PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2004-D29

PROVIDER –
Carney Hospital (Transitional Care Unit)

Provider No. 22-5681

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Associated Hospital Services

DATE OF HEARING -
February 7-8, 2002

Cost Reporting Periods Ended
September 30, 1996
January 31, 1997

CASE Nos. 96-2359 and 01-0142

INDEX

ISSUE:

Was the Intermediary's denial of the Provider's request for an exemption from Medicare's routine service cost limits proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Carney Hospital (Provider) is a general acute care facility located in Boston, Massachusetts. On October 5, 1995, the Provider opened a 27-bed transitional care unit (TCU) that was certified to participate in the Medicare program as a skilled nursing facility (SNF). On January 4, 1996, the Provider submitted on behalf of the TCU a request for a "new provider" exemption from Medicare's routine service cost limits.[1] The Centers for Medicare & Medicaid Services (CMS) reviewed the Provider's request and, by letter dated May 8, 1996, notified C&S Administrative Services for Medicare (Intermediary) that the request was denied.[2] The Provider appealed the denial to the Provider Reimbursement Review Board (Board), which is a five member board established by Congress to resolve payment disputes between providers of health care services and the Medicare program. 42 U.S.C. §1395oo. The amount of Medicare funds in controversy is approximately $1,000,000.[3]

Medicare Statutory and Regulatory Background:

The Medicare program was established in 1965 under Title XVIII of the Social Security Act (Act) to provide health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. CMS is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration.[4] CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Fiscal intermediaries determine payment amounts due providers under Medicare law as well as regulations and interpretative guidelines issued by CMS.

Medicare reimbursement is governed by section 1861(v)(1)(A) of the Act. In part, the statute provides that the reasonable cost of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The statute also authorizes the Secretary to establish cost limits. Essentially, the limits recognize reasonable costs based upon estimates of costs found to be necessary in the efficient delivery of

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1 Intermediary Position Paper at 7. Exhibit I-1.

2 Exhibit I-3. Note: Blue Cross and Blue Shield of Maine, Inc., operating as Associated Hospital Services replaced C&S Administrative Services for Medicare as the Provider's Intermediary.

3 Exhibit I-5. Note also: On October 23, 2000, the Provider appealed the subject denial as it applies to its Medicare cost reporting period ended January 31, 1997. This appeal, designated as "PRRB Case No. 01-0124," is consolidated herein, and is subject to the Board's findings and conclusions. The amount of Medicare funds in controversy applicable to the Provider's 1997 cost reporting period is approximately $100,000.

4 CMS was formerly known as the Health Care Financing Administration (HCFA).

covered items and services.

Program regulations at 42 C.F.R. §413.30 set forth the general rules under which CMS may establish cost limits. These regulations, in addition to program instructions contained in Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1), establish rules under which a provider may obtain an exemption from the limits. The regulations explain that an exemption may be granted to a "new provider," and the manual guidelines explain that new provider status may be granted where an existing provider relocates its facility to a new location. Specifically, 42 C.F.R. §413.30(e) states in part:

> *Exemptions.* 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.

HCFA Pub. 15-1 §2604.1, states:

> [h]owever, for purposes of this provision, a provider which relocates may be granted new provider status where the normal inpatient population can no longer be expected to be served at the new location. The distance moved from the old location will be considered but will not be the determining factor for granting new provider status. . . . A provider seeking such new provider status must apply to the intermediary and demonstrate that in the new location a substantially different inpatient population is being served. In addition, the provider must demonstrate 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.

In September 1997, CMS amended its program guidelines at HCFA Pub. 15-1 §2533.1.E.1, which deal with SNF cost limits. The guidelines now explain that where an institution purchases the right to operate long-term beds from an existing facility which is or has been providing skilled nursing care or rehabilitative services, the transaction will be considered a change of ownership for new provider exemption purposes.

The intent of the new provider exemption is to assist providers who incur start-up costs and operating costs while concurrently experiencing low patient utilization.

Background of the Provider's Request

Prior to Carney Hospital's decision to open a TCU, the State of Massachusetts established a moratorium prohibiting the licensure of any new long-term care beds. Under the State's policies there were exceptions: nursing facilities that were unable to participate in Medicare could upgrade to facilities capable of providing SNF care, and hospitals were permitted to establish SNFs through the purchase of existing nursing facility bed rights. With respect to hospitals, this process resulted in a nursing home's surrender of its bed rights, transferring its patients to other

suitable facilities and then closing. Upon closure, the State granted the hospital a new license.

On August 19, 1994, the Provider entered into an asset purchase agreement with Comeau Health Care, Inc. (Comeau) to purchase the rights to operate twenty-seven (27) long-term care beds and certain other assets associated with Franklin Nursing Home (Franklin). Pursuant to the agreement, the Provider would pay Comeau two hundred and seventy five thousand dollars ($275,000). Comeau would retain ownership of Franklin's accounts receivable, plant and machinery, processing and laboratory equipment, leasehold improvements, furniture, fixtures, and certain other assets.

On September 9, 1994, the Provider filed a "Request for Change in Location of Licensed Beds" with the Massachusetts Department of Public Health in order to relocate the subject beds to its campus. Thereafter, having received the State's approval, the Provider and Comeau entered into the asset purchase agreement on December 3, 1994. On the same day, the Provider leased from Comeau all of the real and personal property that had been excluded from the purchase agreement. The lease agreement was necessary since Comeau no longer owned the right to operate nursing home beds yet some patients remained in its facility awaiting relocation. All patients were ultimately relocated by December 16, 1994, and the Provider filed a Medicaid cost report for the period December 3 through December 16, 1994, as the owner of the facility. Thereafter, Franklin was closed. Approximately ten (10) months later, the Provider's TCU was licensed by the State and was opened to accept patients. The Provider's TCU became certified to participate in the Medicare program on October 26, 1995.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Provider contends that its TCU is entitled to a new provider exemption for three reasons. First the Provider asserts that its TCU meets the definition of a "new provider" contained in 42 C.F.R. §413.30(e). The Provider explains that its TCU had operated as a SNF for less than 3 years having never operated before October 5, 1995. The Provider explains that it is improper to construe its TCU as a continuation or relocation of Franklin Nursing Home so that the services furnished by Franklin would be included in the 3-year measurement. The Provider explains that it only purchased intangible operating rights from Comeau, which cannot be understood to be Franklin itself. The Provider cites South Shore Hospital d/b/a/ South Shore Transitional Care Unit v. Thompson, C.A. No. 99-11611-JTL (D. Mass., Jan. 4, 2002) (South Shore) and Ashtabula County Medical Center v. Thompson, Case No. 1:00CV1895 (N.D. Ohio, March 2002), finding that the purchase of operating rights is not the purchase of a "provider."

Second, the Provider contends that even if it had purchased Franklin Nursing Home, which it did not, it would still meet the 3-year rule because Franklin did not operate as a SNF or its equivalent. The Provider explains that according to state law Franklin was a Level III intermediate care facility that provided "routine nursing services and periodic availability of

skilled nursing." These services were furnished in exigent circumstances to Franklin's patients who usually lived at the facility for several years. This type of operation is not the equivalent of the Provider's Level II TCU that provides "continuous skilled nursing care and meaningful availability of restorative services" to patients whose average length of stay is only about 14 days.

Third, the Provider contends that even assuming *arguendo* that its TCU was a relocation of Franklin, it would still qualify for new provider status pursuant to HCFA Pub. 15-1 §2604.1, because the normal inpatient population at Franklin could no longer be expected to be served at the new location. The Provider asserts that the difference in the average length of stay between the TCU's patients and those of Franklin is clear evidence that a substantially different inpatient population is being served at the Provider's TCU than was served at Franklin.

The Intermediary contends that the Provider did, in fact, purchase and relocate Franklin Nursing Home. Therefore, it is appropriate to look back to the services furnished by Franklin under the "present and previous ownership" provision of 42 C.F.R. §413.30(e) to determine how long the TCU had operated as a SNF. In this regard, the Intermediary asserts that it is clear the TCU does not meet the regulatory definition of a new provider since Franklin had been furnishing skilled nursing care for more than 3 years. In addition, the Intermediary contends that the Provider's TCU does not qualify as a new provider under Medicare's relocation rules. The Intermediary argues that both facilities are located within the same health service area designated by the state and, therefore, the same patient population can expect to be served at the TCU's location as was served at Franklin's location. The Intermediary adds that the Provider's TCU is also not entitled to new provider status based upon the program's relocation rules because it did not comply with the program's requirement to demonstrate that total inpatient days at the new location were substantially less than total inpatient days at the old location.

The Board majority agrees with the Intermediary. A review of the transactions that occurred in this case, coupled with a review of the assets actually purchased from Comeau, show that the Provider did, in fact, purchase and relocate Franklin. Moreover, a review of the evidence shows that Franklin operated as the equivalent of an SNF for more than 3 years immediately preceding its acquisition by the Provider.

Specifically, on August 19, 1994, the Provider filed with the state a "Notice of Intent to Acquire an Existing Health Care Facility," not simply operating rights or bed rights.[5] Thereafter, on September 9, 1994, the Provider filed with the state a request to transfer Franklin Nursing Home to its campus, and on September 16, 1994, the Provider filed with the state a "Notice of Intent to Acquire Ownership of Franklin Nursing Home."[6] Then, on November 11, 1994, the Provider advised the state that "[a]s you are aware, Carney Hospital . . .is in the process of purchasing the Franklin Nursing Home . . ." and on December 2, 1994, the Provider filed a "License Application in Connection with Transfer of Ownership of Franklin Nursing Home, Braintree."[7]

[5] Exhibit I-24 at A.

[6] Exhibits I-25 and I-26.

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

In addition, from December 3, 1994 to December 16, 1994, the Provider operated Franklin, apparently under its existing Medicaid Agreement, and filed a Medicaid cost report for this period as Franklin's owner.[8]

With respect to the assets involved in this case, the Board majority notes that none of Franklin's fixed assets were conveyed to the Provider. However, those assets that were conveyed are far more extensive than just operating rights. For example, the record shows that the Provider acquired Franklin's name and all goodwill associated with that name; all transferable licenses, permits and other rights and interests including any transferable licenses, permits, registrations or authorizations from Federal and state authorities relating to the ownership, management or operation of the facility; certain contracts and agreements and commitments related to the ownership the facility; all books and records, customer and supplier lists, provider agreements, patient lists, approvals, permits, contracts, plans, surveys, policy manuals, accounts and other records used in connection with the ownership of the facility; any and all trademarks, service marks, etc.; and, any and all advances or pre-payments made by patients of the facility for services not rendered prior to the closing.[9]

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 reflects a change of ownership for the purpose of determining new provider status pursuant to 42 C.F.R. §413.30(e). The Board majority points out, however, that it did not rely upon this instruction when reaching its decision that the Provider had, in fact, purchased Franklin. Rather, as discussed immediately above, the Board relied upon general rules of ownership.

With respect to whether or not Franklin operated as the equivalent to an SNF, the Board majority finds that it is undisputed that Franklin furnished skilled nursing care to its patients. The Provider's argument regarding this matter is that Franklin furnished skilled care only rarely or on a sporadic basis and that cannot be equated to operating as an SNF that is primarily engaged in furnishing such services. The Board majority again disagrees with the Provider. The "equivalency" arguments in this case are essentially the same as those presented in South Shore where the Circuit Court declined to substitute its judgment for that of the Secretary. Essentially, the Circuit Court found it reasonable to rely upon the nursing home provisions of the Omnibus Budget Reconciliation Act of 1987 governing the certification of long-term care facilities under the Medicare and Medicaid programs. These provisions indicate that both Medicare SNFs, such as the Provider's TCU, and Medicaid nursing facilities, such as Franklin, provide the same basic range of services described in sections 1819(b)(4) and 1919(b)(4) of the Act.

Finally, the Board majority finds that the Provider's TCU does not qualify for new provider status based upon Medicare's relocation rules. While the Provider argues that a different inpatient population is being served at its TCU than was served at Franklin's location, it did not demonstrate that total inpatient days were substantially less at the TCU than at Franklin. This requirement helps to assure that the intent of the new provider exemption would be met by

[8] Transcript (Tr.) at 130. Exhibit I-104.
[9] Exhibit I-23 at Article II.

showing low or under utilization. With respect to this matter, the record shows that the TCU's utilization was not low. According to testimony elicited at the hearing, the TCU experienced a utilization rate of about 74 percent during its first year of operation.[10]

DECISION AND ORDER:

CMS properly denied the Provider's request for an exemption from the Medicare SNF cost limits as a new provider. The CMS determination is affirmed.

Board Members Participating:

Suzanne Cochran, Esq. (Dissenting)
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Esq.
Elaine Crews Powell, CPA
Anjali Mulchandani

DATE: July 16, 2004

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Dissenting Opinion of Suzanne Cochran

[10] Tr. at 134.

I disagree with the Board majority's decision that Franklin had previously operated as an equivalent to a skilled nursing facility.

The Medicare statute defines a "skilled nursing facility" as one which is

> primarily engaged in providing (A) skilled nursing care and related services for residents who require medical or nursing care, ***or*** (B) rehabilitation services for the rehabilitation of injured, disabled or sick persons. (emphasis added)

42 U.S.C. §1395i-3(a)(1).

The Medicaid statute defines a "nursing facility" (as opposed to a skilled nursing facility). The definition is identical to the Medicare section quoted above and therefore includes a skilled nursing facility. But "nursing facility" contains a third definition:

> . . . ***or*** (C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require services (above the level of room and board) which can be made available to them only through institutional facilities.

42 U.S.C. §1396r(a)(1)(C).

Franklin was certified for Medicaid but not for Medicare. The evidence was overwhelming that Franklin, a residential facility, was *primarily* engaged in providing the type of care described in subsection (C) of the Medicaid statute. It was undisputed that Franklin provided some skilled services. Most of the services identified by the Intermediary as skilled were those typical of what are routinely rendered in a home setting by a parent for a child, or by a spouse or child for an elderly patient (cough syrup for cough; observe for ankle swelling; observe for behavior changes). The Intermediary's witness, Ms. Hake, testified that because a licensed nurse was on Franklin's staff to perform the service, the service therefore became skilled.

Dr. Baer and Ms. McKenna's testimony showed that Franklin operated consistent with its state license in providing only "periodic . . . skilled nursing, restorative or other therapeutic services;" that Franklin's patients were long term residents who were "aging in place," needing primarily "maintenance" or "supportive care;" and that they were transferred to facilities which could offer intensive skilled nursing or rehabilitative care when acute episodes occurred.

The Intermediary's argument that OBRA 87 eliminated all differences between a Medicare "skilled nursing facility" and a Medicaid "nursing facility" is not borne out by the legislative history.[11] On the contrary, even though OBRA redefined nursing facility, subsection (C) of the Medicaid

[11] The Intermediary's witness testified that the phrase "and related services" in the Medicare statute, which modifies 'skilled nursing care', is the same as the more specific provisions the Medicaid section (C) definition pertaining to 'health-related care' and that the existence of both statutory provisions was "mere surplussage." (Tr. Vol. 2 at 676-78; *see also*, Tr. Vol. 2 at 730-36

provision was not eliminated.[12] Moreover, the committee report specifically described the subsection (C) services as continuing to be eligible for Medicaid payment.[13]

There is no parallel to the Medicaid subsection (C) services in the Medicare statute defining a skilled nursing facility. To ignore the distinction would violate fundamental statutory construction principles requiring that interpretations give effect to every word in a statute.[14] A Medicaid subsection (C) facility, therefore, does not equate to a Medicare SNF. The majority's conclusion that provision of any skilled services converts Franklin to a skilled nursing facility requires ignoring the plain language of the statute that the facility must be *primarily* engaged in furnished skilled services. In summary, Franklin was not "primarily engaged" in providing skilled nursing services and was, therefore, not an equivalent to Carney's TCU.

Suzanne Cochran

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[12] The Medicare SNF definition has not been materially changed since Medicare was enacted in 1965. In contrast, prior to OBRA '87, the Medicaid program certified both skilled nursing facilities and intermediate care facilities. The two definitions were combined into one new definition for NFs, which now appears in 42 U.S.C. §1396r(a)(1)(A) - (C).

[13] See Intermediary Exhibit 92. "In redefining nursing facility, the Committee amendment would not in any way alter the entitlement of current Medicaid beneficiaries or applicants, or future beneficiaries or applicants, to what is now an ICF level of care. Those beneficiaries who now reside in an ICF would continue to be eligible to reside in a nursing facility if they continue to meet the current ICF level of care requirement – that is, because of their mental or physical condition they require institutional care and services above the level of room and board."

[14] A statute must be interpreted to give effect to each of its provisions. United States v. Nordic Village, Inc., 117 L. Ed. 2d 181, 112 S. Ct. 1011, 1015 (1992) ("settled rule that a statute must, if possible, be construed in such fashion that every word has some operative effect"); Colautti v. Franklin, 439 U.S. 379, 392, 58 L. Ed. 2d 596, 99 S. Ct. 675 (1979) (it is an "elementary canon of construction that a statute should be interpreted so as not to render one part inoperative"); United States v. Menasche, 348 U.S. 528, 538-39, 99 L. Ed. 615, 75 S. Ct. 513 (1955) ("The cardinal principle of statutory construction is to save and not to destroy. It is our duty to give effect, if possible, to every clause and word of a statute . . . rather than to emasculate an entire section.")