PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D38

PROVIDER -
St. Gertrude's Health Center
Shakopee, Minnesota

Provider No.: 24-5610

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Noridian Administrative Services

DATE OF HEARING -
February 24, 2006

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

CASE NOs.: 00-1032 and 01-2147

INDEX

ISSUE:

Whether the denial of the Provider's request for a new provider exemption from the skilled nursing facility routine cost limits 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. §1395h, 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 portion 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). The Medicare regulations at 42 C.F.R. §413.30(c) set forth rules governing reclassifications, exemptions, exceptions and adjustments to the cost limits. The provider's request must be made to its fiscal intermediary within 180 days of the date of the intermediary's NPR.

CMS provides for an exemption from the cost limits for new providers 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." 42 C.F.R. §413.30(e).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Gertrude's Health Center (Provider) is a 51-bed[1] skilled nursing facility (SNF) located in Shakopee, Minnesota. The Provider's newly constructed facility opened on November 4, 1996 and became Medicare certified on November 8, 1996.

During the fiscal years in question, the State of Minnesota had a moratorium on the licensure and medical assistance certification of new nursing home beds and construction projects. See Minnesota Statute, §144A.071. Exhibit I-15. Thus, there was no Certificate of Need (CON) process available to permit a new facility to be built; however, the moratorium allowed exceptions for replacement beds. Id. at §144A.073. See Exhibit I-16.

Valley View Health Care Center, Inc.(Valley View), a skilled nursing facility located in Jordan, Minnesota, applied for an exception to the nursing home moratorium to replace its entire 102-bed facility on a new site in the city of Jordan. Valley View's request was approved by the State of Minnesota Department of Health by letter dated January 12, 1994. However, the plans to replace the existing facility went unfulfilled and a special request was subsequently made to the Legislature and approved by the Governor in 1995 to allow Valley View to relocate up to 50% of its existing 102 beds to another location. In November 1996, Valley View relocated 51 of its beds to the Provider pursuant to the special legislation.[2] No physical plant assets, residents or staff were transferred from Valley View to the Provider during the years at issue. Valley View continued to operate as a nursing home until its closure on May 9, 2000.[3]

The Provider and Valley View are owned by separate entities that are not related. However, both the Provider and Valley View utilized the same long-term care management company, Health Dimensions, Inc., to manage their long term care facilities.

By letter dated January 7, 1997, the Provider submitted a request to be exempted from the SNF RCLs for cost reporting periods ending June 30, 1997 and June 30, 1998. A final determination was rendered by CMS in August of 1997 denying the Provider's request because: (1) the reallocation and relocation of beds from Valley View to the Provider was considered a change of ownership (CHOW); (2) prior to the change in ownership, Valley View had operated as a SNF/NF for at least the previous three years; and (3) the population served or primary service area did not substantially change. Exhibit I-12. The Provider properly appealed the denial to the Board and met the jurisdictional requirements of 42 C.F.R. §405.1835-405.1841. The amount of Medicare reimbursement in dispute is approximately, $99,853 and $176,644, respectively, for the two years at issue.

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[1] The Provider subsequently obtained 24 additional beds from Valley View Health Care Center. See Tr. at 47-49.

[2] An Additional request was made to and approved by the Legislature in 1999 allowing for up to 75 beds to be relocated. See Minnesota Statues. §144A.073, Subdivision 5, Replacement restrictions, subsection (g). See Intermediary Exhibit I-16 at 285.

[3] See Intermediary Exhibit I-24.

The Provider was represented by Laura S. Weintraub, Esquire, of Johnson, Killen & Seiler, P.A. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider asserts that it is a new provider as defined under the regulation. The Provider points out that it was a newly constructed facility that had never before existed, established with new equipment, new staff and a different population of patients. The Provider contends that it did not purchase or obtain a DON (Determination of Need) or CON, nor did it purchase or lease any assets from another facility, namely Valley View and no consideration in kind or cash was provided for the bed rights. The Provider further contends that it is not related to Valley View because the two facilities were not owned by the same entity. Valley View was owned by two individuals in a for-profit corporation, and the Provider was owned by Benedictine Health Systems (BHS), a non-profit corporation. In addition, the Provider indicates that Valley View continued its operations, albeit with fewer beds, for five (5) additional years following this transaction.

The Provider claims that this case is distinguishable from other cases in which the Board has denied new provider exemptions. In South Shore Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/ C&S Administrative Services, PRRB Dec, 99-D38, April 21, 1999, Medicare & Medicaid Guide (CCH) ¶80,182, the Board denied the exemption because the Department of Public Health, Commonwealth of Massachusetts made a determination that the purchase of the DON rights involved both a CHOW and relocation of operations; and the previous owner of the hospital complex had provided some skilled nursing services within the three-years look back period. Similarly, in Carney Hosptial v. Blue Cross Blue Shield Association/Associated Hospital Services, PRRB Dec. No. 2004-D29, July 16, 2004, Medicare & Medicaid Guide (CCH) ¶81,179, declined rev., CMS Adm., September 10, 2004, the Board majority rejected a new provider exemption because the provider was found to have purchased the previous facility's operating rights, name, goodwill, transferable licenses, permits, federal and state registrations, and existing contracts and agreements related to the ownership of the facility. In this instant case, the Provider did not purchase any assets, tangible or intangible, from another facility; therefore, no CHOW transaction was recognized. Rather, the Provider's bed rights were acquired solely through bed reallocation by the state legislature.

In other cases, ownership was a key factor in determining "new provider" status. In the denial of the new provider exemption in Rogue Valley Medical Center v. Blue Cross Blue Shield Association/Medicare Northwest, PRRB Dec. No. 2005-D26, March 15, 2005, Medicare & Medicaid Guide (CCH) ¶81,297, aff'd, CMS Adm., May 16, 2005, Medicare & Medicaid Guide (CCH) ¶81,369 (Rogue Valley), there the provider delisted beds at one of its facilities and used them at a new facility that it owned. The Rogue Valley decision focused on the joint ownership of the facilities and that the same

population was served. In the instant case, the Provider was under different ownership than Valley View and served a distinctly different population.

The Provider also points out that the Board ruled in favor of granting a new provider exemption where the skilled nursing care and rehabilitation services provided were short-term versus long-term in nature in St. Joseph's Health Services of Rhode Island v. Blue Cross Blue Shield Association/Blue Cross Blue Shield of Rhode Island, PRRB Dec. No. 2005-D40, May 13, 2005, Medicare & Medicaid Guide (CCH) ¶81,354, vac'd and reman'd, CMS Adm., July 13, 2005, Medicare & Medicaid Guide (CCH) ¶81,430. In the instant case, the Provider is providing post-acute SNF services rather than long-term SNF care.

Noridian Government Services (Intermediary) contends that the language of RCL regulation set forth at 42 C.F.R. §413.30(e) is ambiguous regarding how to determine whether a provider has operated under "previous ownership." Therefore, the Secretary properly issued interpretive guidelines in the program manual. According to the Intermediary, in a CON or moratorium state, where a provider acquires (through a purchase) the bed rights or rights to operate from an existing provider, the new owner acquires either the entire institution or a portion thereof. None of the pre-existing institutions, or parts thereof, are considered a new institution; they simply have a new owner. Thus, the Secretary's interpretation of the regulation carefully weighs the purpose of the new provider exemption against a policy that strongly discourages unwarranted Medicare payments.

The Intermediary acknowledges the Provider's assertion that it did not purchase the bed rights from Valley View and the beds from Valley View were not relocated. However, the Intermediary argues that the exception granted to Valley View was specifically to relocate beds to the town of Jordan and that the relocation of the beds to Shakopee did not result in a substantial change in the population served or type of services delivered. In addition, the Intermediary argues that the regulation at 42 C.F.R. §413.30(e) makes no allowance for institutions providing a low volume of skilled nursing and rehabilitative services prior to certification as a SNF. The Intermediary claims that the reason the Provider exceeded the RCL is due to the provision of atypical services for which the Intermediary approved an exception for both FYEs June 30, 1997 and June 30, 1998.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence and parties' contentions the Board finds as follows:

The State of Minnesota had a moratorium on the licensure and certification of new nursing home beds and construction projects. The Provider obtained bed rights under special legislation that permitted Valley View, an unrelated SNF, to transfer 51 of its beds to the Provider. The Provider was a newly constructed facility that had not previously operated, and other than beds right, did not obtain any other assets from Valley View. The Provider applied for a new provider exemption but it was denied

because HCFA considered the transfer of bed rights a change of ownership, and Valley View, the previous owner, had operated as a SNF during the three years prior to the transfer.

The Board has previously found that the acquisition of bed rights alone from an unrelated provider through the purchase of a CON or other mechanism used to transfer bed rights does not, in itself, constitute a CHOW, nor does it affect the "new" provider's right to an exemption. See St. Elizabeth's Medical Center v. Blue Cross and Blue Shield Association/ Associated Hospital Services of Maine, PRRB Dec. No. 2002-D49, September 30, 2002, Medicare & Medicaid Guide (CCH) ¶80,908, Rev'd., CMS Adm., December 3, 2002, Medicare & Medicaid Guide (CCH) ¶80,951 and more recently, Harborside Healthcare-Reservior v. Blue Cross Blue Shield Association/ Empire Medicare Services, PRRB Dec. No. 2006-D14, January 25, 2006, Medicare & Medicaid Guide (CCH) ¶81,462, Rev'd., CMS Adm., March 27, 2006, Medicare & Medicaid Guide (CCH) ¶ 81,526. The Board finds that CMS' guidelines that impute ownership of an unrelated provider to a provider that purchases a CON or obtains bed rights through other mechanisms are inconsistent with the Medicare regulation at 42 C.F.R. §413.30(e).

This issue has also been addressed in a number of court decisions. In Ashtabula County Medical Center v. Thompson, 191 F.Supp.2nd 884 (N.D. Ohio Feb. 8, 2002) Medicare & Medicaid Guide (CCH) ¶300,964 (Ashtabula), aff'd, 352 F.3d 1090 (6th Cir. 2003), the Court found the Secretary's interpretation of the new provider regulation arbitrary, capricious, and erroneous with respect to 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. Under CMS' position, 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.

In Ashtabula, 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) vis-a-vis the Secretary's position to "exclude as a class all providers that purchase CON rights from another, unrelated provider that has existed for more than three years from the reaches of the exemption . . . . (CCH) ¶300,964 at 803,405. The Court found the Secretary's arguments, 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. at 803,407.

In Maryland General Hospital, Inc. v. Thompson, 308 F.3d 340 (4th Cir. 2002), Medicare & Medicaid Guide (CCH) ¶301,188, the court stated,

> In sum, we conclude that "provider" as used in section 413.30(e) unambiguously refers to the business institution providing the skilled nursing services. It therefore follows that the regulation permits consideration of the institution's past and current ownership, but not the past and current ownership of a particular asset [the CON rights] of that institution. The Secretary's interpretation, however, equates the ownership of an institution providing skilled nursing services with the ownership of a particular asset of that institution. Since there is no language in the regulation that would permit the denial of the exemption because an asset of the new institution was previously owned by an unrelated SNF, the Secretary's interpretation is inconsistent with the plain language of the regulation and cannot be allowed to stand. See Gardebring v. Jenkins, 485 U.S. 415, 430 (1988) (explaining that a reviewing court should be "hesitant to substitute an alternative reading for the Secretary's [reading of his own regulation] unless that alternative reading is compelled by the regulation's plain language."); see also 5 U.S.C.A. §706(2)(A) (requiring a reviewing court to "set aside agency action, findings, and conclusions" that are "not in accordance with law").

Id. at 804,228.

The Board finds the decisions in the above referenced cases persuasive and notes that the Provider is not located in the circuits that have held the Secretary's interpretation of the regulation permissible. See South Shore Hospital, Inc. v. Thompson, 308 F.3d 91 (1st Cir. 2002), Paragon Health Network v. Thompson, 251 F.3d 1141 (7th Cir. 2001), and Providence Health System v. Thompson, 351 F.3d 661 (9th Cir. 2003).

The Board finds that there was no common ownership of the Provider and Valley View; therefore, Valley View cannot be considered a past or present owner of the Provider. In addition, though not dispositive to our decision, the Board finds that the Provider did not purchase bed rights from Valley View but merely received from the State the beds that Valley View relinquished.

Based upon the facts in this case, the Board concludes that CMS improperly denied the Provider's request for an exemption to the SNF's RCLs. The Provider's acquisition of bed rights from Valley View through special state legislation does not constitute a change in ownership, and the types of services that were provided by Valley View are not relevant. The Provider meets the definition of a "new" provider as set forth at 42 C.F.R. §413.30(e) in that it is a licensed and Medicare-certified SNF that has operated as this type of provider for less than three years. The Board's finding that the Provider met the

threshold test for entitlement to a new provider exemption obviates the need to address whether the Provider qualified for an exemption under other criteria.

DECISION AND ORDER:

The Board finds that CMS' denial of the new provider exemption was improper. CMS' decision is reversed.

Board Members Participating:

Suzanne Cochran, Esquire
Gary Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

DATE: May 23, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman