PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D70

PROVIDER -
Ashtabula County Medical Center Skilled Nursing Facility
Ashtabula, OH

Provider Nos. 36-0125/36-6048

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/ AdminaStar Federal, Inc.

DATE OF HEARING-
May 25, 2000

Cost Reporting Period Ended -
December 31, 1996

CASE NO. 97-0407

ISSUE:

INDEX

Did the Health Care Financing Administration ("HCFA") properly deny a new provider exemption request for the Provider=s distinct part skilled nursing facility under 42 C.F.R. '413.30(e)?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Ashtabula County Medical Center ("ACMC") is a hospital located in Ashtabula, Ohio, which contains a distinct part skilled nursing facility ("SNF") that is a fully participating 15-bed Medicare and Medicaid long term care facility ("Provider"). The Provider submitted a request for an exemption to the Medicare SNF routine service cost limits as a new provider under the regulatory provision of 42 C.F.R. '413.30(e) for its distinct part SNF. On July 10 1996, AdminaStar Federal, Inc. ("Intermediary") forwarded the Provider=s request with supporting documentation to HCFA with the recommendation that the request be denied.[1] HCFA denied the request in its letter dated July 25, 1996, and the Provider was notified of HCFA=s denial by the Intermediary=s letter dated July 29, 1996.[2] The Provider appealed HCFA=s denial of its exemption request to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. ''405.1835 -.1841 and has met the jurisdictional requirements of those regulations. The Provider was represented by David M. Levine, Esquire, of Benesch, Friedlander, Coplan & Aronoff, LLP. The Intermediary=s representative was Bernard M. Talbert, Esquire, of the Blue Cross ans Blue Shield Association.

In order to assist the Board in deciding the issue in dispute, the parties submitted the following joint stipulations for inclusion in the record:

1. ACMC is a hospital located in Ashtabula, Ohio.

2. In May, 1995, ACMC entered into an "Agreement for Purchase of the Right to Operate Nursing Home Beds" with the County Commissioners of Ashtabula County, the owners of the Ashtabula County Home ("ACH"), under which agreement, ACMC paid ACH $7,500.00 per bed, for the right, title, and interest to 15 beds out of ACH=s 310 bed total. ACMC did not acquire any other assets from ACH.

3. ACMC and ACH are separate and unrelated health care institutions.

4. On its Medicare Cost Report for the period of January 1, 1994 to December 31, 1994, ACH reported 32 Medicare certified beds and 278 Medicaid certified beds (total 310). On its January 1, 1995 to

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[1] See Intermediary Exhibit I-2.

[2] See Intermediary Exhibits I-3 and I-4.

December 31, 1995 Medicare cost report, ACH reported 42 Medicare certified beds and 253 Medicaid certified beds (total 295).

5. Prior to June of 1995, ACMC had 246 acute care beds.

6. In June 1995, ACMC applied for a certificate of need ("CON") from the Ohio Department of Health, pursuant to which it sought authority to acquire, relocate and place into service 15 long term care beds on its premises. Under the Ohio CON laws and regulations, ACMC could not develop a skilled nursing facility without purchasing existing beds from another provider.

7. ACMC=s CON application was granted in October 1995.

8. ACMC became Medicare-certified on March 27, 1996. It had not operated as a nursing facility or a skilled nursing facility within the immediately preceeding three full years.

9. Following the acquisition of the beds, and upon ACMC commencing operations of the skilled nursing facility, no residents of ACH were transferred to ACMC=s skilled nursing facility.

10. ACH continued to operate as a nursing facility with 295 licensed and certified beds following the sale of the 15 beds. No other change in ACH=s licensure or certification status occurred as a result of the sale of beds to ACMC.

11. No ACH personnel became employees of ACMC upon the opening of ACMC=s skilled nursing facility and ACH has never been involved in the operation of ACMC=s skilled nursing facility (i.e., as a manager).

12. The service area for ACH and ACMC is designated by the State of Ohio as HSA #10. HSA #10 consists of Ashtabula, Trumbull, Mahoning and Columbiana counties. The ACH and ACMC physical plants are approximately 7 miles apart.

13. A review of the home addresses of all admissions to and residents of the ACMC distinct part SNF for the first six months of operation, show that patients from this service area constituted 100% of all admissions to the distinct part SNF.

PROVIDER=S CONTENTIONS:

The Provider contends that HCFA=s denial of its request for an exemption under 42 C.F.R. '413.30(e) was clearly erroneous and inconsistent with the plain meaning of the regulation. The regulation states in pertinent part:

> Exemptions from the limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

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

It is HCFA=s position that the 15 beds that comprise the ACMC skilled unit were Medicare-certified for at least three full years under prior ownership by ACH and, therefore, ACMC (as the subsequent purchaser of the CON rights) is deemed to have been Medicare-certified as well for purposes of analyzing a new provider exemption request. The Provider argues that the phrase in the regulation "provider of inpatient services" means, in this case, ACMC. The word "it" similarly refers to the "provider of inpatients services" (here, ACMC -- the institution seeking the exemption). The phrase "under present or previous ownership" also relates to and modifies the phrase "provider of inpatient services." The phrase "under present or previous ownership" does not relate to the CON rights to the beds at issue, but instead relates to ACMC as an institution. Nothing in the Social Security Act or the "new provider" regulation even remotely suggests that the certification status of a prior owner of the CON rights can be considered in determining whether an entirely different provider is entitled to an exemption.

While the unambiguous language of 42 C.F.R. '413.30 (e) cannot support HCFA=s strained interpretation, the Provider notes that the Provider Reimbursement Manual ("HCFA Pub. 15-1") '2604.1 confirms that the proper and exclusive inquiry is whether the institution seeking a new provider exemption (here, ACMC) "has operated in the manner for which it is certified in the [Medicare program] (or the equivalent) under present or prior ownership ...." The repeated references in HCFA Pub. 15-1 '2604.1 to "an institution" or "the institution" demonstrate that HCFA cannot disqualify one institution from receiving a new provider exemption based on the nature of the operations of a different and unrelated institution.

For example, '2604.1 states:

> Although a complete change in the operation of the institution, as illustrated above, shall affect whether and how long a provider shall be considered a "new provider," changes of the institution=s ownership or

> geographic location do not in itself [themselves] alter the type of health care furnished and shall not be considered in the determination of the length of operation.

HCFA Pub. 15-1 ' 2604.1.

In support of its position, the Provider cites Pfizer, Inc.v. Heckler, 735 F.2d 1502, 1509 (D.C. Cir. 1984), citing Udall v. Tallman, 380 U.S. 1, 16, (1965), (quoting Bowles v. Seminole Rock Co., 325 U.S. 410, 414 (1945) with respect to reviewing the validity of an agency=s interpretation of its own regulation, ---"a court should be guided by an administrative construction of regulation only >if the meaning of the words is in doubt.= Deference [by a reviewing court] to agency interpretations [of a regulation] is not in order if the rule=s meaning is clear on its face." The Provider insists that the entire focus of 42 C.F.R. ' 413.30(e) is on the activities of the institution/provider seeking the new provider exemption (here, ACMC), and not the prior activities of another unrelated institution (ACH).

The Provider is aware of the Board=s decision in Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98--D40, April 14, 1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) &46,224. While the Board affirmed the Secretary=s denial of a new provider exemption under circumstances very similar to those in the instant case (ACMC=s only link to ACH was the acquisition of the CON operating rights), the Provider disagrees with the Board in that decision.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that HCFA properly adhered to Medicare law, regulations and program instructions in denying ACMC=s new provider exemption request. It is HCFA=s position that ACMC=s distinct part SNF was established through the purchase and relocation of the operating rights to 15 licensed long term care beds from ACH in accordance with a CON issued by the Ohio Department of Health.[3] A CON is a state requirement that particular categories of health care providers must meet in order to receive approval for building or remodeling new facilities and beds, adding programs or services, or purchase of new equipment. Ohio has had a CON for nursing homes since 1978 with a moratorium initially added to it in 1983 for the purpose of limiting the growth of new health care facilities.

The Intermediary advises that the purchase and relocation of operating rights from an existing institution constitutes a change of ownership ("CHOW") as exemplified in HCFA Pub. 15-1 ''1500.7 and 2533.1.[4] Given the fact that a CHOW occurred with respect to the 15 long term care beds, the

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[3] See Intermediary Exhibit I-16.

[4] See Intermediary Exhibits I-10 and I-17.

Provider was not eligible for a new provider exemption for its distinct part SNF because the prior owner had utilized those beds as part of a dually participating nursing facility under the Medicare and Medicaid programs for more than three years prior to the transfer. The Intermediary notes that the Board affirmed this position in its decision in Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) &46,224 stating that "this type of transaction constitutes a relocation of a portion of a pre-existing facility as opposed to the establishment of a facility that has never before existed."[5] Confirmation that ACMC bought and relocated the operating rights to 15 existing licensed and operating beds from ACH can be found in the following documentation: (1) CON Application dated June 1995;[6] (2) Approval of the CON Application by the State of Ohio dated October 5, 1995;[7] and (3) Agreement for Purchase of the Right to Operate Nursing Home Beds between County of Ashtabula, Ohio, via the County Commissioners of Ashtabula County and ACMC dated May 1, 1995.[8]

The Intermediary points out that since the CHOW transaction resulted in a change in location, ACMC=s exemption request was also considered under the relocation provisions found in HCFA Pub. 15-1 '2533.1 B.[9] This manual provision allows for an exemption based upon a relocation whereby the normal inpatient population can no longer be expected to be served at the new location. As part of its review of the Provider=s exemption request, HCFA requested a list of the names and home addresses of all admissions and residents of ACH for one year prior to the relocation, and the same information for the first six months of operation from ACMC.[10] Based on its analysis of the data, HCFA found that ACH and ACMC were located in the same primary service area, and that patients from this service area constituted 100 percent of all admissions to ACMC=s distinct part SNF. Moreover, ACMC=s distinct part SNF continues to serve the same cities and towns in Ohio as served by ACH. Since the same service area constitutes the normal inpatient population at the new location, ACMC=s distinct part SNF does not qualify for an exemption under the relocation provisions in HCFA Pub. 15-1 '2533.1B.

The Intermediary asserts that there has been no change in HCFA=s longstanding policy on new provider

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5 See Intermediary Exhibit I-18.

6 See Intermediary Exhibit I-19.

7 See Intermediary Exhibit I-16.

8 See Intermediary Exhibit I-20.

9 See Intermediary Exhibit I-10.

10 See Intermediary Exhibit I-23.

exemptions since its inception on June 1, 1979. A new provider is defined in 42 C.F.R. '413.30(e) as "a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare under past and previous ownership, for less than three full years." For purposes of applying this regulation to skilled nursing facilities, the phrase"...has operated as the type of provider..." refers to whether or not, prior to certification, the institution or institutional complex engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons as defined at 42 C.F.R. '409.33(b) and (c), and did not primarily care and treat residents with mental diseases. The Intermediary points out that there is nothing in the regulation that requires that the institution be in "continuous" operation in the three years prior to Medicare certification, and HCFA has routinely considered breaks in service in computing and granting new provider status. Accordingly, HCFA has a longstanding policy that, an institution or institutional complex that reopens or is recertified with or as a Medicare certified SNF, or its equivalent, within the three years prior to its certification in the Medicare program, where it had previously operated or closed as a SNF, or its equivalent, during that same period, would be subject to inclusion of the operation if the initial SNF, or its equivalent, in determining new provider status. In the instant case, the Provider acquired the legal rights to operate and relocate 15 licensed beds from ACH on October 5, 1995. At that time, ACH was and continues to be in full operation. However, ACMC did not reopen its portion of the institution it purchased until January 31, 1996, a period of less than three months in between closure and reopening. Accordingly, the operation of ACH was considered in making a determination regarding the exemption request in accordance with the above-stated policies.

The Omnibus Budget Reconciliation Act of 1987 included the Nursing Home Reform provisions that regulate the certification of long term care facilities under the Medicare and Medicaid programs. These provisions became effective for services rendered on or after October 2, 1990. The result is that both Medicare SNFs and Medicaid nursing facilities (NFs) are required to provide, directly or under arrangements, the same basic range of services which includes those nursing services and specialized rehabilitative services needed to attain or maintain each resident=s highest practicable level of physical, mental and psycho-social well-being. The legislative history indicates that Congress= intent in adopting the Nursing Home Reform provisions was to apply a single, uniform set of requirements to all nursing facilities participating in Medicaid, eliminating the current regulatory distinctions between skilled and intermediate nursing facilities.[11] Under the Nursing Home Reform provisions, a single standard of skilled care was established for all Medicare and Medicaid beneficiaries, and forced facilities to provide skilled care as required by federal law and was in itself self-effectuating. In support of this interpretation, the Intermediary cites the court decision in Newman v. Kelly, 849 F. Supp. 228 (1994) where the court found that the term "skilled nursing facility" is the substantial equivalent of the term "nursing facility."[12] In that decision, the court held that:

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[11] See Intermediary Exhibit I-30.

[12] See Intermediary Exhibit I-9.

> effective October 1, 1990, pursuant to the Nursing Home Reform Law, every nursing home resident covered by Medicare and/or Medicaid is entitled to "skilled nursing care," defined by the statute as the level of care necessary to "attain the highest practicable physical, mental and psycho-social well-being of each resident." ...Viewed in isolation, the difference in the terms "skilled nursing facility" under Medicare and simply "nursing facility" under Medicaid imply that a level of care distinction may be inferred between the two statutes. However, while a technical difference does exist in the terms used to describe the facilities eligible for reimbursement under the two schemes, the substantive definition of the facilities covered is the same in both statutes. The statutory definitions clearly state that "skilled" care must be provided to all residents who require nursing care under either Medicare or Medicaid reimbursement schemes. In addition, there is no indication in these definitions or statutory schemes that any distinction should be made on the basis of level of skilled care required by the resident who is eligible for Medicare or Medicaid reimbursement.

Id.

The Intermediary contends that HCFA=s position that a Medicaid-certified NF is equivalent to a Medicare-certified SNF is not unreasonable. An institution may have restrictions on the types of services it makes available and the types of health conditions it accepts, or may establish other criteria relating to the admission of patients. In addition, a nursing facility might not have furnished skilled nursing or rehabilitative services as frequently as a skilled nursing facility providing those services on a continuous basis. However, the regulation at 42 C.F.R. '413.30(e) makes no allowance for institutions providing a low volume of skilled nursing services prior to certification as an SNF. An institution having provided skilled nursing or rehabilitative services for three or more years prior to certification under past and present ownership, regardless of the specific volume, is not entitled to the new provider exemption. The Intermediary notes that this position was affirmed by the Board in the case of Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/AdminaStar Federal, PRRB Dec. No. 98-D64, June 16, 1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) &80,006,[13] which was upheld by the United States District Court for the Southern District of Ohio, Western Division, Mercy St. Teresa Center v. Department of Health & Human Services, No. C-1-98-547 (D.S.D. Oh., June 16, 1999).[14]

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[13] See Intermediary Exhibit I-34.

[14] See Intermediary Exhibit I-35.

Based on the application of Medicare law, regulations and program instructions, the Intermediary concludes that the Provider has failed to demonstrate that it met the requirements for an exemption to the routine service cost limits for its distinct part SNF. However, the Provider may qualify for an exception to the SNF routine cost limits as set forth in Chapter 25 of HCFA Pub. 15-1. The fact that ACMC decided to increase the variety of skilled nursing and/or rehabilitative services upon relocation of a portion of ACH=s operating beds to its hospital campus does make the SNF a new provider of skilled nursing or rehabilitative services. The Intermediary advises that none of the factors essential for granting an exception (i.e., lower than average length of stay, higher than average ancillary costs and higher than average Medicare utilization) are relevant in the determination for a new provider exemption. The Medicare policies for granting an exemption request were put into place to ensure that truly new institutions were in fact afforded the protection intended during an initial period wherein utilization is lower than the normal level for an established institution. Granting a relocation exemption under the circumstances presented in this case would cause the Medicare program to expend its limited resources to subsidize an institutional relocation where the new location continues to serve the same inpatient population as served in the old location. Accordingly, the Board must affirm HCFA=s denial of the Provider=s exemption request.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

''405.1835-.1841	-	Board Jurisdiction
'409.33 et seq.	-	Examples of Skilled Nursing and Rehabilitation Services
'413.30(e)	-	Limitations on Reimbursable Cost-Exemption

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

'1500.7	-	Other Disposition of Assets
Chapter 25	-	Limitations on Coverage of Costs Under Medicare
'2533 et seq.	-	Request for Exemption from SNF Cost Limits

'2533.1	-	Requests regarding New Provider Exemption
'2604.1	-	Definitions - New Provider

3. Cases:

Pfizer, Inc. v. Heckler, 735 F.2d 1502 (D.C. Cir. 1984), citing Udall v. Tallman, 380 U.S. 1, (quoting Bowles v. Seminole Rock Co., 325 U.S. 410 (1945).

Newman v. Kelly, 849 F. Supp. 228 (1994).

Mercy St. Teresa Center v. Department of Health & Human Services, No.C-1-98-547, (D.S.D. Oh., June 16, 1999).

Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) &46,224.

Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/AdminaStar Federal, PRRB Dec. No. 98-D64, June 16, 1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) &80,006.

4. Other

Omnibus Budget Reconciliation Act of 1987 - (OBRA - 1987).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions and evidence presented, finds and concludes that HCFA properly denied the Provider=s request for an exemption to the routine cost limits for its distinct part SNF. The Provider does not qualify as a new provider under the governing regulatory provisions set forth under 42 C.F.R. '413.30(e).

The Board finds that the joint stipulations of the parties and the evidence in the record clearly demonstrate that the 15 beds obtained by ACMC for the establishment of its distinct part SNF were pre-existing beds that were purchased from ACH pursuant to the "Agreement for Purchase of the Right to Operate Nursing Home Beds."[15] Further, ACMC applied for and received CON approval from the

[15] See Intermediary Exhibit I-20.

State of Ohio for the relocation of these operational, long-term care beds to its hospital facility.[16] Accordingly, the documentation substantiates that ACMC bought and relocated the operating rights to 15 existing and operational beds from ACH, and that the transaction was effected by a CHOW as set forth under HCFA Pub. 15-1 ''1500.7 and 2533.1. Moreover, the Provider does not dispute that the beds were acquired from a pre-existing facility, and that the prior facility (ACH) provided skilled nursing care and related services as defined under 42 C.F.R. '409.33 (b) and (c).

The Board notes that the sole argument advanced by the Provider concerns the interpretation of the controlling regulatory provisions of 42 C.F.R. '413.30 (e) which state in part:

> Exemptions from the limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

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

It is the Provider=s position that the term "provider of inpatient services" only applies to the current provider seeking the exemption; and that the phrase" under present or previous ownership" does not relate to the CON rights to the beds at issue, but to ACMC as an institution. The Board rejects the Provider=s constricted interpretation, and finds that the proper application of the regulation necessitates an examination of 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 for which it is certified. In this regard, the Board concurs with HCFA=s determination that the operation of ACH must also be considered since it was the pre-existing facility from which the CON rights for the 15 existing and licensed beds were obtained. Whereas HCFA determined that ACH operated as a SNF/NF since June 21, 1989,[17] which has not been disputed by the Provider, the Board concludes that the Provider is not eligible for the new provider exemption under 42 C.F.R. '413.30(e). In addition, the Board finds that the Provider does not qualify for an exemption under the relocation provisions in HCFA Pub. 15-1 '2533.1B based on HCFA=s determination that ACMC and ACH are in the same service area which constitutes the normal inpatient population at the new location.

DECISION AND ORDER:

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[16] See Intermediary Exhibits I-16 and I-19.

[17] See Intermediary Exhibit I-3.

HCFA properly denied a new provider exemption request for the Provider=s distinct part skilled nursing facility under 42 C.F.R '413.30(e). HCFA=s determination is affirmed.

Board Members Participating:

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

FOR THE BOARD:

Irvin W. Kues
Chairman