PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D72

PROVIDER - Cameron Community Hospital
Home Health Agency
Cameron, Missouri

DATE OF HEARING-
August 10, 1999

Provider No. 26-7140

Cost Reporting Period Ended -
September 30, 1994

vs.

INTERMEDIARY -Blue Cross & Blue Shield Association/Tri Span Health Services of Jackson, Mississippi

CASE NO. 97-2381

INDEX

ISSUE:

Did the Health Care Finance Administration ("HCFA") properly deny the Provider's request for an exception to the home health agency cost limits based on atypical services?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Cameron Community Hospital Home Health Agency ("Provider") is a hospital based home health agency ("HHA") located in Cameron, Missouri. It filed its Medicare cost report for the fiscal year ended September 30, 1994 ("FY 94") which resulted in $3.81 per visit in excess of the Medicare limit on HHA costs per visit. Since the Provider rendered 9,794 Medicare visits in FY 94, this resulted in total unreimbursed HHA costs of approximately $37,000. As a result the Provider requested an exception to HCFA's HHA cost limits pursuant to 42 C.F.R. §§ 413.30(f)(1) and (8) based on its atypical service intensity and unusual labor costs. The Provider's request is voluminous and detailed.[1] The portions of the request that are pertinent to this appeal are:

> (1) The narrative text in Section I of the request explains that the Provider's increased skilled nursing costs are due to the high acuity level of its patients which necessitated the provision of atypical nursing services resulting in increased costs. The atypical nature of its patient population is summarized in the narrative to the exception request and the attached exhibits. The length of the Provider's average skilled nursing visits during FY 94 was 89 minutes, nearly 50 percent higher than the HCFA norm of 60 minutes.[2] In the narrative text, and in an exhibit attached to the exception request, the Provider compares its facility with three comparable rural, hospital-based HHAs located within a 60-mile radius of CCH. These HHAs are similar in size and provide services similar in scope to that offered by the Provider. The Provider's average cost per visit was $42.15 compared to that of its peers of $36.97.
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> (2) Section II of the exception request contains a report by an independent nurse consultant employed by Baird, Kurtz & Dobson, Certified Public Accountants. This report is based on a review of the medical records of a sample of 68 patients who had received home

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[1] See Provider Exhibit P-5.

[2] See Exhibit P-5, Table 7.

> health care from the Provider during FY 94. The clinical findings of the nurse consultant indicate the high acuity levels of the Provider's patients. This conclusion is based, inter alia, on the advanced average age of the Provider's patients (78); the patient's diagnoses and average number of secondary diagnoses (6); the large volume of ancillary, rehabilitative and social services provided to the patients; the patients' levels in independence in the activities of daily living ("ADL"); and high degrees of functional limitations.

Tri Span Health Services of Jackson, Mississippi ("Intermediary") reviewed the Provider's request and, by letter dated September 15, 1995, recommended that HCFA grant the full amount of the exception sought, i.e., $3.81 per visit in excess in the HHA skilled nursing limit.[3] In forwarding the Provider's exception request to HCFA, the Intermediary also forwarded additional documents such as the home health unit exception and related table, the as-filed Medicare cost report for FY 94, the revised FY 93 Medicare cost report, and the finalized FY 92 Medicare cost report that was issued August 25, 1994. The Intermediary did not request any additional information before making its recommendation and forwarding the Provider's exception request to HCFA.

On March 10, 1997, HCFA notified the Intermediary that it had denied the Provider's request for an exception to the HHA cost limits.[4] HCFA's reasons for denying the Provider's exception request as set forth in its denial letter are : (1) the Provider's average cost per visit of the direct costs associated with providing skilled nursing services decreased from $59.10 in FY 92, to $52.94 in FY 93, to $42.92 in FY 94; (2) in FY 93, the percentage of Medicare skilled visits to total skilled visits was higher than the percentage in FY 94; and (3) the Provider failed to explain why it exceeded the limits in FY 94 but stayed within those limits in FY 93. Finally, HCFA determined that the Provider's costs had exceeded the cost limits due to Congress' elimination of the "A&G add-on." HCFA stated that it was not the intent of Congress to offset the elimination of the administrative and general add-on through the exception process.

The Provider appealed HCFA's determination to the Provider Reimbursement Review Board ("Board"). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§405.1835-.1841. The Provider is represented by Carel T. Hedlund, Esquire, of Ober, Kaler, Grimes and Shriver. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

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[3] See Provider Exhibit P-6.

[4] See Provider Exhibit P-7.

PROVIDER'S CONTENTIONS:

The Provider contends that it meets the criteria for the atypical services exception. Regulations delineating limitations on costs are set forth at 42 C.F.R. § 413.30. Pursuant to subsection (f), an adjustment to the cost limits is required if a provider's costs are reasonable, attributable to the circumstances specified, separately identified and verified by the intermediary. The Provider meets all of these requirements. First, pursuant to the Provider Reimbursement Manual ("PRM") HCFA Pub. 15-1 § 2544.B.3, the Intermediary was required, upon receipt of the Provider's exception request, to include a determination of the reasonableness of all the individual components of cost. This would include a comparison with peer home health agencies. The Intermediary implicitly determined the Provider's costs were reasonable because it approved the Provider's exception request and forwarded it to HCFA with the recommendation that the Provider's exception request be granted based on its atypical services.[5] Second, the Provider's excess costs are attributable to the high acuity levels of its patients which necessitated the provision of atypical services. Third, these costs are separately identified by the Provider in its exception request.[6]

The Provider notes that providers have sought clarification from HCFA on how to comply with the criteria set forth at 42 C.F.R. § 413.30(f)(1). Specifically, providers sought clarification of the nature of the comparative analysis required by the regulation. By letter dated August 19, 1992[7], Charles R. Booth, Director, Office of Payment Policy Bureau of Policy Development, HCFA, responded to this request for clarification. Mr. Booth advised that this requirement would be satisfied for HHAs if the following criteria were met:

1. Minutes per visit--The provider must submit data which demonstrates that its patients receive significantly more minutes of nursing service or home health aide service per visit than the patients of comparable providers located in its peer group. The standard minutes per visit furnished by each classification is as follows:

	Skilled Nursing	Home Health Aide
HCFA Standard Minutes Per Visit (including transportation and in-home care)	60.0	114.0

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[5] See Provider Exhibit P-6.

[6] See Provider Exhibit P-5.

[7] See Provider Exhibit P-9.

2. Patient mix--To establish that more intense nursing services were provided because of the special needs of its patients, the HHA must demonstrated [sic] that its patient mix is significantly different from the patient mix of other providers similarly classified, e.g., urban or rural and freestanding or hospital-based HHAs. The provider must submit diagnostic information showing that a significant percentage of its visits are related to the treatment of more complex cases, and that by comparison to its peer group, a much smaller percentage of its visits are related to the treatment of patients with less complicated conditions. A comparison of the agency's data with data of other similarly classified agencies must demonstrate that the requesting provider's lengthy visits resulted from the special needs of the patients served on a per discipline basis.

3. Other information include [sic], but is not limited to, the following factors as compared to peer providers: a higher percentage of patients with dependencies in activities of daily living or a higher percentage of patients requiring rehabilitative or other therapy services.

Id.

The Provider complied with all of these requirements to the extent they were capable of being satisfied. An independent nurse consultant reviewed the medical records of a sample of 68 of the Provider's patients. The nurse consultant's clinical findings clearly support the Provider's assertion that the cost limits were exceeded because the special needs of its patients, as evidenced by the following, necessitated the provision of more intense nursing services and which, in turn, resulted in increased labor costs:

- The average time per skilled nursing visit was 89 minutes compared to the HCFA norm of 60 minutes. These times periods include transportation and in-home care.

- The Provider's average cost per skilled visit was compared to that of three other rural hospital-based HHAs that are similar in size and scope of services. These HHAs are located within a 60-mile radius of the Provider. The Provider's average cost per visit was $42.15. The average cost per visit of these comparable providers was only $36.97.

- The average age of patients was 78 years. This indicates greater fragility and medical complexities.

- The average number of secondary diagnoses per patient was 6. These patients' complex medical conditions directly affected the number and type of services provided. This, in turn, necessitated a higher staffing level than is typically found in an HHA.

- Laboratory procedures were performed on 75 percent of the patients. During skilled nursing visits, blood had to be drawn by nurses and delivered to the laboratory.

- Pursuant to state and federal law, a large number of the technical procedures that were performed could only be performed by registered nurses.

- Sixty-six percent of the patients required special dietary preparation.

- Eighty-one percent required ancillary services such as physical, occupational and speech therapy as well as social services.

- A large percentage of patients were functionally impaired.

- Several of the types of medications administered to patients were new. This necessitated the provision of detailed patient education.

The Provider observes that although providers are required to compare their services with other HHAs, the fact is that HCFA has not developed any HHA industry-wide norms relating to the nature and scope of services rendered by HHAs. Thus, there are no norms to which an HHA may compare its own data.[8] An HHA is able to obtain cost reports from other HHAs through the Freedom of Information Act ("FOIA") and can therefore compare its costs with that of comparable HHAs. This is exactly what the Provider did. However, an HHA cannot obtain clinical data or patient diagnoses from other comparable HHAs through an FOIA request. In fact, to the Provider's knowledge, the only available industry-wide HHA norm is that for average length of visits. Consequently, the very data that a provider needs in order to undertake the comparative analysis set forth in the regulation is simply not available. It is therefore impossible for any HHA to be able to compare its services to those of other comparable HHAs. A provider cannot be held to a standard that is impossible to achieve. Any requirement mandating that providers undertake this comparative analysis in the absence of any available data will effectively foreclose their ability to seek an exception to the cost limits based on atypical services.

In contrast to the dearth of available data for HHAs, the Provider observes that HCFA has amassed voluminous amounts of data for skilled nursing facilities ("SNFs"). For example, SNFs wishing to request an exception to their cost limits on the basis of atypical service intensity pursuant to 42 C.F.R. § 413.30(f)(1) are able to compare their data to HCFA norms of SNF averages using the data set forth at Appendices A and B to HCFA Pub. 15-1 § 2534. Appendices A and B contain charts indicating SNF norms for average length of stay, average ancillary costs per diem (broken down by category),

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[8] See Provider Exhibit P-10.

wage data (broken down into different components), and average Medicare utilization rates.[9] Also available are industry-wide SNF ADL norms.[10] Despite the fact that the focus of these norms is cost, not services, these are the norms that HCFA requires SNFs to use when making the comparative analysis required by 42 C.F.R. § 413.30(f)(1).

The Provider asserts that HCFA improperly denied the Provider's exception request pursuant to 42 C.F.R. § 413.30(f)(1). HCFA's reasons for denying the Provider's request are stated in the above Statement Of The Case. The Provider contends that HCFA's denial of the Provider's exception request on these bases is arbitrary, capricious and contrary to law for the following reasons. First, the criteria that HCFA has imposed on the Provider as a precondition to granting an exception request i.e., that the Provider explain why its cost of services decreased between FY 92 and 94; why its percentage of Medicare skilled visits was higher in FY 93 than it was in FY 94; or why the cost limits were exceeded in FY 94 but not in FY 93, are legally irrelevant. Nowhere in the governing regulation, manual provision or any document setting forth HCFA's policy is it stated, or even implied that, to qualify for an exception based on atypical services, a provider must conduct a comparative analysis of its own costs or Medicare utilization patterns over a number of cost reporting periods and explain any variation in these costs or utilization. Furthermore, even if the Provider's costs had exceeded the cost limits in prior years, the Provider was not under any obligation whatsoever to request an exception to the cost limits for those years. Finally, HCFA requires a provider to apply for an exception to the cost limits for each fiscal year. Each fiscal year is considered anew. See HCFA Pub. 15-1 § 2544.

Second, HCFA's denial of the Provider's exception request on the grounds that the Provider's cost limits would not have been exceeded had Congress not eliminated the A&G add-on, and that it was not Congress' intent to offset this elimination through the exception process, is similarly invalid. This statement directly conflicts with Congress' intent, as evidenced by the plain language of the amended regulation and the Secretary's interpretation of the changes effectuated by the elimination of the A&G add-on. The Secretary observes that the pre-existing regulatory mechanism governing exception requests would continue to provide relief to providers who are able to show that, based on one of the qualifying criteria set forth at 42 C.F.R. § 413.30(f), they exceeded the applicable limits.

The Provider argues that HCFA's denial of the Provider's exception request on this basis also conflicts with the Secretary's own interpretation of the changes mandated by Omnibus Budget Reconciliation Act of 1993 ("OBRA 93") §13564. The Supreme Court has ruled that an agency's statements in the preamble to a regulation is entitled to deference. Consequently, a HCFA official's statement to the contrary cannot be sustained. In Stinson v. U.S., 508 U.S. 36 (1993)[11], ("Stinson") the Supreme Court analogized a published commentary to the federal sentencing guidelines to an agency's

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[9] See Provider Exhibit P-11.

[10] See Provider Exhibit P-12.

[11] See Provider Exhibit P-14.

interpretation of its rules. The Supreme Court held that this published commentary must be treated as an "agency's interpretation of its own legislative rule." Id. at 44. The Court further held that the commentary interpreting the guidelines, both of which were written by the same government entity, binds a federal court unless: (a) it is inconsistent with the plain language of the guideline, (b) violates the Constitution or a federal statute, or (c) is wholly erroneous. Id. The Court explained its holding:

> [W]e can presume that the interpretations of the guidelines contained in the commentary represent the most accurate indications of how the Commission deems that the guidelines should be applied to be consistent with the Guidelines Manual as a whole as well as the authorizing statute.

Id. at 45.

The Court concluded, based on the facts, that the commentary defining a particular term was a binding interpretation.

The Provider observes that the Secretary's official interpretation of the effects of the proposed change on the exception process appeared in the 1995 Federal Register 60 Fed. Reg. 8389, 8406.[12] This interpretation is binding on the Secretary, and HCFA is not free to ignore it. As the Supreme Court held in Stinson, it is presumed that an agency's official interpretation represents the most thorough and accurate interpretation of that agency. The Secretary specifically stated in the preamble, in response to a direct request for clarification, that she has the authority to provide for exceptions to the cost limits even though Congress had eliminated the A&G add-on for hospital-based HHAs. She stated:

> (iii) Nullification of the Exceptions Process Constitutes a Substantive Change, Requiring Notice-And-Comment Rulemaking.

Id. (Emphasis Added).

Clearly, using the elimination of the A&G add-on to nullify the exception process would be a substantive change of the law because it is inconsistent with the preexisting regulation which provided for exceptions to the cost limits. Substantive rules affecting Medicare reimbursement are invalid unless they are promulgated in accord with the notice and comment rulemaking procedures of the Administrative Procedure Act ("APA").[13] Shalala v. Guernsey Memorial Hospital, 115 S. Ct. 1232

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[12] See Provider Exhibit P-13.

[13] See Provider Exhibit P-15.

(1995).[14] The APA requires that notice of the proposed standard be published in the Federal Register and that interested persons be afforded the opportunity to participate by means of written comment or oral presentation.[15] A final rule can only be adopted after consideration of public comment. Id. Consequently, any such rule that purports to eliminate the exceptions process is void for failure to comply with notice-and-comment rulemaking.

The Provider argues that the criteria on which HCFA relies to deny the Provider's exception request have not been published in any regulation or manual provision. Consequently, the Provider's exception request cannot be denied for failing to comply with these criteria. The Board has consistently ruled that HCFA may not deny a provider's exception request on the basis of criteria not set forth in any regulation or manual provision. To hold otherwise would violate the provider's due process rights. The Board requires providers to be given notice of the criteria with which they must comply in order to successfully obtain an exception. See e.g., Coalinga Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Hearing Dec. No. 95-D27, March 8, 1995, Medicare and Medicaid Guide (CCH) ¶43,223. The HCFA Administrator declined to review this decision.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that 42 C.F.R. § 413.30 sets the rules under which HCFA may establish certain limitations on providers costs which are recognized as reasonable. This regulation also discusses the rules which govern exceptions to the limitations that HCFA has made in consideration of special circumstances. §413.30(f)(l) discusses the individual situations under which an upward adjustment may be made to the limits for atypical services. This section states that the provider must show that:

> (i) The actual cost of items or services are 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.

42 C.F.R. §413.30(f)(8) concerns unusual labor costs that vary more than ten (10) percent from that included in the promulgation of the limits.

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[14] See Provider Exhibit P-16.

[15] See Provider Exhibit P-15.

The Intermediary argues that the exception process is straightforward. An exception request must be filed within 180 days of the Intermediary's Notice of Program Reimbursement. Accordingly, the intermediary makes a recommendation to HCFA on the provider's request. HCFA then renders a decision within 180 days from the date HCFA receives the intermediary's recommendation. The intermediary then notifies the provider of HCFA's decision. The Provider requested an exception on the basis of atypical services and unusual labor costs, which was received by the Intermediary on July 18, 1995.[16] On September 15, 1995, the Intermediary forwarded its recommendation to HCFA and recommended that the Provider's request be granted.
On March 10, 1997, HCFA responded to the recommendation made by the Intermediary and denied the Provider's request. The Intermediary then notified the Provider of this denial by letter dated March 27, 1997.

HCFA stated in their denial letter, in part, that:

> With respect to the hospital's claims that the nursing costs associated with their program are atypical and an adjustment for unusual labor costs is needed, we do not believe the claims are warranted. In comparing the average cost per visit of the direct costs associated with providing skilled nursing services in the hospital's home health agency, we found that the average cost per visit decreased from $59.10 in fiscal year 1992 to $52.94 in fiscal year 1993 and decreased further to $42.92 in fiscal year 1994. Also, in fiscal year 1993 the percentage of Medicare skilled visits to total skilled visits was higher than the percentage in fiscal year 1994. The hospital does not explain how fiscal year 1994 differed from fiscal year 1993 when the home health cost limitations were not exceeded by home health agency cost in the aggregate.

Id.

HCFA further stated in its denial letter that if Congress had not eliminated the administrative and general add-on to the home health cost limitation, then the Provider's home health agency's costs would not have exceeded the home health cost limitation. As a result, the request for an exception to the HHA per visit cost limitations was denied.

The Intermediary notes that HCFA's denial implies that the Provider's cost would not have exceeded the limits had the methodology not changed. Therefore, the Provider's cost is not atypical by this fact alone. The Intermediary agrees. Finally, the Intermediary complied with Program instructions in recommending exception requests to HCFA. HCFA determination complies with Program regulations

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[16] See Intermediary Exhibit 1-2.

and instructions. The Provider has not shown that it is entitled to an exception to the cost limits. HCFA's determination should be affirmed by the Board.

CITATION OF LAW, REGULATION AND PROGRAM INSTRUCTIONS:

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

1395x(v)(1)(A)	-	Reasonable Cost

2. OBRA '93

§13564	-	Reduction in Payments For Home Health Services

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

§§405.1835 -.1841	-	Board Jurisdiction
§413.30	-	Limitations on Reimbursable Costs
§413.30(f), et seq.	-	Exceptions

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

§ 2534	-	Request For Exception To SNF Cost Limits
§2544, et seq.	-	Provider Request For Exception

5. Federal Register

60 Fed. Reg

Pages 8389-8406	-	Scheduled of Limits on Home Health agency Costs Per Visit

6. Cases

Stinson v. U.S., 508 U.S. 36 (1993).

Shalala v. Guernsey Memorial Hospital, 115 S. Ct. 1232 (1995).

Coalinga Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Hearing Dec. No. 95-D27, March 8, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,223.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, evidence and parties' contentions finds and concludes that HCFA improperly denied the Provider's exception request to the HHA cost limits based on atypical services. In reviewing the complete record, the Board finds that the Provider made every appropriate effort to properly document that it had atypical services. It appropriately followed the requirements of the August 19, 1992 "Booth letter"[17] which provided statistical bases for establishing atypical services exemptions. The Provider's average time per skilled nursing visit was 89 minutes as compared to HCFA's norm of 60 minutes. This is supported by Table 7 of the Provider's exception request. The Provider did compare its average cost per visit with three other similar sized HHAs. Its cost exceeded the peer group costs by 12%. Although the "Booth letter" requires peer group comparisons by service discipline, the Provider did not and could not perform such comparisons because as the Provider appropriately points out, HCFA never developed industry-wide HHA norms relating to the nature and scope of services rendered by HHAs. Since competitive providers generally will not provide such information, the Provider did the only thing it could do to meet the HCFA comparison requirement. It used average costs per visits which it obtained from HCFA under a FOIA request.

The Provider did provide patient acuity/complexity analyses and data to support its atypical service exception request. Its average age of patients was 78 years old. It had a higher than average secondary diagnosis per patient (6). This demonstrates that the Provider's patients had more complex medical conditions than an average HHA would have. Further, the Provider had: (1) a high utilization of lab procedures, (2) most services performed by registered nurses, (3) 60% of patients required special diets, and (4) 80% of patients received ancillary services. All of these activities support the Provider's contention that it was an institution that provided atypical services.

The Board notes that the Intermediary initially agreed with the Provider that it deserved the atypical services exemption to the HHA cost limits in its recommendation letter to HCFA.[18] HCFA did not agree with the Intermediary's recommendation. However, the Board believes there are several flaws in HCFA's reasons for denial. First, HCFA used the Provider's costs per services reductions from FY 92 to FY 94 to support its denial. The regulatory requirement at 42 C.F.R. §413.30 (f)(1) requires a comparison of items or services furnished by providers which are similarly classified. HCFA did no peer comparisons. Further, the regulation does not support or require an "in-house" comparison of

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[17] See Provider Exhibit P-9.

[18] See Provider Exhibit P-6.

average costs per visit. In addition, there is no regulatory criteria that states that a drop in costs cannot result in an exception request.

The Board observes that HCFA also used elimination of the A&G add on because of OBRA '93, §13564(b) to support its reasoning for the Provider's cost per visit exceeding its HHA cost limit. The Board finds that the many legitimate factors offered by the Provider, as well as the elimination of the A&G add on, may have caused the Provider's excess cost per visit. However, the Board finds that HCFA presented no evidence to support its position that the A&G elimination, by itself, was the causative determinant.

Based on the above analyses, the Board concludes that HCFA improperly denied the Provider's exception request.

DECISION AND ORDER:

The Provider's exception request for atypical services is correct and proper. HCFA's denial of the request is reversed.

Board Members Participating:

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

Date of Decision: September 30, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman