PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005 - D3

PROVIDER –
Twin Rivers Regional Medical Center

Provider No.: 26-0015

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Premera Blue Cross

DATE OF HEARING -
November 18, 2003

Cost Reporting Periods Ended-
December 31, 1992; December 31, 1993 and
December 31, 1994

CASE NOs.: 96-0211; 97-1061R and 98-2080R

INDEX

ISSUE

Was the Provider entitled to an exemption from the skilled nursing facility routine cost limits for the years ended December 31, 1992, December 31, 1993, and December 31, 1994.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. § 1395(h), 42 C.F.R. §§ 413.20(b) and 413.24(b)

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

The sole issue in dispute in this appeal is whether Twin Rivers Regional Medical Center (Provider) hospital-based skilled nursing facility (SNF) is entitled to a new provider exemption under the provisions of 42 C.F.R. §413.30(e) of the Medicare regulations.

Section 1819(a)(1) of the Social Security Act defines a SNF as an institution engaged in providing skilled nursing care or rehabilitative services for injured, disabled or sick persons. Section 1861(v)(1)(A) establishes the method of reimbursement for SNFs as well as limitations on reimbursable costs. Such limitations are addressed in §§1861(v)(7)(B) and 1886(a) of the Social Security Act. 42 C.F.R. §413.30 implements the cost reimbursement limit for SNFs and also provides an exemption to the limits for "New Providers" at 42 C.F.R. §413.30(e)(2). It states:

> (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. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts it first patient.

Twin Rivers Regional Medical Center is an acute care hospital located in Kennett, Missouri. Effective September 28, 1989, the Provider became certified to operate as a "swing bed hospital." The Provider discontinued participation in the swing bed program effective May 1, 1991. Thus, it furnished swing bed services for approximately 19 months between September 28, 1989, and May 1, 1991.

On August 22, 1992, the Provider admitted its first patient to a newly established skilled nursing facility on its hospital campus. On August 25, 1992, the skilled nursing facility entered into a separate agreement to participate in the Medicare program. Because the per diem costs of its skilled nursing facility services exceeded the per diem routine cost limits, the Provider requested an exemption from the limits as a new provider in February 1994. The Medicare fiscal intermediary recommended that the request for an exemption to the limits be granted under 42 C.F.R. Section 413.30(e)(2) for the Provider's cost reporting periods ending December 31, 1992; December 31, 1993; December 31, 1994; and December 31, 1995. The Intermediary did so notwithstanding the fact that the Provider informed the Intermediary that it had previously provided swing bed services.

By letter dated June 15, 1994, the Bureau of Policy Development at HCFA, notified the Provider that its request for exemption from the routine cost limits was denied. The basis for the denial was that the SNF did not qualify as a new provider because Twin Rivers Hospital had furnished "equivalent services," (swing bed services) during the three years prior to its SNF becoming certified Medicare participation..

The Provider filed a timely appeal with the Board, and initially the majority of the Board ruled that the Board lacked jurisdiction to hear the case. Subsequently, the CMS Attorney Advisor reversed the Board's jurisdictional determination and remanded the case to the Board for a decision on the merits. At the Board hearing on November 18, 2003, the CMS representative indicated that CMS had erred in its original determination. CMS now concludes that the Provider does qualify for an exemption from the routine cost limits as a new provider, but only for the cost reporting period ending December 31, 1992.[1] The Provider was represented by Patric Hooper, Esquire, of Hooper, Lundy and Bookman, Inc. The Intermediary

---

[2] Tr. at p. 33-34

was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association

PARTIES' CONTENTIONS:

The Provider contends that it qualifies for an exemption from the Medicare routine cost limits as a new provider under 42 C.F.R. Section 413.30(e), which defines a new provider as 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. Under the regulation, an exemption "expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient."

The Provider contends, and CMS now agrees, that it was, in fact, a "new provider" of skilled nursing facility services beginning August 25, 1992. The Provider furnished equivalent services, i.e., swing bed services, for only approximately 19 months between September 28, 1989, and May 1, 1991. While CMS now recognizes that the Provider was, in fact, a new provider beginning August 25, 1992, and should be exempt from the routine cost limits for its fiscal year ended December 31, 1992, it continues to argue that the exemption should be limited to the 1992 fiscal year. However, the Provider believes that the plain language of the governing regulation, 42 C.F.R. §413.30(e), requires the 1993 and 1994 fiscal years to be exempted from the routine cost limits because a new provider exemption does not expire until the end of a provider's first cost reporting period beginning at least two years after the provider accepts its first patient. The Provider accepted its first skilled nursing facility patient on August 22, 1992; therefore, its exemption as a new provider should not expire until the end of the cost reporting period beginning January 1, 1995, which is the cost reporting period beginning at least two years after August 22, 1992.

The Provider recognizes that in some situations, swing bed services may be deemed to be the equivalent of skilled nursing facility services for purposes of determining the length of an exemption under 42 C.F.R. Section 413.30(e). However, in this case the swing bed services should not be deemed to be the equivalent of skilled nursing facility services because very few patients were actually provided swing bed services during the 19-month period at issue in this appeal. In addition, the swing-bed services were furnished only on a short-term basis as opposed to a long-term basis for the services furnished in the hospital-based skilled nursing facility beginning August 22, 1992.

Alternately, if swing bed services are treated as the equivalent of skilled nursing facility services for purposes of this case, the Provider contends it is nevertheless entitled to an exemption from the routine cost limits for its 1993 and 1994 fiscal years because the swing bed services were not furnished for three full years prior to August 25, 1992. Rather, during the three-year period prior to August 25, 1992, (the "look back period"), the swing bed services were furnished for only

approximately 19 months, between September 28, 1989 and May 1, 1991. Since the intent of the exemption regulation is to provide for three full years of exemption for a new provider, the period in which the Provider furnished swing bed services may not be counted as 36 months, or three full years, but rather must be counted as 19 months. Accordingly, the Provider would be entitled to another 17 months of exemption as a new provider. The 17-month period covers approximately four months of skilled nursing facility services furnished between August 25, 1992 and December 31, 1992, the twelve months of services furnished between January 1, 1993 and December 31, 1993, and approximately one additional month of services furnished at the beginning of the cost reporting period starting January 1, 1994. As a result, the 1992, 1993, and 1994 cost reporting periods should be exempt from the routine cost limits even if the swing bed services are counted.

The Provider further contends that the CMS position (that the less-than-three-year period during which the Provider furnished swing bed services is irrelevant to determining the length of the exemption) is arbitrary and inconsistent with CMS Pub. 15-1 §2604.1. That section contains a specific example of a provider being treated as a "new provider" even though it furnished equivalent services for two full years prior to the effective date of its Medicare certification. Because the provider in the example furnished "equivalent" services during the three-year look back period, the period during which the equivalent services were rendered must be considered in determining the remaining length of the exemption.

CMS continues to contend that the Provider is not entitled to an exemption for any cost reporting period other than the FYE December 31, 1992 Medicare cost report year. Its contention is based on the argument that under the governing regulation, 42 C.F.R. §413.30(e), the services furnished to swing bed patients must be considered to be equivalent to SNF services. Since the date when the first patient received swing bed services was September 28, 1989, the first cost reporting period beginning two years after that date is the cost reporting period beginning January 1, 1992, and ending December 31, 1992. Thus, the exemption expires at the end of the 1992 fiscal year.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after considering the Medicare law, regulations, program instructions, evidence submitted, testimony at the hearing and the parties' contentions, finds and concludes that the Intermediary properly denied the Provider's new provider exemption request for the years ended December 31, 1993 and December 31, 1994. The Board recognizes that the regulation at 42 C.F.R. §413.30(e)(2) allows for an exemption from Medicare's limit on reimbursable costs as a "new provider" if the provider has operated as the type of provider (or its equivalent) for which it is certified for Medicare under present and previous ownership for less than three full years. In this particular case, the overall timing and the length of time that equivalent services were provided are at issue.

The Board finds that it is undisputed that the Provider was approved for and began providing swing bed services on September 28, 1999. This was acknowledged by the Provider's witness, who also indicated that therapy services were made available to the swing bed patients.[2] The Board also finds that the regulation at 42 C.F.R. §413.114 clearly defines a swing bed hospital as a provider of SNF care.

Based on the facts and the regulations cited above, the Board concludes that the first time the Provider provided an equivalent SNF service was in September of 1989. Applying the time limits in 42 C.F.R. §413.30(e), an exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient. Accordingly, the Board majority finds that the Provider's exemption period ends on December 31, 1992, and the Provider qualifies for an exemption for its FYE December 31, 1992. The remaining years at issue fall after the expiration date of the exemption period established in 42 C.F.R. §413.30. The Board does not concur with the Provider's argument that the "new provider" classification should not begin until August 1992, as that premise does not recognize the rendering of equivalent services some three years earlier. It is irrelevant that the Provider, at its own option, chose to discontinue its swing bed services after only nineteen months. Following the Provider's logic would have allowed the Provider to operate for three full years and then obtain a three-year exemption. This is counter to the regulation's intent to provide relief to a "new" provider.

DECISION AND ORDER:

The Intermediary was correct in granting the Provider's exemption request for the year ended December 31, 1992. The Provider is not eligible to be treated as a "new provider" for the years ended December 31, 1993 and December 31, 1994.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire (Recused)
Martin W. Hoover, Jr., Esquire (Dissenting in Part)
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD

DATE: November 18, 2005

Martin W. Hoover, Jr., Esquire

[3] Tr. at p. 46-47

I respectfully dissent in part:

The regulation, 42 C.F.R. 413.30(e), states:

(e) 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. An exemption under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

I concur with the decision of the Board majority to grant to the Provider an exemption from the limits imposed under this regulation. I do not concur and I respectfully dissent to the decision regarding the duration of the exemption.

The regulation is very clear to me that an exemption expires at the end of the Provider's first cost reporting period beginning at least two years after the provider accepts its first patient. This Provider accepted its first patient on August 22, 1992. According to the Provider's final position paper this provider entered into a separate agreement to participate in the Medicare program and was certified as a newly established skilled nursing facility on its hospital campus. This certification was effective August 25, 1992. As a newly established and certified provider it would be impossible to admit a patient prior to August 22, 1992. It is my opinion that once an exemption is granted to this Provider, it is entitled to an exemption expiring at the end of the Provider's first cost reporting period beginning at least two years after the Provider accepts its first patient.

The Board majority has interpreted the phrase, after the provider accepts its first patient, to mean that the admission can be defined as one which occurs in a different certified provider (swing beds in a certified hospital). It is my opinion that the regulation is clear that the admission must be at the subject provider.

The Provider should be granted an exemption for the term indicated in the regulation.

Martin W. Hoover, Jr.