# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D40

**PROVIDER -**
St. Joseph's Health Services of Rhode Island
Providence, Rhode Island

Provider No.: 41-5122

**vs.**

**INTERMEDIARY** -
BlueCross BlueShield Association/
BlueCross BlueShield of Rhode Island

**DATE OF HEARING**
January 22, 2004

Cost Reporting Periods Ended -
September 30, 1997 and September 30, 1998

**CASE NO.:** 00-2981

**INDEX**

ISSUE:

Whether the Centers for Medicare & Medicaid Services' (CMS) denial of St. Joseph's Health Services of Rhode Island Transitional Care Center's request for exemption from the skilled nursing facility (SNF) routine cost limit (RCL) as a new provider was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

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.

The statute, 42 U.S.C. §1395x(v)(i), authorizes the Secretary to establish prospective limits on provider costs that are reimbursed under Medicare. These limits on costs are referred to as routine cost limits (RCLs).

Because new providers have difficulty meeting the applicable cost limits, HCFA provided an exemption from the costs limits for approximately the first three years of operation. 44 Fed. Reg. 31802 (June 1, 1979). The exemption may be granted if the provider "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." (emphasis added) An exemption expires at the end of the first cost reporting period beginning at least two years after the provider accepts its first patient. 42 C.F.R. §413.30(e).

STATEMENT OF THE FACTS AND PROCEDURAL HISTORY:

St. Joseph Health Service Transitional Care Unit (Provider/TCU) is a Medicare-certified hospital-based skilled nursing facility (SNF). The TCU was established by St. Joseph Health Services, Inc. (SJH) of Rhode Island in 1996 following a certificate of need determination by the Rhode Island Department of Health. SJH was a non-profit integrated health care delivery system – in a single corporate entity – sponsored by the Dioceses of Providence. It offered a variety of health care services through three geographically distinct operating divisions. The TCU is separately certified as a distinct part SNF under the Medicare program and it has a separate Medicare provider number.

On October 30, 1996, the Provider timely filed a request pursuant to 42 C.F.R. §413.30(e) with Blue Cross Blue Shield of Rhode Island (Intermediary) for a new provider exemption from the SNF routine cost limits to which the TCU would have otherwise been subjected.

On January 12, 2000, CMS denied the request stating:

> The distinct part SNF at SJH became Medicare certified on November 1, 1996. However, SJH owns and operates a sheltered care facility known as St. Joseph Living Center . . . [which] has operated since December of 1987. SJH documented the initial provision of a skilled nursing and/or rehabilitative service as identified in section 2533.1G of the Provider Reimbursement Manual, Part I, to have been performed by SJH as a SNF or its equivalent in December 1987. Accordingly, because SJH has operated in a manner equivalent to a SNF, as evidenced by the fact that it provided skilled nursing services as a sheltered care facility for three or more years prior to its Medicare certification, it does not qualify for a new provider exemption. (emphasis added)

The Provider disagreed with the determination and filed a request for hearing with the Board. The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§405.1835 – 405.1841. The Provider was represented by Hillary S. Shultz, Esquire, of Choate, Hall and Stewart. The Intermediary was represented by Eileen Bradley, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, evidence, and parties' contentions, finds and concludes that the Provider is a "new provider" under Medicare regulation 42 C.F.R §413.30(e) and is exempt from Medicare's limitations on its inpatient routine service.

CMS' determined that the St. Joseph Living Center was "equivalent" to the Transitional Care Unit. CMS and the Intermediary argue that the Living Center provided other than

custodial care to its residents. They stated that the Living Center provided skilled nursing and related services as defined in 42 C.F.R. §§409.33(a) – 409.33(c) during 1997, citing subcutaneous injections, overall management and evaluation of patient care plans, and observation and assessment of patients' conditions as examples of skilled services allegedly rendered by the Living Center. CMS thus concluded that because Provider's Living Center had operated in a manner "equivalent" to that of an SNF for more than three years prior to entering the Medicare Program, the Provider's TCU should be denied a new provider exemption.

The Provider argues to the contrary, and the Board agrees. The evidence showed that the TCU was an entirely new facility which provides a broad scope of skilled nursing care and rehabilitative services to patients with relatively intense post-acute needs. The State of Rhode Island licensed the TCU as a "nursing facility." CMS certified the TCU as of November 1, 1996, as a distinct part hospital-based SNF eligible to receive reimbursement under the Medicare program for the reasonable costs of providing care to Medicare beneficiaries.

The TCU utilizes up-to-date physical rehabilitation facilities, and cares for patients in hospital-grade patient rooms outfitted with oxygen lines and which can accommodate other sophisticated medical equipment. TCU patient services are coordinated through a central, hospital-style nursing station. Staffing includes 24-hour 7-day-a-week registered nurses as well as physician and speech therapists.

The Living Center is a markedly different facility. It is a free-standing residential facility that accommodates up to 64 elderly individuals who do not require medical or rehabilitative care. It is licensed as a Residential Care/ Assisted Living facility. The residents live in home-like apartment units which they furnish themselves. The residents come and go as they please – some in their own cars – subject only to a sign out system. Each apartment has its own bathroom and a lockable door. The residents may, if they wish, cook for themselves, either in their unit (using hotplates or microwaves and small refrigerators they supply) or in one of the Living Center's communal kitchens. The Living Center offers a range of supportive services to assist with some activities of daily living.

The TCU's first cost report reflected an average length stay of 17.49 days. Between 65%-75% of the TCU's patients were discharges to their own homes. Less than 10% were transferred back to acute care, and about 15-25% were discharged to assisted living facilities, nursing homes or other housing options. In contrast, the Living Center's occupancy rate in 1996 and beyond was close to 100%. Its residents stayed an average of two years in 1996.

The factual premise that CMS used to determine that the Living Center was "equivalent" to the TCU is inaccurate and inappropriate. The licensing requirements for assisted living facilities and SNFs in the State of Rhode Island do not allow an overlap of services. Further, CMS' reliance on the review of patient care plans and monthly assessments to determine equivalency between an assisted care facility and a SNF is

disingenuous. The evidence showed that the type of reviews performed by assisted living institutions as opposed to that performed in an SNF is considerably different in scope and level of responsibility.[1] The Board further concludes that providing a subcutaneous injections for resident at an assisted living facility is not "equivalent" to the provision of comprehensive services required and provided in an SNF. Even if the injections could properly be characterized as skilled services, CMS is using the occasional B-12 and insulin injections to establish equivalency. The Medicare statute defines an SNF as being:

> (1) . . . primarily engaged in providing to residents--
> (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.
>
> 42 U.S.C.A. §1395i-3(a). (emphasis added )

The plain language of the statute therefore prohibits equating a facility that only occasionally furnishes a skilled nursing service to one that is "primarily" engaged in furnishing such services.

The Provider also argued that the Intermediary improperly applied Medicare's Program Instruction at HCFA Pub. 15-1 §2533.1 which sets out the criteria for exemptions for new SNF providers. The Provider asserts that it would have qualified for the exemption under the old instruction and, because the new instruction was issued in September 1997, it is, therefore, a new policy that should be applied only on a prospective basis. The first cost report period in issue ended on September 30, 1997. Conversely, the Intermediary argues that this policy is a clarification of existing policy and can be applied to any cost report open to its review and adjustment. The Board concurs with the Provider's interpretation of the timing for applying this program instruction; therefore, it cannot be applied to the Provider's situation.

The Board also notes that the new provider exemption 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 rehabilitative services." See. e.g., PRM §5233.1.A. The evidence showed that during its first month of operation, the TCU's average occupancy was 21%; during its first three months, the average occupancy was 28.3%. By the end of its first year of operations, September 30, 1997, the TCU's average occupancy had risen to 57.9%. The Provider's circumstances were, therefore, what the new provider exemption was designed to address.

Based on the above analyses, the Board concludes that the Provider is entitled to a "new provider" exemption under Medicare regulation 42 C.F.R. §413.30(e).

---

[1] See Provider's Post Hearing Brief at pp. 39-40 and reference to the record cited therein.

DECISION AND ORDER:

The Provider qualified for a "new provider" exemption from Medicare's routine cost limits for each of the years at issue. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

DATE: May 13, 2005

Suzanne Cochran, Esquire
Chairperson