# PROVIDER REIMBURSEMENT REVIEW BOARD
# HEARING DECISION

2000-D46

**PROVIDER** -
Campbell County Memorial Hospital
Gillette, Wyoming

Provider No. 53-0002

**vs.**

**INTERMEDIARY** -
Blue Cross Blue Shield Association/
Blue Cross and Blue Shield of Wyoming

**DATE OF HEARING-**
August 19, 1999

Cost Reporting Periods Ended -
June 30, 1993; June 30, 1994

**CASE NOS.** 96-2027; 97-2385

**INDEX**

ISSUE:

Was the Provider entitled to an exception to the home health agency ("HHA") cost limits for the fiscal years ended June 30, 1993 and June 30, 1994?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Campbell County Memorial Hospital ("Provider") is a 119- bed acute care hospital/regional medical center located in Gillette, Wyoming. The Provider=s home health agency, Prairie Home Health Services ("Praire") serves a number of counties in the Gillette area.

On October 9, 1996, the Provider filed, with the Intermediary, a request for an exception to the HHA cost limits for the fiscal year ended June 30, 1993.[1] The request cited geographical factors as extraordinary circumstances pursuant to 42 C.F.R. ' 413.30 (f)(2). On October 23, 1996, the Intermediary transmitted the exception request to HCFA with a recommendation for denial. Just prior to the Board hearing, HCFA issued a response denying the Provider=s request.[2]

A consolidated case covering FY 1993 and FY 1994 was scheduled for a Board hearing in July 1999. However, there was no evidence in the record that identified an exception request for the year ended June 30, 1994. Between July 1999 and the August 19, 1999 Board hearing, the Provider located a copy of its 1994 exception request. The Intermediary reviewed its records and could not determine that it had ever received the request. At the close of the hearing, the Board requested that the 1994 exception request go back to the Intermediary and be processed in the ordinary course of business.[3] On September 28, 1999 the Provider requested that action via a letter to the Intermediary. On February 4, 2000 HCFA advised the Intermediary that the Provider did not meet the requirements for an "atypical services" exception as stated in 42 C.F.R. ' 413.30(f)(1), or the exception for "extraordinary circumstances" as provided in 42 C.F.R. ' 413.30 (f)(2).[4] The Provider has met the jurisdictional requirements of the regulations at 42 C.F.R. '' 405.1835-.1841.

At the hearing, the parties= stipulated they were only dealing with the Provider=s request for cost limit

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1 Intermediary Exhibit I-3.

2 Intermediary Exhibit I-13.

3 Tr . at p. 230.

4 Intermediary Exhibit I-17.

exceptions since the Intermediary reversed its other two adjustments.[5] The amounts in controversy are $117,882 in FY 93, and $306,742 in FY 94. The Provider was represented by Charles F. MacKelvie, Esquire of MacKelvie & Associates, P.C. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross & Blue Shield Association.

Additional Relevant Information:

The Provider is deemed to be a not-for-profit entity for federal and state tax purposes. In addition, as the Provider is considered to be a hospital district; it receives about $4.2 million dollars annually from Campbell County, Wyoming. As a quid pro quo for receiving the tax supported monies, the Provider is required to serve everyone and anyone within its service area. Gillette, Wyoming is in the remote northeast corner of Wyoming and the five county area that the Provider serves is one of the most remote areas in the contiguous United States.

In 1992, the Provider received a Rural Transition Grant from the federal government in order to create or acquire a home health agency. The terms of the grant provided $50,000 a year for three years. In turn, the Provider was required to own an operating home health agency at the end of the grant period. Attempts to create an HHA failed, and the Provider determined that it must acquire an existing HHA.

Only two HHAs existed in Gillette, Wyoming at the time, Prairie Home Health Agency and a small agency owned by a nursing home. After negotiations, the Provider purchased the assets, including the provider number and provider name, of Prairie because state law prevented the Hospital from acquiring the stock of a proprietary entity. The purchase was consummated effective May 1, 1993. At the time of purchase the old Prairie Home Health Agency was under cost caps by approximately $117,500.

Prior to the May 1993 acquisition, Prairie served the Wyoming counties of Campbell, Johnson, Crook and Weston, which encompassed more than 13,000 square miles. There are approximately 48,000 residents in the four counties and sixty three percent of those residents live outside of Gillette. In fact, the population density for those four counties is 4.4 persons per square mile. Crook and Weston County are much more rural than Campbell County, having 1.82 and 2.68 residents per square mile respectively. In 1994, Prairie added an office in the town of Lusk, county of Niobrara, approximately 150 miles over hazardous roads from Gillette. Thus, in 1994, Prairie=s service area consisted of five counties encompassing more than 15,000 square miles, almost 20% of the total area of Wyoming. Topographically, this area is extremely remote, and has limited interstate access. Moreover, the area is subject to extreme weather conditions. Because of the remoteness and sparse population, Prairie provided the only home health care in Weston, Crook and Niobrara Counties during the years in question. While it was true that there was one additional home health agency in both Campbell and

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[5] Tr . at p. 5.

Johnson Counties in 1993 and 1994, neither agency was willing to provide the same geographical coverage as the Provider.

Prior to its acquisition by the Provider, Prairie rendered 6,485 annualized visits. In 1994, the agency rendered 9,726 visits. In January 1994, Prairie opened an office in Lusk, Wyoming. Niobrara County was an entirely new service area. During 1994, the Lusk agency rendered 509 visits, of which 54% were Medicare related. In 1994, Prairie also began to develop an expansive psychiatric home health program to meet the needs of an under-served population.

PROVIDER**:**S CONTENTIONS:

The Provider contends that it meets the evidentiary requirements for a cost limit exception for the same reason other Intermediary's have granted similar requests. Specifically:

1. **Prairie is located in a rural area (non-MSA area).** The Provider is located in a non MSA rural area. The counties that it serves, Campbell, Johnson, Crook, Weston, and Niobrara are very rural in composition.

2. **It was the only HHA in most of the county.** Prairie was the only home health agency providing Medicare services to these counties, and the only home health agency which would provide services outside the urban areas.

3. **The counties in which Prairie was located have a low population density**. The counties which the Provider services encompass 20,000 miles. There are 48,000 residents in the five counties. Therefore, the person per square mile density for the counties is 3.3. Crook and Weston Counties are much more rural than the other counties. Their person per square mile density are 1.821 and 2.684 respectively.

4. **There are adverse topographical conditions.** In the winter, driving in the area around the Provider is extremely hazardous. The majority of the roads are two lanes, are difficult to maintain, and are frequently covered with ice and/ or snow. Numerous times during the year, visibility is poor and it is necessary for the staff and nurses to travel in the dark.

The Provider also contends that it is entitled to be paid the entire amount of its costs in excess of the cost limit based upon the plain language of the applicable regulation. In part, 42 C.F.R. Section 413.30

(f) states:

> (f) Exceptions. Limits established under this section may be adjusted upward for provider under the circumstances specified in paragraphs (f)(1) through (f)(8) of this section ... An adjustment is made only to the extent the costs are reasonable, attributable to the circumstance specified, separately identified by the provider, and verified by the intermediary.
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> (1) Atypical services. The provider can show that the-
>
> (i) 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 typical 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.
>
> (2) Extraordinary Circumstances.
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> The provider can show that it incurred higher costs due to extraordinary circumstances beyond its control. These circumstances include but are not limited to, strikes, fire, earthquake, flood, or similar unusual occurrences with substantial cost effects.

The Provider asserts that its interpretation of 42 C.F.R. ' 413.30(f)(1) is firmly supported by prior case law. In Sacramento Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 80-D56, August 11, 1980, Medicare & Medicaid Guide (CCH) & 30,826, rev'd. HCFA Admin. (as to Issue 4A atypical costs) September 29, 1980, Medicare & Medicaid Guide (CCH) & 30,859, the Administrator held that the provider was entitled to be reimbursed in full for amounts above the routine cost limit for providing atypical services. The Administrator stated:

> [U]nder 42 C.F.R. ' 405.460(f), an exception to the cost limits may be granted upon the provider's demonstration that certain conditions are present. Now ' 413.30(f) provides an exception for the cost of atypical services or items. This subsection defines qualifying atypical service items as "items or services that are atypical in nature and scope

> as compared to the services generally provided by institutions similarly classified and an appropriate reason exists for the provision of such items or services."

Because of the requirements of its grant and the ordinances/regulations of Campbell County that the Provider service everyone and anyone within what eventually became more than 20,000 square miles, Prairie was providing atypical services in 1993 and 1994 because its services were unique and atypical compared to services provided by any other home health agency in Wyoming. No other home health agency provided services in the most remote areas of Wyoming and no other home health agency provided psychiatric care or such extensive charity care as did Prairie.

The Provider contends the following arguments are applicable to the years in question:

FY 1993

Prairie would certainly have been under cost caps for the two-month period of the 1993 cost year had it been able to be acquired by the Provider in a stock transaction. For the ten-month period of July 1, 1992 to April 30, 1993, Prairie was approximately $117,500 under cost caps. Had a stock purchase been affected whereby Prairie became a wholly owned subsidiary of the Provider, the extraordinary costs incurred in May and June 1993 would have been absorbed by the room under the cost cap. Hence, there would have been a wash if July-April were combined with May and June 1993; Prairie would have been some $300 over the cost limits for 1993.

However, Wyoming law and Campbell County ordinances prevented the not-for-profit Hospital from acquiring outright the existing proprietary HHA. There was no other way to structure the resulting acquisition other than an asset purchase, which, in turn, triggered the HCFA change of ownership provisions. (Because of its Rural Transition Grant, the Provider had to acquire or start a home health agency by the end of 1994).

It should also be noted that the Provider expended an additional $26,886 in employee benefits and incurred a 30% increase in salary costs in 1993 after the acquisition of Prairie. This was true because both labor laws and the Tax Code required the Provider, no matter how the acquisition transaction was structured, to pay the same wages and benefits to the newly acquired Prairie employees and the existing Provider employees. In addition, because of its newly expanded service area and the newly empowered employees, the Provider was forced to purchase a $9,000 Subaru station wagon in the 1993 cost year.

Moreover, the Provider allocated $11,923 in capital costs and $94,540 in other overhead expenses to Prairie in 1993. At acquisition, the home health agency changed from a freestanding entity, which filed HCFA Form 1728, to a hospital cost center. Post acquisition, there was automatic inclusion of

allocated Hospital A&G on HCFA Form 2552. This cost accounting was in strict adherence to 42 C.F.R. ' 413.24(d)(1).

Also, the Provider allocated $34,891 in Occupational Therapy costs to Prairie's shared ancillary costs in accordance with 42 C.F.R. '' 413.30 and 413.53. These allocated costs were reasonable costs delivered to Prairie from the respective hospital ancillary departments. Without these services, Prairie patients would not have received the necessary care for their treatment and follow up. Accordingly, the Provider has quantified the reasonable costs above the cost limits of Prairie's services after April 30, 1993.

Therefore, the Provider contends it meets the criteria for a cost limit exception in 1993 because it qualifies for an exception because of both atypical services and extraordinary circumstances.

FY 1994

Prairie was $306,682 over the cost limits in 1994, but if the cost limits had not been reduced between 1993 and 1994, the Provider would have been but $269,449 over the cost limits. As pointed out by the Intermediary at the PRRB hearing, the Physical Therapy and Occupational Therapy costs accounted for $281,000 of the cost limit overage. Much of this "excess cost" was largely the product of cost finding via the Hospital cost report. However, there were significant other reasons for the Provider being over the cost limits.

In 1994, thirteen (13) additional full and part-time personnel were added to service additional patients and to provide the additional home health services. The new employees accounted for $106,579 in additional gross wages. Moreover, fringe benefits accounted for 25% of salaries in 1994, up from 11.1 % of salaries before Prairie was acquired. In monetary terms, the fringe benefit figure increased by $119,317 in 1994. However, as discussed above, for tax, corporate and labor law reasons these costs were mandated.

In addition to maintaining its already existing vehicles, Prairie had to acquire via lease two additional vehicles to service its expanded service area at an additional cost of $9,700 annually.
Also, the opening of the Lusk office added $80,221 to the cost of running Prairie in 1994 above what it had cost to run the agency prior to April 30, 1993. In addition, there were increased costs for the newly created psychiatric home care program and other programs and increased costs associated with the 300% increase in charity patients. The Provider=s overhead allocations added $440,229 to the cost of the agency in 1994 over what it cost to run Prairie pre-acquisition. Finally, costs were allocated to the Shared Ancillary cost center from the therapies and medical supplies; This latter category added $464,392 to the post-acquisition cost of running Prairie over what it cost to run the agency prior to April 30, 1993.

Again, the Provider asserts that it meets the criteria for a cost limit exception in 1994 because it

qualifies for atypical services and based on the extraordinary circumstances cited above.

Finally, the Provider contends that HCFA=s August 17, 1999 denial[6] of its request for an exception to the cost limits is without merit. The Provider asserts that both the Intermediary and HCFA acted improperly with respect to the processing of the Provider=s exception request.[7] First, HCFA denied the Provider=s exception request approximately three years from the initial request, rather than the 180 day window set forth in HCFA Pub. 15-1 ' 2535.1 Second, in processing the request, the Intermediary did not conduct a comparison with peer home health agencies as required by HCFA Pub. 15-1 ' 2544(B)(3). Finally, HCFA did not request that the Provider submit additional documentation to support its request for exception as required by HCFA Pub. 15-1 ' 2544(C)(3).
The Provider points to Coalinga Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D-27, March 8, 1995, Medicare & Medicaid Guide (CCH) & 43,223, dec=d.rev. HCFA Admin. April 24, 1995, wherein the Board stated that ' 2544 "plainly sets forth the criteria HCFA has established in responding to a provider=s exception/exemption request" and that ' 2544 was "void of any reference to the criteria referred to in HCFA=s rejection letter". The Provider asserts that HCFA has neither the authority nor the discretion to base its denial of cost limit exception requests on reasoning which falls outside of ' 2544. In addition, the Provider also points out that Coalinga explicitly confirms that "if the Intermediary=s recommendation does not contain sufficient documentation, HCFA is required to "request additional information from the Intermediary."

The Provider argues further that correspondence in the record[8] shows the granting of an exception for extraordinary circumstances to Peninsula Home Health Care, ("Peninsula") in Soldatna, Alaska. The Provider contends that the correspondence implies that HCFA approved Peninsula=s request for a cost limit exception primarily based on the location of that agency, and that the Provider=s circumstances closely resemble those of Peninsula.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that the Provider is not entitled to the requested cost limit exception because of geographical location and extraordinary circumstances. The Intermediary contended that the Provider was $118,000 over the cost limits in 1993 and $306,000 in 1994. The Intermediary stated that $280,000 of the costs in excess of the cost limits in 1994 were due to excessive costs in Physical Therapy and Occupational Therapy. The Intermediary also contends that the costs incurred in excess

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6 Intermediary Exhibit I-13.

7 See pages 9-13 of Provider=s Post Hearing Brief.

8 Provider Exhibit 4-9 (Volume II).

of the limits could not possibly be attributed to the location of the agency, or new or novel services to patients. Instead, the Intermediary witness indicated that the Provider exceeded the cost limits due to the function of the HHA cost reporting mechanism, ie., allocated overhead from the parent hospital.[9]

The Intermediary contends that with respect to the exception request relating to the June 30, 1993 cost report, it will rely on the HCFA response to the Provider=s exception request.
On August 17, 1999, in response to the Intermediary's recommendation that the Provider's cost limit exception be denied, HCFA denied the Provider's request and based its decision on a belief that the Provider does not meet the same criteria used to grant an exception to Peninsula Home Health Care (Peninsula) located in Soldatna, Alaska. In the August 17, 1999 letter, HCFA indicated that the type of exception given to Peninsula is no longer available and it was never HCFA policy to grant an exception based only on an agency's location. HCFA stated that the Provider failed to provide any quantification of what specific costs caused the Provider to exceed its per visit limitation. HCFA also indicates that the Provider's request lacks an explanation of how its incurred costs relate to its reasons for exceeding the HHA cost limits. HCFA also indicated that 42 CFR ' 413.30(2) was intended to correct the "Extraordinary circumstances" at the time they occur, not circumstances which are continuous in the normal operations of the provider.[10]

The Intermediary points to HCFA=s response to the Provider=s exception request for the year ended June 30, 1994. In its February 4, 2000 letter denying the Provider=s exception request HCFA stated the following:

> [i]n this submission, certain direct and indirect costs are cited, such as labor related, transportation, new programs, charity care, overhead allocation, and ancillary services, as evidence of the provision of atypical services. However, there is nothing in his application that demonstrates that the patient care services furnished are atypical and necessitated by the special needs of the agency=s patients, as is required at 42 C.F.R. ' 413.30 (f)(1).
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> The "extraordinary circumstances" exception, at 42 C.F.R. 413.30 (f)(2), clearly states that this is a circumstance beyond the control of the provider. The circumstances described are the result of management decisions to purchase an existing agency, expand the area in which the

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9 Tr. at p 188-192.

10 Exhibit I-13.

> agency furnishes services, change the salary and benefits structure, and other management decisions and therefore are within the control of the provider. Similarly, to read "strikes, fires, earthquake, flood or similar unusual occurrences . . . (Emphasis added) to encompass the extant conditions cited is well beyond any reasonable interpretation of the plain language of the regulation.

Finally, the Intermediary contends that there was no identification of specific cost categories or quantification of dollar amounts with specific linkage to the noted geographical/weather problems. Accordingly, the Intermediary asserts that HCFA=s determinations should be affirmed by the Board.

CITATION OF LAW, REGULATION AND PROGRAM INSTRUCTION:

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

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| '' 405.1835 -. 1841 | - | Board Jurisdiction |
| ' 413.24(d)(i) | - | Step Down Method |
| ' 413.30 et. seq. | - | Limitations on Reasonable Costs |
| ' 413.53 | - | Determination of Cost of Services to Beneficiaries |

2. Program Instructions - Provider reimbursement Manual Part I HCFA Pub. 15-1):

| | | |
|---|---|---|
| ' 2535.1 | - | Adjustment of Interim Rate |
| ' 2544, et seq. | - | Provider request for exception |

3. Cases

Sacramento Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 80-D56, August 11, 1980, Medicare & Medicaid Guide (CCH) & 30,826, rev=d. HCFA Admin. as to Issue 4A atypical costs September 29, 1980, Medicare & Medicaid Guide (CCH) & 30,859.

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

43,223, decl=d rev. HCFA Admin. April 24, 1995.

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 properly denied the Provider=s exception requests to the HHA cost limits. However, it should be noted that HCFA=s response to the Provider=s FY 1993 request came almost three years after that initial request. In addition, much confusion surrounded the actual submission date of the FY 1994 exception request. In view of these factors, HCFA and the Intermediary are advised to address future exception requests in accordance with the timeframes set forth in 42 C.F.R. ' 413.30 (c).

The Board finds that the regulations at 42 C.F.R. ' 413.30 (f) (1)and (2) provide an exception to the HHA cost limits for two reasons: atypical services and extraordinary circumstances. There is no specific regulatory relief based on location or resulting from geographic, demographic or topographic conditions. Secondly, the Board notes that the same cost limits apply to hospital based as well as free standing HHAs.

With respect to the atypical services issue, the Board finds that the mere incurrence of increased costs does not automatically translate into or justify an atypical exception to the HHA cost limits. For example, in the instant case, there is no medical evidence in the record which reflects the age or acuity of any of the Provider=s patients. Both are factors which could have supported the Provider=s argument of the provision of atypical services. Nor did the Provider present any evidence or quantify how the addition of its new psychiatric home care program related to the Provider exceeding the cost limits. The Provider also contended that it was the sole provider of certain services. However, the evidence indicated that other providers were in the area. The Board finds that the burden of proof is on the Provider to support its claim and in this particular case that burden has not been met.

Regarding the Provider=s assertion of extraordinary circumstances, there is little evidence to indicate that the Provider=s increased costs were beyond management=s control. The Board concurs with HCFA=s finding that the circumstances proffered by the Provider are not comparable to fire, earthquake, or flood (examples of unusual circumstances cited in 42 C.F.R.
' 413.30 (f)(2).

Finally, the Board was not persuaded that the Provider=s references to the factors in Sacramento Medical Center and Coalinga Regional Medical Center were relevant to the case at hand.

DECISION AND ORDER:

The Provider has not met its burden of proof and failed to properly document its request for exceptions to the HHA cost limits. HCFA=s denial of the Provider=s exception requests is affirmed.

Board Members Participating:

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

FOR THE BOARD

Irvin W. Kues
Chairman