PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2008-D33

PROVIDER -
Oak Knoll Health Care Center
Framingham, Massachusetts

Provider No.: 22-5682

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services

DATE OF HEARING -
March 13, 2008

Cost Reporting Periods Ended -
December 31, 1995 and December 31, 1999

CASE NOs.: 98-0019 and 02-0785

INDEX

ISSUES:

1. Whether the Provider is entitled to a new provider exemption from the skilled nursing facility (SNF) routine service cost limits under 42 C.F.R. §413.30(e) for the cost reporting year ended December 31, 1995.

2. Whether the Intermediary's denial of the Provider's request to be reimbursed the Transitional Period Rate for SNFs under 42 C.F.R. §413.340(e) for the cost reporting year ended December 31, 1999 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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Oak Knoll Health Care Center (Provider or Oak Knoll) is a skilled nursing facility located in Framingham, Massachusetts. Since 1990 the facility had provided skilled nursing services and received payment from Medicare under present and previous ownership under several different provider numbers.[1] Oak Knoll first received payment

[1] See, Provider Exhibit 1 and Exhibit 2. (Unless otherwise noted, references to Provider and Intermediary Exhibits are for those contained in their respective position papers for case number 02-0785, FYE December 31, 1999.)

under its existing provider number after October 1, 1995,[2] but it first received payment from Medicare under previous ownership in 1990.[3]

Oak Knoll is a replacement facility for two former skilled nursing facilities: Heritage Long Term Care Center (Heritage) and Colonial House Nursing Home (Colonial). Oak Knoll is located on the same site as Heritage and Colonial in Framingham, Massachusetts. Heritage and Colonial were merged and rebuilt as Oak Knoll pursuant to a certificate of need issued by the Commonwealth of Massachusetts Department of Public Health, Determination of Need Program.[4] On November 6, 1995, the new building opened under its new name Oak Knoll Skilled Nursing Facility. At that time thirty-five residents of Heritage were transferred to the new building and the old building was closed.[5]

Colonial was certified for participation in the Medicaid program May 1, 1980.[6] Heritage was certified for participation in the Medicaid program on July 1, 1981,[7] and assigned provider number 22-A287.[8] It was Medicare-certified from July 1, 1990 until its participation was terminated on October 13, 1995. Oak Knoll was Medicare-certified and assigned provider number 22-5682 on November 20, 1995.[9] It operated a total of 61 beds during the cost reporting year ended December 31, 1995 of which 20 were certified to participate in the Medicare program.

Prior to their merger into Oak Knoll, Colonial and Heritage were owned and operated by FRM Corporation I and FRM Corporation II, respectively. Oak Knoll was owned by Arbetter Corporation. All of these corporations were owned and controlled by Dr. Alfred L. Arcidi.[10]

On January 18, 1996, the Provider submitted a written request for an exemption from the Medicare skilled nursing facility routine service costs limit (SNF-RCL) for the 1995 year[11]. On January 24, 1996, the fiscal intermediary forwarded the Provider's request to CMS along with its recommendation that an exemption to the routine cost limit be granted under 42 C.F.R. §413.30 based on the "new provider" status.[12] CMS denied the request in a letter dated February 14, 1996,[13] and the fiscal intermediary notified the Provider of this denial in a letter dated February 22, 1996.[14]

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[2] See, Provider Exhibit 2.
[3] See, Provider Exhibit 1.
[4] See, Provider Exhibit 3.
[5] See, Provider Exhibit 4.
[6] See, Provider Exhibit 5.
[7] See, Intermediary Exhibit 13 at 2.
[8] See, Provider Exhibit 2.
[9] See, Provider Exhibit 6.
[10] See, Provider Exhibit 7.
[11] See, Intermediary Exhibit 1 (Case No. 98-0019, FYE December 31, 1995)
[12] See, Intermediary Exhibit 2, Id.
[13] See, Intermediary Exhibit 3, Id.
[14] See, Intermediary Exhibit 4, Id.

For the 1999 year the Provider sought transition period rate payments because it was a SNF that first received payment from Medicare prior to October 1, 1995. The Intermediary denied this treatment based on the requirements of CMS Pub. 15-1 §2834A.
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The Provider appealed the adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 – 405.1841. The Provider is represented by Nicholas J. Nesgos, Esquire, of Posternak, Blankstein & Lund LLP. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS

With respect to the 1995 year, the Provider contends that CMS determined that Oak Knoll was not a new provider entitled to an exemption from SNF-RCL under 42 C.F.R. §413.30(e). The new Oak Knoll facility opened on or about November 6, 1995. However, CMS determined that Oak Knoll had operated as a SNF for more than three years because it was merely a successor to Heritage and Colonial. CMS determined that Heritage and Colonial had merged into Oak Knoll.[15]

With respect to the 1999 year, the Provider contends that a SNF that first receives payment from Medicare under present or previous ownership prior to October 1, 1995, is eligible for transition period rate payments. See, 42 C.F.R. §413.340(e). In this case, Heritage received Medicare payments prior to October 1, 1995. Since CMS has determined that Oak Knoll is merely a successor to and replacement for Heritage, Oak Knoll is entitled to transition period rate payments for the 1999 year. CMS cannot both: (i) preclude Oak Knoll from receiving an exemption from SNF routine service cost limits on the grounds that Oak Knoll is the same provider as Heritage and (ii) preclude Oak Knoll from receiving transition period rate payments on the grounds that it is a different provider than Heritage.

Regarding the 1995 year, the Intermediary agrees that Oak Knoll was a replacement facility for Heritage and Colonial. Thus, Oak Knoll met the definition of an existing SNF as set forth in 42 U.S.C. §1819 (a)(l) of the Social Security Act and is not a new provider. However, the Intermediary contends that its payment of the federal rate, and not the transition period rate, for the 1999 year is nevertheless in accord with CMS Pub.15-1 §2834A and 42 C.F.R. §413.340(e).

The Provider responds that Section 2834A of CMS Pub. 15-1 is an invalid exercise of CMS' rule making authority because it was not promulgated pursuant to the notice and comment period of the Administrative Procedure Act and is inconsistent with and contrary to 42 U.S.C. §1395yy(e)(2)(E)(ii) and 42 C.F.R. §413.340(e). This Section of CMS Pub. 15-1 is invalid because it derogates from the clear and unambiguous intent of Congress and is inconsistent with the statute and regulation.

[15] See, Provider Exhibit 8.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, parties contentions and evidence submitted, the Board finds and concludes that: (1) in 1995 the Intermediary properly treated the Provider as an ongoing facility and not a new provider under 42 C.F.R. §413.30(e) and (2) the Intermediary improperly denied the Provider a transition period rate in 1999 under 42 C.F.R. §413.340(e) because it had a new provider number.

The Board notes that CMS has at least two regulations dealing with the treatment of payments to SNFs depending upon previous or current ownership. First, 42 C.F.R. §413.30(e) allows an exemption from the limits on reimbursable costs for new providers if the new provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present or previous ownership for less than three full years. Second, 42 C.F.R. §413.340(e) titled, "SNFs Excluded From The Transition Period" states:

> SNFs that received their first payment from Medicare, under present or previous ownership, on or after October 1, 1995, are excluded from the transition period, and payment is made according to the Federal rates only.

The Board observes that these two regulations deal with the same subject matter, i.e., how SNFs are reimbursed. The reimbursement criteria in both regulations are dependent upon "previous or current ownership." However, in its Program Instructions, CMS presents different interpretations depending on whether a provider is a "new provider" or a provider is subject to a transition period or the federal rate for reimbursement. In the instant case, CMS has determined that the Provider was not a "new provider" under 42 C.F.R. §413.30(e) because previous ownership had offered SNF-type services. The Board agrees with this determination. However, in 1999, CMS determined that the Provider was limited to federal rate payment only under §413.340(e) and CMS Pub. 15-1 §2834A because the Provider did not receive payment from Medicare under its current provider number on or before October 1, 1995.

The Board finds language in these two regulations similar in scope but subject to different interpretations by CMS, especially in the Program Instructions. Specifically, CMS Pub. 15-1 §2834(A) states:

> SNFs Receiving the Federal Rate. – SNFs who first received payment from Medicare (i.e., based on when the payment was issued by the intermediary), under its current provider number, on or after October 1, 1995 are paid based on the Federal rate only. For example, an institution that was assigned a Medicare provider number prior to October 1, 1995, but did not receive its first payment from Medicare until after October 1, 1995, would receive the Federal rate. Where a merger or a consolidation has occurred, a determination is made based

> on the payment history of the surviving entity as indicated by the surviving SNF provider number.
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> SNFs Receiving the Transition Period Rate. – SNFs who first received payment from Medicare (i.e., based on when the payment was issued by the intermediary), under its current provider number, prior to October 1, 1995 are paid based on the transition rate only and are excluded from receiving the Federal rate. For example, an institution that was assigned a Medicare provider number prior to October 1, 1995, and received its first payment from Medicare on or before September 30, 1995, would receive the transition rate. Where a merger or consolidation has occurred, a determination is made based on the payment history of the surviving entity as indicated by the surviving SNF provider number.
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> SNFs Who Do Not Have a Cost Report Beginning on or After October 1, 1994 and before September 30, 1995. – Payment to those SNFs who do not have a cost reporting beginning on or after October 1, 1994 and before September 30, 1995 will be made based on the federal rate only. For example, a SNF had a no Medicare utilization cost report for the cost reporting period beginning November 1, 1994 and ending October 31, 1995 or, the provider had a 13 month cost reporting period that began prior to October 1, 1994 and included the entire base year.

The Board finds the Provider's analysis[16] of the Federal Statute insightful and relevant. It states that 42 U.S.C. §1395i-3(a) defines a SNF as an institution which is primarily engaged in providing skilled nursing care to its residents. The Provider argues that an institution is an establishment or place, not limited to a provider with a particular provider number. The Board agrees with this analysis. The Medicare regulations also provide similar language.

The Board is bound by the Medicare statute and regulations, and it gives great weight to CMS' interpretations of the law in its Program Instructions. In this case, however, the Board finds that CMS Pub. 15-1 §2834A goes beyond the clear meaning of the controlling law and attempts to add an additional criterion to restrict entitlement to a transition period payment rate by including the phrase "under its current provider number." Therefore, the Board finds that the Manual provision is arbitrary and capricious.

The Board finds correct CMS' determination that the Provider was not a new provider because it had existed previously as Heritage and Colonial, and those facilities had provided SNF-type services for more than three years. Moreover, it is undisputed that the same individual owned and controlled the three corporations that owned and controlled the three facilities, Heritage, Colonial, and Oak Knoll. However, the Intermediary's finding that as replacement facility for these former Medicare providers, Oak Knoll was

[16] See pages 1-17 of the Provider's 1999 Final Position Paper.

not entitled to a transition period payment rate is inconsistent with CMS' new provider determination. CMS' assignment of a new provider number to a replacement facility is clearly not a sufficient basis upon which to disqualify the Provider for a transition period payment rate. Therefore, the Board concludes that since the Provider received Medicare payment before October 1, 1995, even though it was under different providers numbers, it qualifies for a transition period payment rate for 1999.

DECISION AND ORDER:

Under the provisions of 42 C.F.R. §413.30(e) the Provider does not qualify as new provider. The Provider is entitled to a transition period payment rate because it received Medicare payment before October 1, 1995.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, CPA
Yvette C. Hayes
Michael D. Richards, CPA

FOR THE BOARD:

Suzanne Cochran
Chairperson

DATE: August 12, 2008