys Spellman, in Cheverly, Maryland.

At the suggestion of the CON Authority, the CON applications for all three projects were merged.[3] The Bowie Center-Oakwood project was scaled back to 60 beds and moved from the proposed location in Glenn Dale, Maryland to the current location of Larkin Chase in Bowie, Maryland. Madison Manor was approved for the 18 additional beds and a relocation of its 27 existing beds from Hyattsville, Maryland to a new site in Bowie, Maryland (not that of the Provider). The Gladys Spellman project was withdrawn.

When one of the partners in the Bowie Center Limited Partnership experienced financial difficulties, Dimensions then acquired a 100% interest.[4] Construction of the current Larkin

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1 Provider's Post Hearing Brief at p. 2.

2 Id.

3 Id at p. 4.

4 Tr. at p. 32.

Chase facility began in January, 1993.[5] After assessing its financial situation, Dimensions brokered a joint venture arrangement wherein Harborside Healthcare would become a 75% partner and Dimension's partnership share would be reduced to 25%.[6] Harborside became a partner in Bowie Center LP on April 7, 1993. Upon Harborside acquiring its 75% interest, it signed a management agreement with the Bowie Center, LP for the management and operation of the new Larkin Chase facility. Dimensions serves in an advisory role to the Provider and does not operate the facility.

The Provider filed a request for exemption from the Routine Cost Limit (RCL) on June 29, 1994 as a new provider of services.[7] Specifically, 42 C.F.R. § 413.30(e)(2) states that:

> [a] new provider is an institution that has operated in the manner for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than 3 full years.

The request was denied by HCFA per its letter dated August 23, 1995, stating that the Provider failed to meet the definition of a new provider as defined by 42 C.F.R. § 413.30(e)(2), in that the Provider had operated as the type of provider for which it is certified for Medicare in the preceding three year period.[8] The Provider requested reconsideration of this decision by letter dated November 9, 1995.[9] This was denied by HCFA per a letter dated May 8, 1996.[10] The Provider filed a timely appeal on January 26, 1996, with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations.

At HCFA's suggestion, the Provider then filed for an exception to the Routine Cost Limit for atypical services for the period May 2, 1994 through December 31, 1994. That request was dated June 27, 1996.[11] The Intermediary reviewed the request and determined that the Provider was not eligible for an exception for atypical services because of a low occupancy adjustment applied to equalize their costs for comparison to providers whose average occupancy is 75%. By letter dated October 10, 1996, HCFA concurred with the position of

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5 Id at p. 33.

6 Id at p. 9.

7 Intermediary Exhibit I-5.

8 Intermediary Exhibit I-12.

9 Intermediary Exhibit I-13.

10 Intermediary Exhibit I-15.

11 Intermediary Exhibit I-14.

the Intermediary.[12] The Provider added this issue to its original appeal per a letter to the Board dated November 19, 1996. The Medicare reimbursement effect per the Revised Notice of Program Reimbursement dated November 22, 1996 is $176,863.[13]

The Provider was represented by Peter R. Leone, Esquire of McDermott, Will and Emery. The Intermediary was represented by Bernard M. Talbert, Esquire, Blue Cross and Blue Shield Association.

Issue No. 1 -- Was HCFA's denial of the Provider's request for an exemption from the skilled nursing facility routine cost service limitation, as a new provider, proper?

PROVIDER'S CONTENTIONS:

The Provider contends that it is entitled to an exemption from Medicare's routine service cost limits because it qualifies as a "new provider" in accordance with 42 C.F.R. § 413.30(e) which states, in part:

> [e]xemptions from the limits imposed under this section may be granted in the following circumstances: . . . The provider has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership for less than three full years.

42 C.F.R. § 413.30(e).

The Provider contends that it is, in fact, a new provider. It began operations on April 29, 1994, and first became Medicare certified on May 2, 1994. Accordingly, the Provider asserts it had operated for less than three full years when filing its request.

The Provider contends that HCFA's analysis of Maryland Certificate of Need proceedings that resulted in the construction of Larkin Chase is plainly wrong on the facts in concluding that Larkin Chase was a relocation of Madison Manor. The CON that ultimately resulted in the construction of Larkin Chase at the 15005 Health Center Drive was the Oakwood LifeCenter project resulting from the competitive CON proceedings to determine the award of new comprehensive care beds in the Southern Maryland Health Planning Area. The resulting project for Oakwood LifeCenter was not the replacement project for Madison Manor. Contrary to the position of HCFA, the Maryland Health Resources Planning Commission did not approve Larkin Chase as the replacement facility for Madison Manor. HCFA erroneously relied upon an earlier CON approval for Madison Manor that authorized a project for a total of 45 comprehensive care beds, including the existing 27 Madison Manor beds, and 51

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[12] Intermediary Exhibit I-17.

[13] Intermediary Exhibit I-4.

domiciliary beds at a location in Bowie that is not the location of Larkin Chase. The vast majority of the beds for the construction of the Larkin Chase project were new beds under the Oakwood LifeCenter CON, beds that were never before in existence in the Southern Maryland Health Planning Area that includes Prince George's County. Harborside, as the 75% owner and operator of Larkin Chase, had never operated any nursing homes in Maryland. In April, 1991, the Maryland Health Resources Planning Commission approved the modification of Oakwood LifeCenter CON to the location site where the Larkin Chase project was constructed at Health Center Drive in Bowie. This is the CON approval that ultimately resulted in the construction of Larkin Chase at Health Center Drive in Bowie. In view of the overwhelming evidence in support of granting the- exemption request, and the Intermediary's initial recommendation that it be granted, the Provider contends HCFA improperly concluded that Larkin Chase was "previously" Madison Manor, and was relocated from Hyattsville to Bowie.

The Provider contends that incorporating intangible CON operating rights into the approval of a new CON project is not, for purposes of a "new provider" exemption, the same thing as relocating a provider. When a provider is relocated, there would be a transfer of an ongoing operation. This would include management, personnel, clinical operations, patient records, facilities and equipment, physicians, referral sources and most importantly, the clinical and operational know-how to run the relocated facility. In the instant case, none of these items moved, nor would they, because Larkin Chase is not Madison Manor reincarnated in Bowie. Larkin Chase, under Harborside's management agreement, is operated by Harborside Healthcare, a skilled nursing home chain corporately based in Boston, with a regional support group in New Jersey, to assist in the operation of Larkin Chase. While Madison Manor had an obligation to arrange for care of its residents, it did not provide for the automatic transfer of all of its residents to Larkin Chase, as it would have done if it were a relocating provider.

The Provider contends that it meets the very circumstances that the "new provider" exemption was intended to address - the start-up of a new operation where the Provider is incurring the costs for clinical and administrative staff training and education, developing a patient referral base, filling the beds of a newly constructed facility in the start-up phase of the facility, that the "new provider"exemption was intended to address. It further asserts that HFCA's conclusion that Larkin Chase was a relocated Madison Manor is erroneous based on the following: The institution that was Madison Manor did not move to Bowie, it is now a shelter for battered women and children. There was no change of ownership of a nursing home, or of any of its operating assets. The fixtures, equipment, and inventory of Madison Manor did not move to Bowie. The staff and clinical personnel of Madison Manor, and their experience, even limited as it was to primarily custodial care, did not move to Bowie. The medical records of Madison Manor residents that are required to be maintained by law did not move to Larkin Chase in Bowie. The expert on Maryland Health Planning law, who was the former

Director of the Maryland Health Resources Planning Commission, testified that, apart from the bed rights, he did not see any element of a relocating facility.[14]

The Provider also contends that HCFA's denial of the "new provider" exemption was based on the inappropriate conclusion that Larkin Chase, as Madison Manor, had operated as the "equivalent" provider of skilled services in the three year "look back" period. The Intermediary witness testified: "the Medicare program does not want to incur expenses that have already been incurred providing the type of services that in this instance a (Medicaid) NF would provide, which would be skilled nursing and rehabilitative services."[15] The Provider contends that the Intermediary inappropriately relied on the term "equivalent services" rather than "equivalent provider" as stated in 42 C.F.R § 413.30. Using self-reported survey information reporting nursing services provided to Medicaid patients at Madison Manor, the Intermediary concluded that the Provider was disqualified for the "new provider" exemption based on those services provided by Madison Manor in the prior three years. The Provider claims this conclusion is faulty based on the following:

1. The lack of instructions for the self-reporting survey resulted in various patient activities being erroneously reported as skilled services.[16]

2. The HCFA policy disqualifying "new providers" based upon the episodic provision of certain skilled nursing services is an inconsistent policy.[17]

The Provider's trained nursing clinician testified that the Madison Manor staff could not have operated Larkin Chase because they lack the training and skills necessary to operate a facility of that complexity.[18] Accordingly, Larkin Chase was incurring for the first time costs associated with the start-up of a new facility. Costs were not being incurred twice, as was the concern of the HCFA witness, since the Madison Manor personnel never had the training and experience in nursing and rehabilitative therapy services necessary to provide Medicare certified skilled nursing services , such as those offered at Larkin Chase. The Provider therefore contends that since the very purpose of the new provider exemption is to recognize these costs in the initial period of operation, the exemption should be granted.

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14 Tr. at pp. 71-72.

15 Tr. at p. 186.

16 Tr. at pp. 119, 154-155 & 176.

17 Provider Exhibits P-21, P-22, P-23.

18 Tr. at p. 94.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends and agrees with HCFA that the Provider is not a new provider of services, as Madison Manor of Hyattsville, Maryland, whose 27 beds are now part of Larkin Chase, did provide skilled nursing services during the three year look-back period prior to May 1994. In support of this contention, the Intermediary points out that in 1986 Dimensions Healthcare bought all of the stock in Madison Manor, a 27 bed nursing home in Hyattsville, Maryland. That purchase came with an inherited CON project on file with the state agency to add 18 skilled nursing and 51 domiciliary beds.[19] Testimony at the hearing indicated that Dimensions would not have purchased the facility without the inherited CON project.[20] Dimensions then engineered the formation of the partnership that exists today, with Harborside Healthcare operating Larkin Chase as a 75% partner in Bowie Center LP, and Dimensions retaining a 25% partnership interest.

The Intermediary also points out that testimony indicated that the Provider, Larkin Chase, and Madison Manor both served a patient population from the same Health Systems Area (HSA) identified as Prince George's County.[21] The HCFA witness testified that 69% of the patients served by Larkin Chase came from Prince George's County and that 95% of the population served in terms of cities and towns by Madison Manor continued to be served in the Larkin Chase location.[22] This adds to the fact that Larkin Chase replaced Madison Manor.

The Intermediary also contends that the Provider did not meet the requirements of 42 C.F.R. § 413.30(e) in that the Provider did provide skilled nursing services or their equivalent during the three year look-back period. The Intermediary witness testified that in this particular case it was determined that another institution, Madison Manor, existed during the three year look-back period.[23] Accordingly, HCFA's responsibility was to determine how that facility operated in the look-back period.

The Intermediary points out that Madison Manor had existed since 1974 and was licensed as a Comprehensive Care Nursing Facility (NF). It was certified for Medicaid purposes, but never obtained Medicare certification. The Intermediary witness testified that HCFA extracted resident census and characteristics reports for Madison Manor from HCFA's On-line Survey

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19 Tr. at p. 27.

20 Tr. at p. 42.

21 Tr. at p. 74.

22 Tr. at pp. 123-126.

23 Tr. at p. 113.

Certification and Reporting system ("OSCAR").[24] OSCAR accumulates information over time regarding the survey and certification history of an institution.

The Intermediary witness testified that Madison Manor had reported the presence of catheters and bowel and bladder training programs, and had even provided ostomy care.[25] The Intermediary indicated that HCFA has a self-reporting mechanism submitted by providers, and reviewed and corrected, if necessary, during annual state surveys. Standardized forms along with instructions are provided to each provider.[26] The Intermediary's same witness, in discussing the concept of equivalent service, pointed to the case of Staff Builder Home Health Care, Inc. v. Bowen, U.S. District Court for the District of Maryland, No. R-86-3317, April 13, 1988.[27] In that case, the court ruled that the private nursing care rendered during the three preceding years before Medicare certification was equivalent to that rendered after Medicare certification.[28]

The Intermediary also noted that the Provider's witness was unable to prove that the OSCAR reporting did not report skilled level of care.[29] In addition, a second Provider witness testified that most of the Madison Manor patient records were in storage in another Dimension's facility.[30] The Intermediary now contends that, absent evidence to rebut the OSCAR report, the OSCAR information is an accurate representation that skilled services were performed during the three year look-back period.

Issue No. 2 -- Was the Intermediary's denial of the Provider's request for an exception to the skilled nursing routine service cost limitations, based upon atypical services, without an occupancy adjustment, proper?

Medicare Statutory and Regulatory Background:

Under the provisions of 42 C.F.R. § 413.30(f)(1)(ii) governing exceptions for atypical services, the provider must show that the atypical items or services are furnished because of the special need of the patient treated and are necessary in the efficient delivery of needed

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24 Tr. at p. 116.

25 Tr. at pp. 117-119.

26 Intermediary Exhibit Sup. I-4-B.

27 Tr. at p. 122.

28 Intermediary Exhibit Sup. I-4-A.

29 Tr. at pp. 102-103.

30 Tr. at p. 35.

health services. It has been HCFA's interpretation of this regulation that SNFs with low occupancy levels are incurring excessive costs due to fixed costs applicable to excessive amounts of underutilized space, thereby resulting in higher costs being spread over fewer inpatient days. Therefore, since the inception of the SNF cost limits and the SNF exception process, HCFA has evaluated all exception requests to ensure that costs in excess of the limit are not due to excessive staffing or low occupancy.

HCFA Pub. 15-1, Section 2534.5 A states: [i]f 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 rate is below 75 percent, all fixed per diem costs by cost center, are adjusted to reflect its per diem equivalent at the 75 percent occupancy rate." The maximum standard developed was 75 percent because this was approximately two standard deviations from the mean occupancy level of 92 percent for SNFs. As explained to providers whose occupancy is below 75 percent, HCFA deems that certain costs are fixed costs and certain costs are variable costs. Providers are afforded the opportunity to rebut the low occupancy adjustment by identifying which costs vary with occupancy and, accordingly, would not be subject to the low occupancy adjustment. A provider may also rebut the low occupancy adjustment by presenting valid reasons why its occupancy is below 75 percent.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's calculation of the 75% occupancy adjustment using the year end licensure figure was incorrect. HCFA Pub. 15-1 § 2534.3 authorizes a low occupancy adjustment to a provider's per diem cost based on an atypical services exception. The 75% occupancy factor used to make the adjustment is based upon the average occupancy rate for all skilled nursing facilities. The purpose of the low occupancy adjustment is to disallow costs on an atypical services exception that are associated with the inefficient operation of a provider. That is why the 75% factor is derived from the average occupancy rate of all skilled nursing facilities.

In the case of the ongoing operation of a skilled nursing facility, the calculation of available bed days is simply made by multiplying the number of licensed beds at the end of the period times the number of days that the facility operated in that period. If the resulting figure is less than 75%, the intermediary makes a low occupancy adjustment. The intermediary then disallows those costs associated with low occupancy (i.e., costs associated with occupancy at a level lower than 75%.)

The Provider contends that it acted as an efficient provider. Since Larkin Chase was in a fill-up mode as a new provider, it could only admit patients to beds as it was permitted to do by the Prince George's Health Department. On April 29, 1994, Provider was issued a license for a maximum capacity of 30 beds, admissions explicitly limited to two residents per day, ten residents per week. On June 29, 1994, the Provider was issued a license for a maximum capacity of 58 beds, admissions explicitly limited to two residents per day, ten residents per

week. On September 1, 1994, these 58 beds were designated as a distinct part unit. On September 9, 1994, Provider was issued a license for a maximum capacity of 111 beds, admissions explicitly limited to two residents per day, ten residents per week. Finally, on December 5, 1994, Provider was issued a license for a maximum capacity of 116 beds without further conditions on admissions.

The Provider contends that, in light of these license restrictions, it could only admit patients at the rate permitted by the licenses issued by the Prince George's Health Department. These licenses limited admission at the rate of two patients per day, ten patients per week, during the initial phases of opening and operating Larkin Chase in 1994. The Provider contends that if the actual bed days available in the certified distinct part unit in the period from April 29, 1994 through December 31, 1994 are used to calculate occupancy, the Provider had a total of 12,220 available bed days and an occupancy rate of 74.42%.[31] Based on those numbers, the Provider contends it is entitled to an atypical services exception for 1994, based upon 75% occupancy of the beds to which it was permitted to admit patients in the initial phases of operation of the new facility.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly denied the Provider's request for an exception to the skilled nursing routine service cost limitation by applying the occupancy adjustment per HCFA Pub. 15-1, Section 2534.5 A.[32] The denial was made because the Provider's reported census reflected an occupancy rate of 42 percent.[33]

The Intermediary does not concur with the Provider's contention that the calculation of the occupancy determination should reflect the graduated licensing. During the hearing the Provider contended that the County Licensing Authority limited the Provider initially to 30 beds.[34] They were then permitted to open and to accept two patients per day, up to a maximum of ten per week. Two months later, after opening, the bed complement was increased to 58, with the same limitation on the rate of admissions. Subsequent increases incurred in September and December of 1994. The Intermediary contends that testimony reveals that this was a voluntary act by the Provider and not one imposed on them by the

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31 Tr. at 222. Wherein the Board allowed the Provider to enter additional evidence into the Board proceedings relative to issue 2. See, July 21, 1998 letter from Harborside Healthcare to Mutual of Omaha. See, Intermediary Post Hearing Exhibits I-2 through I-9.

32 Intermediary Post Hearing Exhibit I-1.

33 Intermediary Exhibits I-16 & I-17.

34 Tr. at p. 12 & p. 209-210.

licensing authority.[35] This was a business decision by the operator, Harborside Healthcare and their facility administrator.[36] The Provider's other witness also testified that graduated licensure is more of a practical matter rather than mandated by authority.[37]

The Intermediary notes that a review of the graduated licensure information, as agreed to at the conclusion of the hearing, finds an occupancy rate of 74.42 percent. Further, neither the regulations nor HCFA Pub. 15-1 reflect an occupancy calculation based on a formula using graduated licensure data. Since the revised calculated amount is still below the 75 percent threshold, the Intermediary concludes that its denial of the exception request was proper.

The Intermediary points out that the routine cost limit (RCL) exception formula is applied from a separate calculation to the Medicare cost report. In the event the Board would agree to grant the exception request, it will be necessary for the Intermediary to correct Cost Report Worksheet S-3 and Worksheet B-1 for the number of beds, beds days available and square footage for the:
1) distinct part, 2) non-distinct part and 3) the beds waiting authorization to be used. The Intermediary requests that the Board compel the Provider to supply the necessary square footage statistics for the three areas listed above, to comply with pre-opening cost requirements.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1819(b)(4)	-	Requirements for Provisions of Skilled Nursing Facility Services
§ 1919(b)(x)(4)	-	Requirements for Nursing Facilities

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.30	-	Limitations on Reimbursable Costs

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35 Tr. at p. 45.

36 Tr. at p. 47-48.

37 Tr. at p. 64-65.

§ 413.30(e) et. seq. - Exemptions

§ 413.30 (f) et. seq. - Exceptions

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

§ 2534.3 - General Exception Request Requirements

§ 2534.5A - Determination of Reasonable Costs

4. Program Instructions - Provider Reimbursement Manual, Part 2 (HCFA Pub. 15-2):

§ 3006 - SNF Cost Report Instructions

5. Cases:

Staff Builders Home Health Care, Inc. v. Bowen, U.S. District Court for the District of Maryland, No. R-86-3317, April 13, 1988. Medicare & Medicaid Guide (CCH) ¶ 37,133.
Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/Administar Federal, PRRB Dec. No. 98D-64, June 16, 1998. Medicare & Medicaid Guide (CCH) ¶ 80,006.

6. Other:

HCFA's On-line Survey Certification and Reporting System ("OSCAR")

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony at the hearing, and post hearing briefs, finds and concludes as follows:

Issue 1 -- Request for an Exemption from the Skilled Nursing Facility Routine Service Cost Limitations, as a New Provider

The Board finds and concludes that the Provider is not entitled to an exemption from the routine cost limits as a "new provider." The Board finds that the controlling authorities in this case are the regulations at 42 C.F.R. § 413.30 et seq. which set forth the Medicare regulatory provisions covering the "Limitations on Reimbursable Costs." The Provider claims an exemption under the "Limitations on Reimbursable Costs". The Provider claims an exemption under the regulation as a new provider which states:

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

42 C.F.R § 413.30(e)(2)

The Board finds that there is insufficient evidence in the record to substantiate the Provider's contention that it was not a SNF provider or an equivalent provider prior to its Medicare SNF certification in May 1994. First, the Board noted that the Health Care Financing Administration, in denying the exemption request, clearly stated that Larkin Chase replaced an existing facility, Madison Manor. The Board finds that an analysis of the certificate of need information/ documents in the record indicated that there were, in fact, 27 relocated beds from Madison Manor, to the new provider Larkin Chase, which initially opened 30 beds. This fact was also supported by testimony which indicated that in essence 27 beds of Larkin Chase replaced the 27 Madison Manor beds and the capability for providing services. Additional testimony revealed the 27 bed Madison Manor facility was acquired with an authorized CON project on file, and that the acquisition probably would not have taken place without the inherited CON project. Further testimony revealed that Larkin Chase and Madison Manor both served a patient population from the same Health Systems Area (HSA). The Board finds that these factors, taken as a whole, support HCFA's contention that Larkin Chase replaced Madison Manner.

The Provider raised the issue of an inconsistency between this case and the exemption approval of another facility wherein CON rights were relocated from one facility to another. However, the Board finds that there is insufficient evidence in the file to indicate inconsistency.

The Board believes it is important to note that HCFA's stated purpose of the new provider exemption is to recognize the costs associated with the initial periods of developing the ability to furnish inpatient SNF services. However, in that the regulations do not provide for any type of proration factor, relative to the number of beds previously and currently operated, it appears that HCFA's narrow interpretation of the regulations may serve to prevent many new providers from recovering appropriate operating costs.

With the Board's finding that Larkin Chase is a replacement facility for Madison Manor, the Board is compelled to review the previous owner's operation to determine whether or not the Provider meets the regulatory requirement of having not operated for more than three full years as the type of provider (or the equivalent) for which it is certified. The Board finds that Madison Manor was licensed as a Comprehensive Care Nursing Facility (NF) in the Maryland State Medicaid Program since October 1990. It continued to operate in this capacity until its closure in 1994. The Intermediary review indicated that Madison Manor did perform some level of skilled services in the three years prior to the opening of Larkin Chase. This was documented by the Provider's self reported resident census reports. In testimony at

the hearing , the Provider was unable to rebut the contention that skilled services were not performed at Madison Manor. Therefore, the Board considers the self reported census information as the best available evidence that skilled services were performed during the three year look-back period.

The Board finds that although Madison Manor did not furnish skilled care as frequently as the Provider, it did furnish a low volume of some skilled services. Also, the Board did note that the length of stay for Madison Manor patients was much greater than those of Larkin Chase. However, the regulation at 42 C.F.R. § 413.30(e)(2) makes no allowance for institutions providing a low volume of skilled nursing services prior to certification as a SNF.

The Board also finds that a nursing facility as described in Section 1819(b)(4) of the Social Security Act, must be capable of providing, either directly or under arrangements, a basic range of services. Both Medicare skilled nursing facilities and Medicaid nursing facilities are required to provide the same basic range of services as described in sections 1819(b)(4) and 1919(b)(x)(4) of the Social Security Act. This was established in the recent Board decision of Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/Administar Federal, PRRB Dec. No 98-D64, June 16, 1998, Medicare & Medicare Guide (CCH) ¶ 80,006. The Provider (in the form of Madison Manor) did furnish some skilled services for the three years prior to certification, and thus is not entitled to the new provider exemption.

Issue 2 -- Request for an Exception to the Skilled Nursing Routine Service Cost Limitations, Based on Atypical Services, Without a Low Occupancy Adjustment

The Board finds that the evidence reveals and that both parties concur that the Provider did incur some atypical costs as per the Medicare regulation at 42 C.F.R. § 413.30(f)(1), which states:

> (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
> >
> > (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.

The Board notes that the Intermediary, in calculating the Provider's routine per diem cost, applied a low occupancy adjustment factor as authorized by HCFA Pub. 15-1 § 2534.3. An occupancy factor of 42% was developed by using year end licensed beds as reflected on the Medicare cost report. Adjusting for this low occupancy factor served to reduce the Provider's

allowable routine costs below the routine cost limit amounts. Thus, the Intermediary determined and HCFA concurred that the Provider was not entitled to an exception based on atypical costs.

The Board finds that the key issue in contention is the Intermediary calculation of the low occupancy adjustment. The evidence in the record indicates that the Provider was only licensed to operate 30 beds upon opening in April 1994. Over a six month period beds were phased in until the Provider reached its licensed bed capacity. Evidence submitted by the Provider, using graduated licensure data, reflects an occupancy rate of 74.42%. The Provider has produced additional evidence (Provider Exhibit P-15) to show that if a 75% low occupancy adjustment factor were applied, the Provider would have routine costs in excess of the cost limits.

The Board notes the Intermediary's argument that the phased in beds may have been voluntary on the part of the Provider, and constituted a business decision which resulted in excess costs due strictly to the initial low occupancy. However, the evidence clearly indicates that the Provider was limited by the Prince Georges' County phasing in of beds, via the issuance of three separate licenses. The Board is persuaded by testimony which indicated that the key purpose of a phase in approach is to assure that a new facility can adjust to the realities of new patients, and the State can be assured of some measure of patient safety. Therefore, the Board finds that whether the phase in was voluntary or mandated, the decision was indicative of good business judgement on the part of the Provider.

The Board finds that HCFA Pub. 15-1 § 2534.5, Appendix B provides an example of how to compute the low occupancy adjustment. The term used is bed days available, with no reference made to licensed beds. Further, the SNF cost report instructions in HCFA Pub. 15-2 § 3006 state in part:

> [e]nter the total bed days available. Bed days are computed by multiplying the number of beds available throughout the period by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, the number of beds available for each part of the cost reporting period are multiplied by the number of days for which that number of beds were available. Id. (Emphasis added).

DECISION AND ORDER:

Issue 1-- Request for an Exemption from the Skilled Nursing Facility Routine Service Cost Limitations, as a New Provider

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

Issue 2 -- Request for an Exception to the Skilled Nursing Routine Service Cost Limitations, Based on Atypical Services, Without a Low Occupancy Adjustment

The Board finds that the Provider had an occupancy rate of 74.42% and that the Intermediary should calculate an atypical services exception from the routine costs limits based upon that occupancy factor. The Intermediary's initial denial of the requested exception to the routine service cost limitations based on atypical services is reversed. The Board compels the Provider to supply square footage statistics to the Intermediary for the following areas: 1) distinct part, 2) non-distinct part, and 3) beds waiting authorization to be used. This will allow the Intermediary to recalculate the appropriate Medicare cost report worksheets.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: November 24, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman