PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2002-D31

PROVIDER –
Mercy Medical Skilled Nursing Facility
Mobile, Alabama

Provider No. 01-5426

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING-
March 13, 2002

Cost Reporting Period Ended -
December 31, 1994

CASE NO. 97-0135

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ISSUE:

Was the Centers for Medicare & Medicaid Services' (Formerly the Health Care Financing Administration) denial of a new provider exemption proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mercy Medical Skilled Nursing Facility ("Provider") is a freestanding, Medicare certified skilled nursing facility ("SNF") located in Mobile, Alabama. The Provider is a subsidiary of Mercy Medical Hospital ("Mercy Medical") which is located in Daphne, Alabama. Mercy Medical's complex in Daphne consists of a rehabilitation hospital, Provider No. 01-3027, and a hospital-based SNF, Provider No. 01-5049, which are separately licensed, certified, and do not share any common location with the Provider.[1]

On October 5, 1994, Mercy Medical submitted a written request for an exemption to Medicare's SNF routine service cost limits on behalf of the Provider. The request was made for the cost reporting periods ending December 31, 1994, December 31, 1995, and December 31, 1996, and was based upon Medicare's "new provider" exemption rules found at 42 C.F.R § 413.30(e).[2] Mutual of Omaha Insurance Company ("Intermediary") reviewed the request and forwarded it to the Centers for Medicare & Medicaid Services ("CMS") on December 15, 1994, along with its recommendation that the request be granted.[3] In a letter dated June 20, 1995, CMS advised the Intermediary that it had denied the new provider exemption request. In part, CMS explained that the Provider had operated a hospital-based SNF since January 1967, referring to the Daphne location, Provider No. 01-5049. CMS explained that each SNF, i.e., the SNF located in Daphne as well as the Provider had been established as hospital-based facilities and that both SNFs' costs will be allocated on Mercy Medical's cost report. In pertinent part CMS stated:

> [f]urthermore, the Health Care Financing Administration (HCFA) has previously determined that a hospital-based complex with two distinct SNFs is not consistent with applicable statutory provisions. Section 1819(a) of the Social Security Act (The Act) defines a SNF as ". . . An institution (or a distinct part of an institution). . . (emphasis added). We believe this reference in the singular to "a" distinct part indicates that Congress did not contemplate permitting the establishment of more than one distinct part SNF in a given institution. This language is also reflected in the committee report accompanying the original Medicare legislation (Sen. Fin. Comm. Rep. No. 404, 89th Cong., 1st Sess. 31-32

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1 Provider Position Paper at 2.

2 Intermediary Position Paper at 5. Exhibit I-1.

3 Exhibit I-2.

(1965):

> . . . A posthospital extended care facility could be an institution, such as a skilled nursing home, or a distinct part of an institution, such as a ward or wing of a hospital or a section of a facility another part of which might serve as an old-age home.
>
> Section 1919 (a) of the Act, which defines a Medicare nursing facility (NF), contains identical distinct part language. Thus, we believe that the authority contained in section 1819 (a) of the Act permits an institution to establish a distinct part SNF, and that the separate authority contained in section 1919 (a) of the Act permits that same institution to establish a distinct part NF (which may or may not overlap with the institution's SNF distinct part). However, a single institution cannot establish more than one distinct part SNF, or more than one distinct part NF.

CMS Letter, June 20, 1995.[4]

Subsequent to CMS' denial, the Provider established that it was in fact a freestanding facility rather than a hospital-based facility.[5] Accordingly, since there had been an apparent error, CMS agreed to and made a new determination regarding the Provider's new provider exemption request. On July 5, 1996, CMS advised the Intermediary that it had reviewed the Provider's request, as a freestanding facility, and found that the Provider did "not qualify for a new provider exemption because;

1. To establish MM-Mobile [the Provider], nine beds were purchased and subsequently relocated from LSP [Little Sisters of the Poor Nursing Home] at

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[4] Exhibit I-3.

[5] Exhibits I-9 and I-10.

1655 McGill Avenue to 3712 Dauphin Street, in Mobile, Alabama, in accordance with a transfer of ownership, approved by the State of Alabama, State Health Planning Agency.

2. The portion of the existing long term care institution, prior to relocation, operated as a SNF/NF and is considered an equivalent provider of skilled or rehabilitative services.

3. Upon relocation, the population served did not substantially change, nor was there a change in the primary service area."

Department of Health and Human Services Letter, July 5, 1996.[6]

On July 17, 1996, the Intermediary notified the Provider that its request for an exemption to the SNF routine service cost limits based upon its status as a freestanding facility was denied. On October 31, 1996, the Provider appealed CMS' denial to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations.[7] The amount of Medicare funds in controversy is approximately $74,000 for the Provider's 1994 cost reporting period.[8]

The Provider was represented by Thomas C. Fox, Esq., of Reed Smith Shaw & McClay, LLP. The Intermediary was represented by Thomas Bruce, Senior Consultant, Mutual of Omaha Insurance Company.

BACKGROUND:

Mercy Medical needed to obtain a certificate of need pursuant to Title 22, Chapter 21, Article 9 of the Code of Alabama in order to construct and begin operating a SNF in the Mobile area, i.e., the Provider.[9] Accordingly, on October 4, 1990, Mercy Medical submitted a certificate of need application to the Alabama State Health Planning Agency.[10] An executive summary of the project included in the application states that: "Mercy Medical proposes to construct in Mobile a dispersed-site continuing care retirement community consisting of a mixed-use independent (congregate) living facility (35 units), a domiciliary (assisted living) facility (60 units) and a 20-

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6 Exhibit I-11

7 Exhibit I-12.

8 Intermediary Position Paper at 4.

9 Intermediary Position Paper at 7.

10 Exhibit I-13.

bed freestanding hospice facility."[11] In the discussion of the hospice unit found in Part Two of the application, Project Narrative, Page 7, Mercy Medical states: "the 20 bed complement for the hospice component will be composed of nine (9) skilled nursing beds and eleven (11) free-standing hospice beds. . . the nine (9) skilled nursing beds are to be incorporated as a result of a recent de-certification of these beds by the Little Sisters of the Poor ("LSP"), and a subsequent agreement with them to make these beds available as the skilled component of the facility." Id.

The State Health Planning Agency assigned the request Project Number AL-9 1002. On October 25, 1990, Mercy Medical entered into a Letter of Agreement with LSP to transfer and relocate nursing home capacity, i.e., the right to operate 9 nursing home beds owned and operated by LSP.[12] On February 25, 1991, the Alabama State Health Planning Agency approved the transfer i.e., the right to operate 9 nursing home beds owned and operated by LSP to Mercy Medical.[13]

On January 20, 1994, the State of Alabama, Department of Public Health, issued a temporary license to operate Mercy Medical SNF-Mobile and McAuley Place, a nine bed skilled nursing facility and 60 bed assisted living facility (congregate), to Mercy Medical.[14] Following licensure, on January 20, 1994, Mercy Medical, d/b/a Mercy Medical Skilled Nursing Facility - Mobile entered into an agreement with the Secretary of Health and Human Services to participate in the Medicare program as a SNF. The Provider was found to meet the Requirements for Long Term Care Facilities on February 2, 1994, and was assigned provider number 01-5426 for administrative purposes.[15] Subsequently, the Provider submitted documentation indicating that it did not accept its first patient requiring skilled nursing and related service or a rehabilitative service, taking into consideration the operation of the institution under both past and present ownership, until January 25, 1994.[16]

Thereafter, CMS reviewed a request by the Provider for an exemption to the cost limits under 42 C.F.R. § 413.30(e) for the cost reporting period ended December 31, 1994, as if it were operating as a freestanding SNF, and sought additional documentation from the appropriate authorities prior to making a determination. CMS denied the Provider's request on the grounds that the bed rights were purchased from LSP. It reasoned that LSP had operated as an equivalent provider of services and that the relocations of bed rights to Mercy Medical did not substantially change the

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[11] Id. at 2.

[12] Exhibit I-15.

[13] Exhibit I-16.

[14] Exhibits I-17, I-18 and I-19.

[15] Exhibits I-20 and I-21.

[16] Exhibit I-22.

primary service area.

PROVIDER'S CONTENTIONS:

The Provider contends that CMS' denial of its request for an exemption to Medicare's routine service cost limits is improper.[17] The Provider asserts that it meets both the requirements and intent of 42 C.F.R. § 413.30(e)(2), which is the rule for granting an exemption to a "new" provider. The Provider explains that a "new" provider is one 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)(2). Moreover, the purpose and intent of this rule is: "to assist new providers who experience high costs due to low occupancy rates and start-up costs because they lack an established patient population." San Diego Physicians and Surgeons Hospital v. Aetna Life Insurance Company, PRRB Dec. No. 91-D6, November 15, 1990, Medicare and Medicaid Guide (CCH) & 38,966, rev'd., CMS Administrator, January 12, 1991, Medicare and Medicaid Guide (CCH) & 39,007 ("San Diego"). Respectively, the Provider asserts that it is a new provider pursuant to 42 C.F.R. § 413.30(e)(2), which experienced high costs due to low occupancy rates and start-up costs because it lacked an established patient population.

The Provider contends that it is licensed, certified, and accredited as a freestanding SNF.[18] The Provider explains that in October 1990, Mercy Medical obtained a certificate of need from LSP for nine SNF beds in Mobile County, Alabama. On October 14, 1992, Mercy Medical undertook the construction of a new 20 bed facility, which included 11 hospice beds and nine SNF beds, to be located at 3712 Dauphin Street, Mobile, Alabama 36608. This facility is 25 miles from Mercy Medical's hospital-based SNF located in Daphne, and is located in another county which is 30 minutes driving time by automobile. Construction of the new facility was completed on January 3, 1994. The Alabama State Board of Health licensed the Provider as a freestanding SNF under Alabama law, to begin operation January 20, 1994. See Ala. Admin. Code R. 420-5-10.

The Provider contends that it meets all of the requirements as a "new" provider pursuant to 42 C.F.R. § 413.30(e)(2).[19] The Provider explains that it was a newly constructed facility and needed to borrow money to begin operations. In addition, it had low occupancy rates, and had never operated under any other license or certification or provided health care services of any kind to patients in Mobile, Alabama or any other geographic area.

The Provider explains that as of June 30, 1989, LSP owned and operated a 109-bed nursing

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[17] Provider's Supplemental Position Paper at 4.

[18] Provider Position Paper at 10.

[19] Provider Position Paper at 17.

home facility, located at 1655 McGill Avenue, in Mobile, Alabama.[20] This facility utilized 91 beds that were Medicaid certified to provide intermediate care facility ("ICF") services and 18 beds that were Medicare and Medicaid certified to provide SNF services. Around December 1989, LSP converted nine of the semi-private ICF rooms to private ICF rooms and notified the State of Alabama that LSP no longer intended to use the remaining nine ICF beds to provide intermediate care services. Instead, LSP would operate the facility as an 82-bed Medicaid certified ICF and an 18-bed Medicare and Medicaid SNF. By 1993, LSP had further downsized to 75 beds. Of these beds, only eight or nine are and have been Medicare certified.

The Provider also explains that in accordance with the policy of the Alabama State Health Planning and Development Agency (the "Agency"), the nine beds removed due to the 1989 conversion were reported in the Alabama State Health Plan Inventory as dormant nursing home beds and therefore lost any service designation. Around January 1, 1990, the Agency informed LSP that the nine beds would be removed from the State Health Plan Inventory if LSP maintained its current Medicaid-certified 82 ICF beds and made no arrangements for an alternate use of the beds within a one-year time frame.

Pursuant to a Letter of Agreement dated October 25, 1990, LSP transferred its rights to these nine beds to Mercy Medical to permit construction of Mercy Medical's Project AL-91002, a 20-bed freestanding hospice facility in Mobile, with the understanding that the nine beds within this new facility would be licensed and certified to provide skilled nursing care. The Agency approved Mercy Medical's Project AL-9 1002 with the nine SNF beds designated to provide skilled nursing services.

The Provider asserts that the nine beds LSP transferred to Mercy Medical had always been certified as Medicaid ICF beds. They had been taken out of service in December 1989, before the time (October 1, 1990) the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987 ("OBRA") required Medicaid nursing facility beds to meet certification requirements equivalent to those for Medicare-certified SNFs. 42 U.S.C. § 1396r(a); P.L. No. 100-203 (Dec. 22, 1987), Title IV, Subtitle C, § 4214. The nine beds remained out of service from December, 1989, until January 1994, a period of four years and one month.

Continuing, the Provider explains that it was licensed as a freestanding SNF under Alabama law and issued a new Medicare provider number (01-5426) on March 22, 1994. Accordingly, for the fiscal period ended December 31, 1994, the Provider had operated as a Medicare-certified freestanding SNF for less than three full years.[21] Prior to its establishment, Mercy Medical had never before operated any type of SNF in the Mobile area. Moreover, it had never operated under any other license or certification, or provided health care services of any kind to patients in Mobile or any other geographic area. Working capital borrowed to cover the Provider's start-up costs in 1994 totaled $399,000.

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[20] Provider Position Paper at 3.

[21] Provider Position Paper at 5.

In addition, the Provider asserts that it had an occupancy rate of only 63 percent in 1994, because it had no existing patient base.[22] That is, the Provider had to establish a new patient population different from Mercy Medical's Daphne location and different from the LSP location since neither patients from Mercy Medical-Daphne nor LSP were transferred to the Provider. The Provider asserts that the patients it admitted were referred primarily from Mobile County hospitals such as Providence Hospital and Spring Hill Memorial Hospital. During the period of January 1, 1994, through December 31, 1994, 91 percent of the Provider's patients were referred from Mobile County hospitals. On the other hand, patients admitted to Mercy Medical's Daphne location are referred primarily from Baldwin County hospitals, such as Thomas Hospital. During the same period of January 1, 1994, through December 31, 1994, 67 percent of Mercy Medical's Daphne SNF patients were referred from Baldwin County hospitals.

The Provider asserts that it is located six miles from LSP, in Mobile, Alabama, a metropolitan area of about 477,000 persons (1990 census), which by 1994, had a population of about 512,000. As reflected in the following table, both the occupancy rates and the total inpatient days at LSP were substantially higher in the year prior to the transfer of the nine beds (1989) and in the year prior to the Provider's commencement of operations (1993) than they were at the Provider in its first full year of operation (1994):

	FYE 6/30/89	FYE 6/30/93	FYE 12/31/94
LSP (All Beds)			
Census	32,682	27,908	N/A
Occupancy	82.1%	87.3%	N/A
Provider (All Beds)			
Census	N/A	N/A	4,243
Occupancy	N/A	N/A	63.7%

Additionally, the Provider asserts that the inpatient populations which it served are entirely different than the inpatient populations served by LSP in terms of patient care needs. For example, in the year ended June 30, 1989, the last full year before LSP down-sized by nine beds,

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[22] Id.

almost 98 percent of LSP's patient days were ICF days and only 2 percent were SNF days. In 1994, the first year of the Provider's operation, more than 51 percent of its patient days were SNF days and the remainder were hospice days. The different inpatient populations served are also reflected in divergent payor sources as demonstrated by its 1993 census; LSP's patients are primarily Medicaid (91 percent) and private pay (9 percent)-- none or virtually none are Medicare days. On the other hand, the Provider's patient days are almost exclusively Medicare (95 percent). Indeed, the Provider's beds are not even Medicaid certified though its hospice is.

Finally, the Provider contends that CMS' denial of its request for an exemption to the SNF routine service cost limits should be deemed granted because CMS did not act in a timely manner.[23] The Provider asserts that both program regulations and manual instructions limit the time period in which CMS must respond to a provider's request for an exemption to the limits. As noted in this case, the Intermediary recommended that the Provider's initial request be granted and, pursuant to HCFA Pub. 15-1 § 2531.1. C, "[i]f HCFA does not respond to the intermediary's recommendation within 90 days, the intermediary's recommendation is HCFA's final decision." Id.

The Provider explains that the original regulations relating to routine service cost limit requests required CMS to make a determination within 180 days after the date it received a request from an intermediary. The comments in the preamble originally implementing the regulation explain that the intent of the deadline "is to expedite the final resolution of cost reimbursement to the provider and to avoid possible duplication of work by the intermediary." 44 Fed. Reg. 31,802 (1979). Effective October 1, 1988, CMS removed the word "exception" from the regulations, thus making the 180 day time limit applicable to all requests. 53 Fed. Reg. 38,476 at 38,533 (1988). The regulation was changed to read: "HCFA responds to the request within 180 days from the date HCFA receives the request from the intermediary." 42 C.F.R. § 413.30(c). The preamble stated:

> [i]n summary, we are proposing to revise §§ 413.30(c) and 413.40(e) to clarify that the time it takes HCFA to review a request for an exception, exemption, or adjustment (and, in the case of § 413.30(c), a request for reclassification) is good cause for extending the period allowed for requesting PRRB review.

53 Fed. Reg. 9,337, 9340 (1988).

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[23] Provider Position Paper at 20.

This change demonstrates that CMS intended all types of requests to be treated alike because the rationale underlying the deadline applies equally to all types of requests.

The Provider also explains that in July 1994, CMS issued manual instructions that took similar action by limiting the time period in which CMS had to respond to a provider's request, and imposed a sanction if it did not respond in a timely fashion. At HCFA Pub. 15-1 § 2531 entitled: "Provider Requests Regarding Applicability of Cost Limits," the manual lists the requests SNFs may make relating to cost limits. These requests include reclassifications, exemptions, and exceptions. A sub-section entitled "General Requirements" sets out the requirements both SNFs and intermediaries must meet. See generally HCFA Pub. 15-1 § 2531.1(A), (B). According to the manual, intermediaries must review a SNF's request and supporting documentation for completeness. The manual provisions do not make any distinctions among the different kinds of requests that may be made. The manual then sets forth a 90 day deadline for the intermediary to make its recommendation to CMS and another 90 day deadline for CMS to make its determination. HCFA Pub. 15-1 § 2531.1(B)(2) and (C). If CMS does not respond to the intermediary's decision in 90 days, the intermediary's recommendation is CMS' final decision. Id. These provisions, contained within the "General Requirements" section of the manual simply refer to the different kinds of requests identified above as exception requests. Like the regulations in 1988, the manual removes any distinction on the application of the 90 day deadline.

With respect to the instant case, the Intermediary recommended that CMS grant the Provider's exemption request on December 15, 1994. CMS responded to this recommendation with a letter dated June 20, 1995. This response was not received by the Intermediary until June 26, 1995, and was not forwarded to Mercy Medical until June 28, 1995. Mercy Medical received CMS' response along with the Intermediary's cover letter on July 5, 1995. In sum, 187 days elapsed from the time the Intermediary made its recommendation until the time CMS made its determination. Even assuming that it took three business days for CMS to receive the Intermediary's recommendation (the time generally presumed for a letter to reach its destination), CMS still did not respond within the required 180 days. Therefore, CMS' denial did not meet either the 180 day or 90 day deadline. Accordingly, since CMS did not follow its own regulations, its determination with respect to the new provider exemption should be deemed invalid.

The Provider notes that when an agency does not follow its own regulations the agency's action is invalid. For example, in U.S. ex rel. Accardi v. Shaughnessy, 347 U.S. 260 (1954), the Supreme Court held that legally promulgated regulations have the force and effect of law and must be obeyed by the agency. In Service v. Dulles, 354 U.S. 363, 372 (1957), the Supreme Court declared the discharge of an employee illegal where the Secretary of State's dismissal was without the required approval of the Deputy Undersecretary and consultation of the hearing record, both of which were required by regulation. See also Vitarelli v. Seaton, 359 U.S. 535, 540 (1959) (holding where procedural protections provided by the regulations were not followed, the agency action was illegal and had no effect).

The Provider also notes that in 1993 the CMS Administrator upheld a Board decision denying an exception to routine cost limits even though CMS' determination had not been made within 180 days. Hospice of Saint John v. Blue Cross and Blue Shield of New Mexico, PRRB Dec. No. 93-D28, March 10, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,353, rev'd., CMS Administrator, May 3, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,463 ("Hospice of St. John"). The Provider asserts, however, that decision is no longer relevant. The Provider explains that in Hospice of St. John the CMS Administrator reasoned that because the statute and regulations did not provide for the intermediary's decision to be deemed final, CMS' final determination would not be overturned. However, this case was decided in March 1993, prior to the addition of the manual revision providing specific consequences for CMS' failure to meet its self-imposed timeliness deadlines in acting upon such requests.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider does not qualify for an exemption to the routine service cost limits as a "new provider" pursuant to 42 C.F.R. § 413.30(e)(2). According to this rule a "new provider" is one that: "has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years." Id. Respectively, the Intermediary argues that the patient beds used by the Provider to furnish skilled nursing care had been used in that capacity for more than three years by the previous owner, LSP.[24]

The Intermediary explains that on February 25, 1991, the Alabama State Health Planning Agency approved the transfer of ownership and relocation of existing nursing home capacity (i.e., the right to operate 9 nursing home beds) owned and operated by LSP to Mercy Medical.[25] Therefore, CMS identified a change of ownership, and the regulatory requirement to review the operation under past as well as present ownership was triggered, i.e., to determine if the nursing home capacity that had been transferred to the Provider had operated in the manner of a SNF or its equivalent.

Upon review, CMS found that LSP had participated in the Medicaid program as a nursing facility ("NF") and in the Medicare program as a SNF since July 1, 1977.[26] Moreover, CMS found that LSP had been providing skilled nursing and related services and rehabilitative services for more than three years prior to the change of ownership. Specifically, CMS extracted data from the Residents Census and Conditions of Residents Reports (Form HCFA-672)[27] that

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[24] Intermediary Position Paper at 32.

[25] Intermediary Position Paper at 36.

[26] Intermediary Position Paper at 38.

[27] Exhibit I-23.

LSP had self-reported at the time of its March 25, 1992 survey. The data revealed that LSP had provided both skilled nursing and related services and rehabilitative services which included, but were not limited to: insertion, sterile irrigation and replacement of catheters, rehabilitative nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment, e.g., the institution and supervision of bowel and bladder training programs, care of pressure ulcers, respiratory therapy, and specialized rehabilitation services.[28] The Intermediary asserts that these services represent what was actually being provided to inpatients on the dates of the survey and in no way represent all of the skilled nursing and related services or rehabilitative services provided by LSP since it was certified to participate in the Medicare and Medicaid programs.

In addition, the Intermediary asserts that LSP consistently filed low volume Medicare cost reports for the cost reporting periods ended December 31, 1988, December 31, 1989, December 31, 1990 and December 31, 1991, wherein it reported SNF days of service. These cost reports provide further evidence that LSP was providing SNF levels of care.

The Intermediary adds that LSP's Medicaid status required it to provide NF services. Regulations at 42 C.F.R. § 440.40 define these services as those needed on a daily basis and required to be provided on an inpatient basis under 42 C.F.R. §§ 409.31 through 409.35, provided by a facility or distinct part of a facility that is certified to meet the requirements for participation and ordered by and provided under the direction of a physician. Custodial care on the other hand is essentially personal care that does not require the attention of trained medical or paramedical personnel. It consists of assisting an individual in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication.[29]

The Intermediary acknowledges that there was a break in service between the time the State approved the Provider's certificate of need application and the time the Provider began operating.
The Intermediary asserts, however, that the break in service was less than three full years and, therefore, it was appropriate for CMS to consider the services provided by LSP in determining whether or not the Provider was "new" pursuant to 42 C.F.R. § 413.30(e)(2).[30]

The Intermediary explains that 42 C.F.R. § 413.30(e)(2) does not require an institution to have been in continuous operation prior to its participation in the Medicare program. Therefore, CMS has routinely considered breaks in service in computing and granting new provider status.[31]

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[28] Exhibit I-24.

[29] Exhibits I-26 and I-27.

[30] Intermediary Position Paper at 36.

[31] Intermediary Position Paper at 26.

Specifically, CMS established a policy which looks at whether or not an institution that has operated as a SNF or its equivalent and has closed and then re-opens, under past or present ownership in the same or different location, for less than three full years between the date of closure and the date of re-opening. In these instances, the operation in the prior location is included when determining eligibility for new provider status. See CMS Administrator Decision, San Diego, January 12, 1991.[32]

With respect to the instant case, the Intermediary asserts that the State approved the certificate of need application submitted by Mercy Medical on February 25, 1991. The Provider and McAuley Place began operating on January 20, 1994. Because the break in service was less than three full years, it was actually 1,059 days not 1,095 days, the operation in the former location, LSP, had to be considered by CMS in making its determination.

The Intermediary contends that the Provider also does not qualify as a "new provider" pursuant to program instructions at HCFA Pub. 15-1 § 2533.1.B.3 (formerly HCFA Pub. 15-1 § 2604.1). According to the Intermediary these instructions explain that "new provider" status is granted to a provider that undergoes a change in location even if it has operated in the manner of the "type of provider" for which it had been certified or its equivalent, if the institution can demonstrate that: "the normal inpatient population can no longer be expected to be served at the new location," and "that the total inpatient days at the new location were substantially less than at the old location for a comparable period during the year prior to relocation. The periods being compared must be at least 3 months in duration." HCFA Pub. 15-1 § 2604.1.[33]

With respect to these rules and their application to the instant case, CMS found that the Provider did not change its primary service area which is Mobile County. Both the Provider and LSP are included in the Health Service Area designated by the Alabama State Health Planning and Development Agency, as Mobile County. In fact, in its first three months of operation 67 percent of the population served by the Provider came from Mobile County with the majority of admissions coming from Mobile, Alabama, itself .[34] Thus, CMS determined that the normal inpatient population can continue to expect to be served at the new location, thereby eliminating the possibility of an exemption for the Provider based upon the provisions HCFA Pub. 15-1 § 2533.l.B.3.

The Intermediary asserts that this determination or denial is consistent with other determinations by CMS that have been upheld by the Board. The Intermediary cites Indian River Memorial Hospital (Florida) v. Blue Cross and Blue Shield Association/Blue Cross of Florida, PRRB Dec. No. 87- D104, September 24, 1987, Medicare and Medicaid Guide (CCH) ¶ 36,670, decl'd rev.,

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[32] Exhibit I-48.

[33] Intermediary Position Paper at 40.

[34] Exhibit I-53.

CMS Administrator, November 23, 1987 (Exhibit I-54); Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,224, decl'd rev., CMS Administrator, June 8, 1998 (Exhibit I-55), upheld U.S. District Court, Eastern District of Wisconsin, Case No. 98-C-553, August 16, 2000 (Exhibit I-56); Larkin Chase Nursing and Restorative Center v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D8, November 24, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,145, decl'd rev., CMS Administrator, January 15, 1999, upheld U.S. District Court for the District of Columbia, Civil Action 99-00214 (HHK), February 16, 2001(Exhibit I-57 and I-58); South Shore Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/C&S Administrative Services, PRRB Dec. No. 99-D38, April 21, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,182, decl'd rev., CMS Administrator, June 23, 1999), rev'd and reman'd, South Shore Hospital Transitional Care Center v. Thompson, Civil Action No. 99-11611-JLT (D.C. MA January 3, 2002), Medicare and Medicaid Guide (CCH) 2002-1 ¶ 300,934 ("South Shore") (Exhibit I-59); and, most recently Maryland General Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Maryland, PRRB Dec. No. 99-D69, September 20, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,334, rev'd, CMS Administrator, November 22, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,406, ("Maryland General") (Exhibit I-60 and Exhibit I-61); Stouder Memorial Hospital Subacute Unit v. AdminaStar Federal and Anthem Insurance Companies, PRRB Dec. No. 2000-D46, April 18, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,437, rev'd, CMS Administrator, June 15, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,517 ("Stouder Memorial") (Exhibit I-62 and I-63); and, Ashtabula County Medical Center Skilled Nursing Facility v. Blue Cross and Blue Shield Association/AdminaStar Federal, Inc., PRRB Dec. No. 2000-D70, June 29, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,516, decl'd rev., CMS Administrator, August 16, 2000 (Exhibit I-64), rev'd and reman'd, Ashtabula County Medical Center v. Thompson, Case No. 1:00CV1895 (U.S. District Court for the Northern District of Ohio, Feb. 8, 2002) ("Ashtabula").

The Intermediary contends that a NF that provides skilled nursing and related services or rehabilitative services is in fact equivalent to a SNF.[35] The Intermediary asserts that the Omnibus Budget Reconciliation Act of 1987 ("OBRA") 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 1, 1990. The result is that both Medicare SNFs and Medicaid NFs are required to provide, directly or under arrangements, the same basic range of services described in section 1819(b)(4) and 1919(b)(4) of the Social Security Act ("Act"). This range of services includes those nursing services and specialized rehabilitative services needed to attain or maintain each resident's highest practicable level of physical, mental, and psychosocial well-being. Therefore, CMS utilizes language to this effect in its determination on an exemption request, i.e., the letter sent to the fiscal intermediary informing it of CMS' decision, to clearly indicate that it has verified that, if the institution requesting an exemption operated as a NF prior to becoming a SNF, it has in fact provided, directly or under arrangements, the same basic range of services described in sections 1819(b)(4) and 1919(b)(4) of the Act (skilled nursing or rehabilitative services).

[35] Intermediary Position Paper at 43.

The Intermediary asserts 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 regulatory distinction between skilled and intermediate nursing facilities." OBRA, P.L. 100-293 at 452, 453 (Exhibit 1-69). Moreover, the Nursing Home Reform law established a single standard of skilled care 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 Gray Panthers Advocacy Committee, et el., v. Louis W. Sullivan M.D., Secretary, Department of Health and Human Services, 936 F.2d, 1285, No. 90-5306, June 18, 1991 (Exhibit 1-70), the court held that "the fact that the regulation (OBRA 1987) merely reiterates the statutory language precludes any serious argument that the regulation affects the agency or (regulated individuals) in such a way as to require notice and comment procedures pursuant to 5 U.S.C. § 553 . . . because the Secretary determined that portions of the statute were self-effectuating." Id.

The Intermediary also asserts that this interpretation was upheld in Russel Newman v. Sharon Pratt Kelly, 848 F. Supp. 228 (1994) ("Newman v Kelly") and in Kansas Health Care Association Inc. v. Kansas Department of Social and Rehabilitation Services, 754 F. Supp. 1502 (D. Kansas 1990).[36] According to the Intermediary, the court in Newman v Kelly held that. . . . "[e]ffective 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. Therefore, the court finds that the term 'skilled nursing facility' in § 1395i-3 is the substantial equivalent of the term 'nursing facility.' Id.

The Intermediary adds that an institution that is certified to participate in the Medicare program 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 accordance with section 134 of the Skilled Nursing Facility Manual, HCFA Pub. 12 (Exhibit 1-73). In addition, a NF may not have furnished skilled nursing or rehabilitative services as frequently as a SNF providing those services on a continuous basis. However, regulations at 42 C.F.R § 413.30(e) make no allowance for institutions providing a low volume of skilled nursing

[36] Exhibits I-71 and I-72.

services prior to certification as a SNF. In fact, 42 U.S.C. § 1395yy allows CMS to make payment to SNFs who furnish less than 1,500 Medicare covered days based upon a low volume prospective payment rate. 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.

Finally, the Intermediary contends that the reason the Provider exceeded the SNF routine service cost limits is because it provided atypical services.[37] The Intermediary explains that relief from the cost limits for the provision of atypical services is provided under the "exception provisions" at 42 C.F.R. § 413.30(f). As stated under this section, cost limits may be adjusted upward for a provider under the circumstances specified only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary. An exception may be granted if an institution can demonstrate that it has a lower than average length of stay, higher than average ancillary cost per day and higher than average Medicare utilization than that of its peers. Respectively, the Intermediary explains that the Provider requested and received relief from the effects of the SNF routine service cost limits through the exception process due to the provision of atypical services in the amount of $109.29 per day for the cost reporting period ended December 31, 1994.[38] The Provider demonstrated that it provided atypical services since it had a lower than average length of stay compared to its peers, a higher than average ancillary cost per day and higher than average Medicare utilization. Notably, the Provider continued to receive an exception to the limits for subsequent cost reporting years which are not at issue in this appeal.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C:

§ 1395i-3(a)	-	Definition of Skilled Nursing Facility
§ 1395yy	-	Payment to Skilled Nursing Facilities for Routine Service Costs
§ 1396r(a)	-	Nursing Facility Defined

2. Regulations - 42 C.F.R:

§§ 405.1835-.1841	-	Board Jurisdiction

[37] Intermediary Position Paper at 46.

[38] Exhibit I-75.

§ 413.30 et seq.	-	Limitations on Reimbursable Costs
§ 409.31	-	Level of Care Requirement
§ 409.35	-	Criteria for "Practical Matter"
§ 440.40	-	Skilled Nursing Facility Services for Individuals Age 21 and Older (Other Than Services in an Institution for Mental Diseases.) EPSDT, and Family Planning Services and Supplies

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

§ 2531 et seq. (formerly § 2604.1)	-	Provider Requests Regarding Applicability of Cost Limits
§ 2533.1.B.3	-	Definitions-New Providers

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

§ 2406	-	Worksheet S-2 - Hospital and Hospital Health Care Complex Identification Data
§ 2807	-	Worksheet A - Reclassification and Adjustment of Trial Balance of Expenses

5. Program Instructions-Skilled Nursing Facility Manual ("HCFA Pub. 12"):

§ 134	-	Admission of Medicare Patients for Care and Treatment

6. Case Law:

San Diego Physician and Surgeons Hospital v. Aetna Life Insurance Company, PRRB Dec. No. 91-D6, November 15, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,966, rev'd., CMS Administrator, January 12, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,007.

North Shore University Hospital Center for Extended Care and Rehabiltation v. Commissioner of the New York State Department of Health, CC67304 (N.Y. Supreme

Court 1993).

U.S. ex rel. Accardi v. Shaughnessy, 347 U.S. 260 (1954).

Service v. Dulles, 354 U.S. 363, 372 (1957).

Vitarelli v. Seaton, 359 U.S. 535, 540 (1959).

Hospice of Saint John v. Blue Cross and Blue Shield of New Mexico, PRRB Dec. No. 93-D28, March 10, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,353, rev'd., CMS Administrator, May 3, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,463.

Indian River Memorial Hospital (Florida) v. Blue Cross and Blue Shield Association/Blue Cross of Florida, PRRB Dec. No. 87- D104, September 24, 1987, Medicare and Medicaid Guide (CCH) ¶ 36,670, decl'd rev., CMS Administrator, November 23, 1987.

Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,224, decl'd rev., CMS Administrator, June 8, 1998; aff'd sub nom Paragon Health Network, Inc. v. Thompson, 251 F.3d 1141 (7th Cir.2001).

Larkin Chase Nursing and Restorative Center v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D8, November 24, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,145, decl'd rev., CMS Administrator, January 15, 1999, upheld U.S. District Court for the District of Columbia, CA 99-00214 (HHK), (2001 U.S. Dist. Lexis 23655) (February 16, 2001).

South Shore Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/C&S Administrative Services, PRRB Dec. No. 99-D38, April 21, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,182, decl'd rev., CMS Administrator, June 23, 1999, rev'd and reman'd, South Shore Hospital Transitional Care Center v. Thompson, CA 99-11611-JLT (D. Mass Jan. 3, 2002), (2002 U.S. Dist. Lexis 289) Medicare and Medicaid Guide (CCH) 2002-1 ¶ 300,934.

Maryland General Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Maryland, PRRB Dec. No. 99-D69, September 20, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,334, rev'd, CMS Administrator, November 22, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,406; aff'd sub nom Maryland General Hospital v. Thompson, 155 F. supp. 2d 459 (D. Md. 2001).

Stouder Memorial Hospital Subacute Unit v. AdminaStar Federal and Anthem Insurance Companies, PRRB Dec. No. 2000-D46, April 18, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,437, rev'd, CMS Administrator, June 15, 2000, Medicare and Medicaid

Guide (CCH) ¶ 80,517.

Ashtabula County Medical Center Skilled Nursing Facility v. Blue Cross and Blue Shield Association/AdminaStar Federal, Inc., PRRB Dec. No. 2000-D70, June 29, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,516, decl'd rev., CMS Administrator, August 16, 2000, rev'd and reman'd, Ashtabula County Medical Center v. Thompson, Case No. 1:00CV1895 (ND Ohio, Feb. 8, 2002); (2002 U.S. Dist. Lexis 5499).

Gray Panthers Advocacy Committee. et el, v. Louis W. Sullivan M.D., Secretary, Department of Health and Human Services, 936 F.2d. 1284, (D.C. Cir 1991).

Russel Newman v. Sharon Pratt Kelly, 848 F. Supp. 228 (D.D.C.1994).

Kansas Health Care Association Inc. v. Kansas Department of Social and Rehabilitation Services, 754 F. Supp. 1502 (D. Kan.1990).

7. Other:

CMS Letter, June 20, 1995.

Department of Health and Human Services Letter, July 5, 1996.

Mercy Medical Certificate of Need Application Mobile County Projects.

Ala. Admin. Code R. 420-5-10.

Sen. Fin. Comm. Rep. No. 89-404 (1965).

44 Fed. Reg. 31,802 (1979).

53 Fed. Reg. 38,476 (1988).

53 Fed. Reg. 9,337 (1988).

Nursing Home Reform Provisions, Omnibus Budget Reconciliation Act of 1987.

House Report, No. 100-391.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Mercy Medical, a hospital located in Daphne, Alabama, initiated a project to construct a new

freestanding hospice/SNF in the Mobile, Alabama area. To facilitate this project the hospital acquired the "operating rights" for nine nursing facility beds from LSP. The operating rights were acquired in this fashion, i.e., from another facility, due to a moratorium restricting the number of new health care beds in the State.

Subsequently, Mercy Medical completed construction of the new facility, the Provider in this case, and began furnishing SNF services in the Mobile area on January 20, 1994. In addition, on October 5, 1994, Mercy Medical requested that the Provider be granted an exemption from Medicare's routine service cost limits on the basis of Medicare's "new provider" rules at 42 C.F.R. § 413.30(e). In part, these rules state:

> (e) *Exemptions.* Exemptions from the limits imposed under this section may be granted in the following circumstances:
>
> (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)(emphasis added).

Upon review, CMS determined that the Provider did not qualify for the exemption and denied the Provider's request. CMS stated that Mercy Medical had purchased the subject bed rights from LSP, which reflects a change of ownership. CMS further explains that the change of ownership triggered a review of the services performed by LSP pursuant to the "present and previous ownership" provision of 42 C.F.R. § 413.30(e), quoted above, and that LSP had, in fact, performed skilled nursing services for more than three years.

The Board majority also finds, however, that the nine beds acquired by Mercy Medical for the purpose of establishing the Provider were decertified by LSP on December 22, 1989. These beds were not operational and had not been used to render patient care since that time. The Provider asserted, and CMS did not dispute, that the subject beds stem from an action taken by LSP around December 1989, when it converted nine of its semi-private intermediate care service ("ICF") rooms to private ICF rooms. At the same time, LSP notified the State that it no longer intended to use the remaining nine beds, which were ultimately reported to the Alabama State Health Plan Inventory as dormant nursing home beds. Notably, these nine beds remained out of service until January 20, 1994, approximately four years, when the Provider began furnishing health care services.

Also, the Board majority does not find that Mercy Medical factually "purchased" the subject bed rights from LSP as stated by CMS. Rather, the Board majority finds no evidence in the record indicating that an actual (or perceived) exchange of money or its equivalent occurred between Mercy Medical and LSP. As opposed to a purchase or sales agreement, the record contains only a letter agreement transferring the subject bed rights to Mercy Medical without regard to remuneration.

Upon further analysis, the Board majority finds that it has been confronted several times with the issue of whether or not the acquisition of bed rights (operating rights, certificate of need, determination of need, etc.), in and of itself, constitutes a change of ownership for the purpose of determining whether or not the "present and previous ownership" provision of 42 C.F.R. § 413.30(e) is applicable; that is, whether or not a "change of ownership" occurs triggering a review of a relinquishing facility's historical operations that could result in denial of a "new provider" exemption.[39]

With respect to this matter, the Board majority finds that it has followed CMS' interpretation, in most instances, finding that such action does result in a change of ownership. Importantly, however, the Board majority also finds that its deliberations regarding this matter have always contained a measurable degree of disagreement and have resulted in dissenting opinions being rendered in some instances. See e.g., South Shore, Sleep dissenting; Maryland General, Wessman dissenting, Hoover dissenting; and, Stauder Memorial, Wessman dissenting. In addition, a number of district court decisions as well as one circuit court decision have now been rendered on this issue, and they also contain varying conclusions. In light of these circumstances, the Board majority finds the courts' analyses in these cases especially helpful. In particular, the Board majority finds the court's decision in South Shore instructive with respect to the instant case. In part, the court states:

> ". . . South Shore opened after the DON rights to 40 beds were purchased from the receiver of the defunct Prospect Hill [Nursing Facility]. The sole connection between Prospect Hill and South Shore was the intangible DON rights. South Shore did not acquire any building, land, patients, staff or equipment from Prospect Hill. As the dissenting member of the Board said,
>
> > [t]he DON rights. . . .[were] at best an intangible asset because it only evidenced the 'right to create and operate nursing beds.' The DON rights had some residual value only because the State had instituted a cap on the number of beds that could be licensed within the State. . . . [Prospect Hill] was like a 'totaled vehicle' with some parts being sold from the carcass. Thus, the

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[39] The Board majority acknowledges that HCFA Pub. 15-1 § 2533.1.E.1.b. was modified to explain, in general, that the acquisition of operating rights to long term care beds, albeit from an open or closed facility, reflects a change of ownership for the purpose of determining "new provider" status pursuant to 42 C.F.R. § 413.30(e). However, the Board majority also notes that this modification was not published until September 1997, and may not be applicable to the instant case. Moreover, the Board majority wishes to point out that while it is bound by applicable program statutes and regulations, it is not so bound by program instructions and guidelines.

> receiver was merely selling available assets to generate funds to pay creditors. Hence, the sale of the intangible DON rights in 1994 did not affect the licensure and certification of Prospect Hill within the meaning of section 1500.7 since licensure and certification was lost due to other reasons.
>
> . . . The Secretary's finding that South Shore's purchase of intangible DON rights once owned by Prospect Hill constituted a change of ownership, thus triggering an inquiry into the operational history of Prospect Hill and leading to the denial of the new provider exemption, was clearly not in accordance with the law. Since there was no change of ownership, the inquiry into Prospect Hill's operational history was unwarranted.

South Shore at CCH 2002-1 & 300,934.

The Board also notes Ashtabula where the court found the Secretary's interpretation of the "new provider" regulation arbitrary, capricious, and erroneous. The court focused on the Secretary's position that the acquisition of bed rights from another provider is a completely different situation than when bed rights are acquired, for example, from a state authority. In the first situation the acquisition causes an immediate "lookback" into the services furnished by the relinquishing provider and the potential denial of a new provider exemption. In the second situation there is no lookback and a new provider exemption is granted.

The court's analysis of this matter focused on the intent of the "new provider" exemption (to allow providers the opportunity to recoup higher costs associated with low occupancy and start-up), and the basis of the Secretary's position to: "exclude [from such relief] as a class all providers that purchase CON rights from another, unrelated provider that has existed for more than three years. . ." Ashtabula at Medicare and Medicaid Guide (CCH) ¶ 300,964. Respectively, the court found the Secretary's arguments regarding this matter, which essentially view state CON/moratorium programs as evidence that additional beds are unnecessary for the efficient delivery of needed health care, to be unsupported and little more than conjecture. After consideration of each of the Secretary's arguments the court states in pertinent part:

> ACMC [Ashtabula County Medical Center] and other providers in moratorium states that purchase CON rights from unrelated providers fit comfortably within the language and purpose of the new provider exemption. The Secretary has advanced no reasonable argument to support a distinction between these providers and other "new providers" deserving of a subsidy to offset high startup costs in the first three years of operation.

Id.

Based upon these facts, the Board majority finds that CMS improperly denied the Provider's

request for an exemption to Medicare's routine service cost limits. Similar to the courts' findings in both South Shore and Ashtabula, the Board majority finds that Mercy Medical's acquisition of bed rights in the instant case does not represent a change of ownership, and that the services that may or may not have been performed by LSP are irrelevant. The Provider meets the program's definition of a "new provider" at 42 C.F.R. § 413.30(e)(2); it is licensed, certified, and accredited as a freestanding SNF, and it had operated as this type of provider for less than three full years as required.

Also, as discussed immediately above, CMS established the "new provider" exemption because it recognized that new SNFs could have difficulty meeting the cost limits. In manual instructions at HCFA Pub. 15-1 § 2533.1, CMS succinctly spells out the purpose of the exemption as follows:

> [t]his provision was implemented to recognize the difficulties in meeting the applicable cost limits due to underutilization during the initial years of providing skilled nursing and/or rehabilitation services. . .

HCFA Pub. 15-1 § 2533.1.

The Board majority notes that the Provider achieved only about a 63 percent occupancy level during its initial 1994 cost reporting period.

Finally, the Board majority notes the Provider's argument that its request for an exemption to the routine service cost limits should be granted based upon CMS' timeliness rules at HCFA Pub. 15-1 § 2531.1.C. These rules state in part that: " [i]f HCFA does not respond to the intermediary's recommendation within 90 days, the intermediary's recommendation is HCFA's final decision." Id. The Provider points out that on December 15, 1994, the Intermediary submitted its recommendation to CMS that the Provider's request be granted. CMS did not respond to this request until June 20, 1995, well beyond the 90-day limit.

The Board majority finds, however, that the decision rendered by CMS on June 20, 1995, and the findings and conclusions contained in that decision as well as program requirements generally applicable to such decision, are not subject in this appeal. As discussed in the STATEMENT OF THE CASE AND PROCEDURAL HISTORY section of this decision, the Provider did not appeal CMS' June 20, 1995 decision. Rather, the Provider, over the succeeding 12 or so months proved to CMS that its June 20, 1995 decision was based upon the unfounded premise that the Provider was a hospital-based facility. The Provider, proving that it was in fact a freestanding facility impelled CMS to re-evaluate the Provider's request and issue a second decision, which it did on July 5, 1996. This second decision, which was appealed by the Provider and is properly before the Board, renders all arguments pertaining directly to CMS' June 20, 1995 decision moot. This specifically includes the Provider's timeliness argument.

DECISION AND ORDER:

CMS' denial of the Provider's request for an exemption to Medicare's routine service cost limits on the basis of being a "new provider" pursuant to 42 C.F.R. § 413.30(e) is improper and is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq. (Dissenting)
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esq. (Concurring)

Date of Decision: August 07, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman