PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D46

PROVIDERs -
Franklin Square Hospital Transitional Care Unit
Baltimore County, Maryland
Good Samaritan Hospital Comprehensive Care Unit
Baltimore City, Maryland

Provider Nos.: 21-5279 and 21-5280

vs.

INTERMEDIARY
BlueCross BlueShield Association/
CareFirst of Maryland, Inc. (n/k/a
Highmark Medicare Services)

DATE OF HEARING -
September 21, 2005

Cost Reporting Periods Ended -
June 30, 1996; June 30, 1997 and
June 30, 1998

CASE NOs: 97-1239 and 97-1240

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ISSUE:

Whether the Intermediary properly denied requests by Franklin Square and Good Samaritan for New Provider Exemptions from the routine cost limits for fiscal years ending 6/30/96, 6/30/97 and 6/30/98.

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 on the intermediary's NPR.

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

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Franklin Square Hospital Transitional Care Unit ("Franklin Square TCU") and Good Samaritan Hospital Comprehensive Care Unit ("Good Samaritan CCU") (collectively, the Providers) are members of the Helix Health System, Inc. (Helix). Helix was initially incorporated on September 10, 1987.[1] In November of 1987, the Maryland Health Resources and Planning Commission (Commission)[2] approved the merger of Franklin Square Hospital Center, Inc. (FSH), the Union Memorial Hospital (UM) and their affiliated corporations to create Helix. Helix became the sole stockholder of Franklin Square and the sole member of Union Memorial Hospital, with reserved powers to take action or to approve or disapprove actions of these entities with respect to matters, including but not limited to the election or appointment of individuals to fill vacancies on the board of directors or the removal of a director from a board. See Exhibits I-20 and I-24. In June of 1994, the Commission approved a merger between Helix and the Good Samaritan Health System, Inc., which included Good Samaritan Hospital of Maryland, Inc. and the Good Samaritan Nursing Center, Inc.[3] Helix became the sole member of both Good Samaritan facilities and had reserve powers to take action or to approve or disapprove actions of these entities. Exhibit I-24. Tr. at 43. The parties have stipulated that these mergers did not result in a change of ownership (CHOW) within the meaning of the applicable Medicare regulations and manual provisions. See Stipulation, September 21, 2005, No. 8. On April 1, 1995, Church Home and Hospital of the City of Baltimore and its controlled entities also became wholly-owned subsidiaries of Helix. Exhibit I-19 at 510. In Articles of Amendment and Restatement filed on June 1, 1995, Helix indicated that Church Hospital Corporation, Church Home Corporation and Church Nursing Center, Inc. were also under its control.[4]

On July 7, 1995, Helix filed a Notice of Intent and Request for Exemption from CON Review to Commission seeking to reallocate comprehensive care facility beds among member health facilities of Helix in order to establish a 23-bed subacute care unit at Good Samaritan and a 24-bed subacute care unit at Franklin Square, and to delicense a total of48 acute care beds at those facilities. See Exhibit I-26.

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[1] See Joint Stipulation No. 5.

[2] See Maryland Health-General Article Title 19 – Health Care Facilities, Subtitle 1, Comprehensive Health Planning, Part I, Health Planning and Development (the Code). The State of Maryland utilize a State Health Resources Planning Commission (Commission) to develop a State health plan. See §19-114 of the Code. A certificate of need (CON) is required to establish a new health care facility, to relocate a health care facility to another site, or to change a facility's bed capacity or type or scope of services. See §19-115(e) of the Code. Health care facilities may change their bed capacity or services offered without a CON if they notify the Commission and it finds that the proposed change is pursuant to the consolidation or merger of two or more health care facilities and meets all other criteria. See §19-115(h)(2)(iii) and (i)(2)(iv) of the Code. See Intermediary's Exhibit I-18.

[3] See Intermediary's Exhibit I-23 and Provider's Exhibit P-83.

[4] Per Intermediary's Final Position Paper at 16.

The parties have stipulated that:

The Franklin Square TCU, a hospital-based skilled nursing facility, received beds from the following sources:

14 beds Church Nursing Center (CON-approved beds but not yet licensed)
2 beds Union Memorial Hospital's SNF (creep/waiver beds)
2 beds Church Hospital's RecoverCare SNF (creep/waiver beds)
6 beds Good Samaritan Nursing Center (creep/waiver beds)

Stipulation No. 9.

The Good Samaritan CCU, a hospital-based skilled nursing facility, received beds from the following sources:

15 beds Church Nursing Center (CON-approved beds but not yet licensed)
2 beds Union Memorial Hospital's SNF (creep/waiver beds)
2 beds Church Hospital's RecoverCare SNF (creep/waiver beds)
4 beds Good Samaritan Nursing Center (creep/waiver beds)

Stipulation No. 10.

Church Nursing Center, Union Memorial Hospital's SNF, Church Hospital's RecoverCare, and the Good Samaritan Nursing Center were business entities owned and operated by subsidiaries of Helix. See Stipulation No. 11. All four facilities operated as comprehensive care facilities and were certified as SNFs in the Medicare and Medicaid programs. Exhibit I-29. In addition, 3 of the 4 facilities had been granted new provider exemptions from the SNF RCLs. See Exhibit I-64.

The Commission approved Helix's request to merge and reorganize its existing beds among its member facilities on December 12, 1995. See Exhibit I-28.

The Franklin Square TCU opened on December 13, 1995 and was Medicare certified on December 15, 1995.[5] The Good Samaritan CCU was opened on January 11, 1996 and Medicare certified on January 16, 1996.[6]

The Providers timely requested new provider exemptions on May 9, 1996 and July 12, 1996. CMS denied the exemption requests on November 20, 1996. See Exhibits I-7 and I-14. The Providers filed timely appeals of the denials and met the jurisdictional requirements of the regulations at 42 C.F.R. §§405.1835-405.1841.

[5] Per Intermediary's Exhibits I-2 and I-12. See also Provider's Post-Hearing Brief at 2.
[6] Per Intermediary's Exhibits I-1 and I-4. See also Provider's Post-Hearing Brief at 2.

The Providers were represented by Carel T. Hedlund, Esquire, and John J. Eller, Esquire, of Ober, Kaler, Grimes & Shriver, P.C. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers contend that the legal standards that must be applied in this case are the regulation at 42 C.F.R. §413.30(e) and the interpretation of that regulation in Maryland General Hospital, Inc. v. Thompson, 308 F.3d 340 (4th Cir. 2002) (Maryland General).

First, the Medicare regulation that governs exemptions from the routine cost limits defines a new provider as follows:

> 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.

The Providers point out that for a provider to be eligible for a new exemption, it must be a "provider of inpatient services" which is "certified for Medicare." Further , this a threshold requirement that must be met before evaluating whether that provider (the provider that filed the cost reports at issue and that is seeking the exemption to the routine cost limit) previously operated as a SNF under present or previous ownership during the preceding three years.

Second, the Providers point out that in Maryland General the Court unequivocally stated that it is the Medicare-certified provider i.e., "the business institution that is providing the skilled nursing services" that is the subject of the inquiry. The Providers claim that for the Intermediary to prevail in its assertion that new provider exemption status be denied, the Intermediary must demonstrate that Franklin Square TCU and Good Samaritan CCU failed to meet all established criteria. The Providers claim that they qualify for new provider exemptions because they meet all of the following criteria: (1) providers of inpatient (skilled nursing care) services; (2) Medicare-certified SNF (providers); (3) Hospital-based (HB)-SNFs (providers) that have never previously "operated;" (4) the hospitals in which the the SNFs are based did not previously own or operate a SNF (prior to opening the Providers).

The Providers also indicate that only the bed rights were acquired from other SNFs; therefore, no change of ownership had occurred according to the manual provisions, and CMS is precluded from "looking back" to the prior ownership of those beds (rights). CMS Pub. 15-1 §1500.7. In addition, the Providers point out that the beds in question were not "used to render patient care," since they had never previously been operated, licensed or certified; and the Providers' acquisition of bed (rights) did not affect the licensure or certification of the facilities from which they were acquired.

The Providers also assert that the exemption is warranted because they experienced the low utilization that the new provider exemption was designed to remedy.

The Provider disagrees with the Intermediary's assertion that Helix, the parent holding company that owned both the Providers and the SNFs that furnished the beds to the Providers, is the business institution providing skilled nursing services and thus was providing skilled nursing care during the three-year look back period. On the contrary, the Providers claim that Helix does not meet the statutory definition of a "provider," as it is not an entity (or institution) providing services for which it is certified to participate in Medicare. Although the Providers acknowledge that Helix is a related party, they contend that the regulations do not test whether an entity "related to" the provider seeking the exemption has previously operated SNF services, but rather whether the provider that is seeking the exemption previously operated SNF services.

The Providers note that Helix, in itself, is not a provider under CMS manual instruction where a parent or other entity within a chain organization functions as a "home office" providing administrative services. CMS Pub. 15-1 §2150. See Exhibit P-77. Moreover, CMS has not issued any policy guidance to the effect that, with respect to a chain organization such as Helix, only one provider may receive a new provider exemption, and that other providers owned by the other corporations in the chain or system that thereafter apply for new provider exemptions should be denied. In fact, CMS granted a new provider exemption to the Recover Care Unit at Church Hospital in 1994 even though Church Nursing Center, with the same mailing address, had been certified as a Medicare SNF since 1987. Each of these related SNFs were owned and operated by separate corporations within one system. See Exhibit I-14 at 337.

The Provider also asserts that the Court in Maryland General held that anything less than the transfer of the entire "business institution providing the skilled nursing services," such as the mere transfer of operating rights, could not be used to deny the provider a new provider exemption. The Providers contend that without regard to any level of control that Helix may exercise over all its wholly owned subsidiaries, it does not divest the Providers of their provider status or elevate Helix to provider status.

The Intermediary asserts that Helix is a legal entity, commonly referred to as a holding company, with broad authority over its family of corporations. The Intermediary notes that Helix is the sole stockholder of Franklin Square and the sole member of Good Samaritan, and as such, may appoint all hospital directors. The Intermediary notes that Helix has customary and reserve powers to regulate the financial affairs of each of its subsidiaries and to coordinate the strategic plan for each of them. Further, the Intermediary points out that Helix facilitated the transfer of bed rights through the state health planning process[7] and used its staff to help establish the SNFs at the Providers. The Intermediary relies on these facts to treat Helix as the underlying provider which has merely utilized some of its existing SNF resources to form the Providers' hospital-based SNFs. The Intermediary notes that all of the facilities from which the beds were allocated to form the Providers' SNFs had operated SNFs in the three years preceding

[7] See Transcript at 110-11.

this transaction. The Intermediary also indicates that the donating SNFs were benefiting or had benefited from an RCL exemption in the past. Exhibit I-64.

The Intermediary asserts the decision in Maryland General does not control in this case because of the distinguishing fact that the business entity in this case, Helix, owns and controls the Providers and all its subsidiaries. The Intermediary claims that the decision in Paragon Health Network v. Thompson, 251 F.3d 1141 (7th Cir. 2001), provides a more relevant framework. In that case, the provider opened a sub-acute center with bed rights it had obtained from another facility owned by Paragon, and both facilities were located in the same health service area. The Board concluded that this was a relocation of resources rather than a new facility. The Intermediary indicates that the same type of reshuffling of resources in the form of beds (hospitals beds) among the Helix family of corporations has occurred; therefore, there is no basis to grant a new provider exemption.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

As noted in the facts above, the Providers are members of the Helix Health System. In addition to the Providers, Helix owns a number of hospitals and SNFs. In this case, the Providers obtained the SNF bed rights they needed from other SNFs owned by Helix. This transaction was approved under the State of Maryland CON legislation. The Providers applied for new provider exemptions that were denied by HCFA because the transfer of beds was considered a change of ownership, and the facilities that provided the beds had previously operated as SNFs during the preceding three years.

The Board notes that in previous decisions it has found that the acquisition of bed rights alone from an unrelated provider through the purchase of CON rights or other types of bed rights does not by itself constitute a change in ownership (CHOW) and does not affect the provider's right to a new provider exemption. 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 Administrator, March 27, 2006, Medicare & Medicaid Guide (CCH) ¶81,526. The Board finds that CMS' guidelines that impute ownership of an unrelated provider to the provider that purchases CON rights or other bed rights are inconsistent with the Medicare regulations. CMS Pub. 15-1 §2604.

This issue has clearly been addressed in various 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.

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 [from such relief] as a class all providers that purchase CON rights from another, unrelated provider that has existed for more than three years . . . . (CCH) ¶300,964 at 803,405. 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 stated 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, 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").

Medicare & Medicaid Guide (CCH) ¶301,188, at 804,228.

The Providers contend that the holding in Maryland General is applicable to this case; that under Maryland General the term "provider" in the regulation is the business institution that is providing the skilled nursing services, and the test is whether that institution, under current or prior ownership, has operated a skilled nursing facility in the preceding three years. Since both the Providers and the hospitals, in which the SNFs were based met the test, a new provider exemption is warranted. The Providers indicate that Helix, the parent holding company of the Providers, cannot be considered the business institution providing SNF services under Maryland General because it is not a "provider." Helix is not licensed by the State to provide health care services, provides no health care services, is not an institution or institutional complex providing SNF services, has no Medicare provider agreement and holds no health care accreditations. Although Helix is a related party, the test in the regulation is not whether an entity related to the provider seeking the exemption had previously provided SNF services, but whether the provider seeking the exemption had previously provided SNF services.

The Intermediary notes that as a result of various mergers, Helix became the holding company with controlling interests in both Franklin Square Hospital and Good Samaritan Hospital, which established the Providers, and the other health care providers that were providing SNF services. The Intermediary indicates that the beds obtained to establish the Providers came from business entities owned and operated by subsidiaries of Helix. The Intermediary further notes that Helix participated in establishing the Providers by facilitating the reallocation of bed rights from its existing SNFs to Franklin SquareTCU and Good Samaritan CCU. These existing SNFs had all provided SNF services within the preceding three years. The Intermediary contends that since the Providers are part of Helix and it provided SNF services, no new provider exemption should be permitted. The Intermediary further points out that 3 of the 4 related SNFs that provided bed rights to the Providers had previously benefited from new provider exemptions.

The Board notes that the Providers are located in the 4th Circuit in which Maryland General is the controlling precedent as opposed to other Circuits that have held that the regulation is ambiguous and that the Secretary's interpretation of the regulation is permissible. See South Shore Hospital, Inc. v. Thompson, 308 F.3d 91 (1st Cir. 2002), Paragon, supra, and Providence Health System v. Thompson, 353 F.3d 661 (9th Cir. 2003). Even though Maryland General applies to the current case, the Board finds that the facts in this case are different and should result in a different decision.

In Maryland General, a hospital that had never operated a SNF under its current or previous ownership established a hospital-based skilled nursing facility. To establish the provider, the hospital purchased from three SNFs the right to operate 24 beds. The facilities from which the hospital purchased the bed rights were not connected or related to the hospital in any way. In the instant case, the Providers and the hospitals that established the Providers were owned by the same parent holding company, Helix; therefore, the bed rights obtained to establish the Providers were from related SNFs. Based on these facts, the Board finds that Helix is the present owner of the Providers, and as such, an integral part of the business institution providing SNF services. The Board finds that it must consider the fact that Helix is the present owner of the Providers in

order to give meaning to the portion of the regulation that requires consideration of the provider under present and previous ownership. The Board finds that it must consider the Providers as part of Helix and not simply ignore the complicated nature of health care ownership that exists in the health care industry in general and in this case in particular.

Helix is the sole stockholder or member of each of the subsidiary corporations that contributed beds to establish the Providers. As such, Helix has the capacity to control the subsidiary corporations through their respective boards of directors and by exercising its control in the areas of budget, strategic planning and financial matters. In this instant case, Helix represented the business entities before the Maryland Health Resources Planning Commission to facilitate the transfer of bed rights to the Providers. The Board notes that the 47 beds used to establish the Providers came from the existing resources of the corporations owned by Helix, i.e., Union Memorial Hospital's SNF, Church Nursing Center, Church Hospital's RecoverCare and the Good Samaritan Nursing Center. All of these facilities provided SNF services in the preceding three years, and 3 out of 4 enjoyed the benefits of new provider exemptions themselves. In this case, the Board finds that the Providers are wholly owned subsidiaries of Helix, and under the regulations at 42 C.F.R. §413.30(e) and Maryland General, Helix was providing SNF services at its wholly-owned subsidiaries. In addition, the Board finds that Helix has merely reallocated some of its bed rights among its related member health care facilities. The Board finds operational status (i.e., waiver or creep beds) of the transferred beds to be irrelevant.

The Board disagrees with the Providers' argument that because Helix is not a "provider" in and of itself under Medicare law its association with the Providers should not be considered. The Board notes that the regulation requires one to examine the past and current ownership of the provider; however, it does not specify that the past or current owner be a provider. If this were the case, any health care chain organization could continually obtain new provider exemptions by shifting bed rights to newly incorporated subsidiaries every three years. The Board finds the facts in this case similar to those 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). In Rogue Valley, both the provider and the SNF it obtained beds from were owned by the same corporation, and the Board found that the same corporate owner was providing SNF services under present and past ownership. The fact that the facilities had different provider numbers was irrelevant

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The Providers also argue that if the Intermediary's interpretation is correct only one provider of a health care organization would be entitled to a new provider exemption for all of their subsidiary facilities. The Board notes that this rationale was specifically rejected in Spalding Rehabilitation Hospital v. Mutual of Omaha Insurance Company, PRRB Dec. No. 2003-D18, March 7, 2003, Medicare & Medicaid Guide (CCH) ¶80,969, CMS Administrator declined rev. May 5, 2003 (Spalding). In Spalding, CMS denied the request for a new provider exemption because another SNF owned and operated by the same rehabilitation hospital and located in an adjacent state, was considered part of the same institutional complex. The Board found that even if an institutional complex exists,

the geographic location and populations served were material factors that had not been considered. The Board believes that to the extent that a SNF is providing new services or SNF services to a new or different population, a new provider exemption would be warranted.

Finally, the Board considered the fact that the Providers had related SNFs on or near their campuses. For Good Samaritan CCU, it was the Good Samaritan Nursing Center located right on its campus. Franklin Square TCU participated in a joint venture delivering SNF services near its campus. Tr. at 140-141. Although the Providers claim these separate corporations had no involvement with each other's operations, the Board finds that Helix already had the knowledge and expertise to commence operations which underlie the basis for granting a new provider exemption.

In summary, the Board finds that the regulation at 42 C.F.R. §413.30(e) and the Court in Maryland General require that one look at the present and previous ownership of the provider. In this case, the Providers are part of the larger business entity, Helix, which was providing SNF services. The Board finds that ignoring Helix' ownership of the Providers because Helix itself is not a Medicare provider would be incorrect.

DECISION AND ORDER:

The Board finds that CMS' decision to deny the new provider exemptions was proper. The decision is affirmed.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

DATE: July 12, 2007

Suzanne Cochran, Esquire
Chairperson