CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
St. Joseph's Health Services of Rhode Island – Transitional Care Unit **Provider** ***vs.*** **BlueCross BlueShield Association/ BlueCross BlueShield of Rhode Island** **Intermediary**	**Medicare Reimbursement for Cost Years Ending: 09/30/97 and 09/30/98** **Review of:** **PRRB Dec. No. 2005-D40** **Dated: May 13, 2005**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. Comments were received from the Center for Medicare Management (CMM), requesting reversal of the Board's Decision. The parties were then notified of the Administrator intention to review. The Provider submitted comments requesting affirmance of the Board's Decision. Accordingly, the case is now before the Administrator for final administrative review.

BACKGROUND

St. Joseph Hospital (SJH) is a multi-campus institutional complex comprised of Our Lady of Fatima Hospital, St. Joseph Hospital for Specialty Care, and St. Joseph Living Center (the Living Center). The Living Center, which the State certified as a "residential care and assisted living facility," has been in operation since December 1987. [1]

[1] See Provider's Position Paper at 1-7, unless otherwise indicated.

Pursuant to an application for a determination of need (DON), the State of Rhode Island licensed the Provider as a skilled nursing facility (SNF) in 1996.[2] The State's approval was contingent upon the requirement that "the hospital de-license 15 rehabilitation beds at the Providence Unit and 5 medical/surgical beds at the Fatima Unit…."[3] CMS certified the Provider in November 1996 as a distinct-part SNF of the St. Joseph Hospital for Specialty Care.[4] The Provider admitted its first patients in October 1996.

A new provider exemption from the routine cost limits (RCLs) for the Provider was submitted in October 1996.[5] In response to a CMS request for further information, St. John's Health Services of Rhode Island certified that the Living Center provided the following "nursing services": administration of oral medications; insulin injections by nurses along with monitoring of blood sugar; assistance with activities of daily living as needed, including bathing, dressing, and ambulation; and monitoring of vital signs.[6] By letter to the Intermediary, CMS denied the exemption request, and the Intermediary notified the Provider of the denial by letter dated January 26, 2000.[7] The Provider timely requested a Board hearing.[8]

ISSUE AND BOARD DECISION

The issue was whether CMS' denial of the Provider's request for an exemption from the SNF RCLs was proper.

The Board found that CMS' denial of the exemption request was improper because the Provider met the "new provider" requirements established at 42 CFR 413.30(e). The Board found that the evidence showed the Provider to be a new facility providing a broad range of skilled nursing and rehabilitative services which were markedly different than the services furnished at the Living Center. The Board characterized the Living Center as home-like apartment units to which residents freely come and go. Moreover, the Board found that the State of Rhode Island licensed the Living Center as a "residential care/assisted living facility," in contrast to the Provider, which the State licensed as a nursing facility, and which CMS certified as a distinct-part, hospital-based SNF.

---

[2] See Intermediary Exhibit No. I-55 at 645 *et. seq*.
[3] Id. at 648.
[4] See Provider Exhibit No. 11, worksheet S-3, Part I from the FY 1997 Medicare Cost Report for St. Joseph Health Services of Rhode Island (multi-campus institutional complex, Provider No. 41-0005).
[5] See Provider Exhibit No. 12.
[6] See Provider Exhibit No. 16. Letter from St. Joseph's Health Services of Rhode Island to Blue Cross of Rhode Island (Intermediary), dated Sep. 30, 1999.
[7] See Provider Exhibit No. 18.
[8] Id.

The Board further observed that the Provider's first cost report reflected an average length of stay of 17.49 days. Less than 10 percent of the Provider's patients were transferred to acute care, and 65 to 75 percent of the patients were discharged to their own homes. About 15-25 percent of the patients were discharged to assisted living facilities, nursing homes, or other housing. In contrast, the Board stated, the Living Center's occupancy rate from 1996 and beyond was close to 100 percent, with its residents staying an average of two years.

The Board found fault with CMS' determination that the Living Center's services were "equivalent" to the Provider's services. In that regard, the Board observed that the State of Rhode Island does not permit the services of assisted living facilities and SNFs to overlap. CMS' reliance on the Living Center's patient care plans, monthly assessments, and the furnishing of subcutaneous and B-12 injections to support that the Living Center was providing SNF services was incorrect.

Moreover, the Board continued, even if the injections could be characterized as skilled services, CMS was using the *occasional* injection to establish equivalency, in contravention of the plain language of §1819(a) of the Act. That section defines a SNF as being "'*primarily*' engaged in providing'" skilled nursing care and related services, as well as rehabilitation, to residents requiring medical, nursing, and/or rehabilitative care [Board's emphasis]. The Board further agreed with the Provider's contention that it would have qualified for the exemption under §2533.1 of the Provider Reimbursement Manual (PRM) both before and after it was modified in September 1997, although the modified version, as "new policy," would not apply to the Provider's case because of the timing of the cost years at issue.

Finally, the Board noted that the Provider's low occupancy in the first years of operation resulted in the kind of hardship the new provider exemption was designed to address. Accordingly, based on this analysis, the Board found that the Provider was entitled to a new provider exemption consistent with §413.30(e), for each cost year at issue, and reversed the Intermediary's adjustments.

SUMMARY OF COMMENTS

CMM requested reversal of the Board's decision for the FY 1997 cost year and dismissal of the Board's decision for FY 1998 for lack of jurisdiction. First, CMM contended that the Living Center is a provider of long-term services, which makes it equivalent to a SNF. Moreover, in accordance with a Senate Committee Report related to the original Medicare legislation,[9] §2104 of the State Operations Manual includes a personal care home as a type

[9] CMM cited to Sen. Fin. Comm. Rep. No. 404, 89th Cong. 1st Sess. 31-35 (1965). CMM quoted this document as stating that a "'posthospital extended care facility'" could be "a

of facility which may qualify as a SNF.[10] CMM further observed that the State of Rhode Island licenses residential care and assisted living facilities, which may admit residents according to several levels of service. CMM explained that "[a]ll facilities" are required to provide staffing adequate to furnish the care and services needed for the highest practicable well-being of the residents according to the appropriate level of licensing. At the M1 licensing level, CMM stated, the facility may furnish medications to the resident. If a resident is unable to self-inject a medication, it must be given by a licensed nurse. Further, licensed or unlicensed individuals who have completed a state-approved drug administration course, may furnish medications and monitor health indicators. At least once every thirty days, a registered nurse (RN) must visit the facility to monitor the residents' medication regimen and evaluate their health, making changes to plans of care as needed.

CMM further observed that the State of Rhode Island has a waiver under §1915(c) of the Act which permits Medicaid recipients in the State who require the level of care provided in a nursing facility to be cared for in a residential care and assisted living facility. Such a facility might have a part which serves as an "old age home," consistent with the Senate Committee Report and §2104 of the State Operations Manual. Thus, "CMM believe[d] that a residential care and assisted living facility is a long term care facility therefore making it the same 'type of provider' as a SNF."

In addition, CMM noted that long-term care (LTC) facilities include SNFs which are defined in §1819 of the Act as facilities that are "'primarily engaged in providing to residents … skilled nursing care and related services for residents who require medical or nursing care, or … rehabilitation services for the rehabilitation of injured, disabled, or sick persons.'" CMM added that, to participate in Medicare or Medicaid, all LTC facilities, whether SNF or NF, must meet the LTC requirements established at 42 CFR 483, subpart B.

Next, CMM pointed out that CMS did not make a finding of how often the Living Center provided skilled nursing care, related services, or rehabilitative services, contrary to the Board's assertion that CMS found that the Living Center only occasionally furnished a skilled nursing service. In this regard, CMM observed that, in the recent case of St. Elizabeth's Medical Center of Boston v. Thompson,[11] the Court rejected CMS' longstanding approach in determining whether a facility is operating for the first time as a SNF or the equivalent. The Court held that CMS must determine if a facility is "primarily

---

section of a facility another part which [sic] might serve as an *old age home*." [CMM's emphasis.]

[10] CMM cited to Rev. 255, page 2-35, 10-92.

[11] 396 F.3d 1228 (D.C. Cir. 2005).

engaged" in skilled nursing, related, or rehabilitative services to qualify as a SNF or the equivalent. However, CMM noted that the Court omitted defining "primarily engaged," and CMS has also not defined it; thus, CMM was "unaware" of how the Board made its finding. Accordingly, CMM maintained, the key questions in this case are what it means to be "primarily engaged" in skilled and rehabilitative services, and whether the Living Center was "primarily engaged" in providing such services.

Nevertheless, CMM stated that it believes "primarily engaged," under §1819(a)(1), refers to the type of care that a facility provides to its patients generally rather than the type of care a particular patient may receive at a given point in time, because the definition relates to the overall character of the institution itself rather than the type of care that an individual patient receives.

CMM went on to explain that it might be useful to review medical records to determine if a facility is "primarily engaged," but, in this case, such records were destroyed. Thus, CMS relied solely upon provider-submitted information and the State's regulations which require a registered nurse (RN) to visit the facility at least once every thirty days to monitor medications and evaluate resident health, and make changes to the residents' plans of care as appropriate. CMM also quoted the regulation at §409.33(a) which defines services which could qualify as either skilled nursing or skilled rehabilitation to include overall management and evaluation of a care plan, and observation and assessment of the patient's changing condition. "These are exactly the types of services the [Provider witness] testified to under cross examination," CMM contended and quoted the witness at length.

Turning to other findings by the Board, CMM disagreed with the Board's statement that the State of Rhode Island's licensing regulations do not permit an overlap of services in SNFs. Rather, CMM contended that the State licenses nursing facilities, not SNFs, and the regulations do not prohibit an overlap of services.

Next, CMM argued that the definition of a SNF at §1819(a)(1) of the Act does not require a SNF to offer a broad scope of skilled nursing care. Although§1819(b)(4)(A) requires a Medicare SNF to provide certain services, these requirements are for purposes of participation in Medicare and not part of the definition of a SNF at §1819(a)(1). Furthermore, CMM pointed out that a LTC facility that chooses to participate in Medicare as a SNF may restrict the range of services it intends to provide, pursuant to §134 of the Skilled Nursing Facility Manual (HCFA Pub. 12). That provision states that: "'A provider may have restrictions on the types of services it makes available and the types of health conditions it accepts or may establish other criteria relating to the admission of patients.'"

CMM also noted that in 1994, a freestanding SNF's average length of stay was 236.71 days. Thus, a two-year length of stay was "not out of the question" in a SNF. Moreover,

underutilization does not automatically qualify a facility to be exempt from the SNF routine cost limits.

CMM went on to disagree with the Board's finding that CMS improperly applied §2533 of the PRM. In this case, the Provider's request was not received by CMS until 1999. Section 2533 was published in 1997, and prior to that, there was no formal guidance in the manual.

Finally, CMM contended that the Board did not rule on the jurisdictional challenge that was presented at hearing, regarding FYE September 30, 1998. St. Joseph Health Services of Rhode Island limited its request to the FYE September 30, 1997 cost year. CMS also did not render a decision on FY 1998. Thus, a decision regarding the exemption for FY 1998 cannot be appealed. CMM noted that several Administrator decisions have agreed with its position that a request must be made for each cost year in which an exemption is sought, i.e., an exemption is not automatically applied to subsequent cost reporting years.[12] These decisions were also consistent with §2531 of the PRM and the regulations at §413.30. In this case, all documents state that the request was being made solely for FYE 09/30/97.

The Provider opposed CMM's request for review on the grounds that CMM's arguments were substantively and procedurally flawed. The Provider contended that CMM's argument that the Living Center should be deemed an LTC facility under Medicare is not supported by any credible evidence. CMM cited non-precedential work as authoritative, and stretched the language of the State Operations Manual to reach its conclusion that there is no legal distinction between the operations of the Living Center, which has been licensed by the State as a residential care and assisted living facility, and the Provider, licensed by the State as a nursing facility.

The Provider went on to state that there is no need to remand the case so that a record can be developed regarding the definition of "primarily engaged." The Provider believed that "primarily engaged," under any reasonable definition, could not support CMS' position in this case. Moreover, CMM's suggestion that the Provider's inadequate record-keeping prevented it from demonstrating sufficient facts to support its contention "border[ed] on the defamatory."

Further, the Provider contended that CMS stipulated at the hearing that the Provider was created from de-licensed medical/surgical beds following a DON process which established there was a need for a TCU at St. Joseph's Hospital for Specialty Care. CMS

[12] CMM cited to Twin Rivers Regional Medical Center, PRRB Dec. No. 96-0211, 97-1061, 98-2080 (FYEs 12/31/92 through 12/31/94) May 29, 2003, and Citrus Nursing and Rehabilitation Center, PRRB Dec. No. 2003-D40 (FYEs 05/31/96 through 05/31/98), Sep. 11, 2003.

also failed to challenge facts presented in the pleadings and at hearing which distinguished the Provider from the Living Center. Moreover, the Provider maintained, CMS conceded that, "'but for a CMS finding that the Living Center provided skilled nursing, skilled services, the application of [the] TCU for [a] new provider exemption would have been granted.'"[13] The Provider argued that both CMS and the Administrator are bound by CMS' prior admissions and thus, CMS was limited to arguing and the Administrator is limited to analyzing whether the Living Center was an LTC which was primarily engaged in furnishing skilled nursing and/or rehabilitative services. The Provider asserted that the Board's decision was based on substantial record evidence.

Next, the Provider stated that the Living Center was not a provider of LTC services or a SNF equivalent and that CMM's reliance on "merely expository" language in the 1965 Senate Finance Committee Report and the State Operations Manual was not supportive. CMM's reliance on a Committee Report definition is misplaced for it carries no precedential value.

In addition, CMM's insistence that the Living Center was an LTC facility was based on that classification being the sole basis upon which CMS could apply the analysis at §2533.1 of the PRM. However, the Provider maintained that the applicable section to have been applied by CMS was §2604.1, which was in effect when the Provider opened and applied for the exemption. However, the Provider continued, the Administrator need not reach that issue because there was no "factual predicate" in the record for determining that the Living Center was an LTC facility or the equivalent.

The Provider stated that Rhode Island law generally defines residential care and assisted living facilities as those that care for residents not requiring medical or nursing aid but who may need help with medication. Nowhere does Rhode Island law state or imply that a residential care and assisted living facility is an "old age home" or "personal care home," nor does CMM reference such law. Rather, CMM argued that Rhode Island has a waiver under §1915 of the Act, for residential care and assisted living facilities, and therefore, such facilities are partly old age homes and at the same time distinct part nursing facilities or personal care homes.

However, the Provider maintained that the §1915 Medicaid waiver is immaterial and irrelevant to the issues in this case. There was no evidence that the Living Center ever furnished Medicaid-eligible or Medicare-eligible services to its residents, was Medicaid-certified, or sought reimbursement for such services. Nor was there evidence that the waiver applied to level F2-M1 residential care and assisted living facilities, or that any Living Center resident would have been required to be placed in a hospital or NF but for the assistance the individual was receiving at the Living Center. Rather, the Provider

[13] The Provider cited to the Board Hearing Transcript (Tr.) at 25-29, 338-41, and 346-50.

emphasized, the uncontroverted evidence was that the Living Center residents were quite functionally independent.

Next, the Provider contended that there is no basis to CMM's argument that the Living Center's conducting pre-residence and monthly resident interviews constituted skilled nursing services in a LTC. Moreover, if this contention were true in this case, then every hospital, hospice, dialysis clinic, etc., would qualify as an LTC, which clearly they do not.

In addition, the Provider pointed out that, under Rhode Island law, and under the Living Center's license, an individual who the staff determines needs regular healthcare services will not qualify for a lease at the Living Center. The reviews of residents are to ensure that residents who have declined over the preceding month so much that they need regular healthcare services will, as statutorily required, be asked to leave the Living Center. As to medication assistance, the Provider stated that the F2-M1 classification of the Living Center means that medications which are commonly self-administered may be administered. Hearing testimony confirmed that the only medication assistance provided at the Living Center was insulin and monthly B12 injections, which were given to only one or two residents at any time, or one to three percent of its population. Moreover, even if such services were considered skilled, a facility providing those services to a miniscule percentage of its population would not be considered "primarily engaged" in providing skilled nursing and rehabilitative services, the standard the Board applied.

The Provider maintained that there was no need to remand the case to determine the meaning of "primarily engaged" since it is an unambiguous term. The Court in St. Elizabeth's held that CMS' interpretation of the new provider exemption regulation was not reasonable or supported by substantial evidence because CMS failed to consider whether the predecessor institution had been primarily engaged in providing skilled nursing services and rehabilitative care. "Primarily engaged," the Provider argued, has been used in Medicare and Medicaid law for decades and no court has held that such words were in need of any explanation beyond that which common sense directs.[14] Nor has CMS promulgated any regulations further defining "primarily engaged," indicating that CMS did not think further explanation was required. The Provider concluded that CMM's remand argument was an *ad hoc* attempt at rulemaking in the form of adjudication, which is inconsistent with the U.S. Supreme Court's decision in Bowen v. Georgetown University Hospital.[15]

The Provider further maintained that a remand to perform a comprehensive review of medical records to determine if the Living Center was primarily engaged in SNF care is unwarranted as substantial and unchallenged evidence on this issue has already been

[14] The Provider cited to Rodriguez v. American International Insurance Company of Puerto Rico et. al., 402 F.3d 45, 48-9 (1st Cir. 2005).
[15] 488 US 204, 209-11 (1988).

presented by the Provider. CMM's statement that the records were "destroyed" is a gross distortion of facts and supports the unnecessity of a remand. Only minimal personal data, medication information, and the 30-day review records were required to be kept by law. Moreover, regulations require retention of only five years; thus, the records CMM claimed were "destroyed" were eliminated in accordance with Rhode Island regulations. In addition, the Provider observed, CMS did not request any resident records prior to rendering its denial of the new provider exemption, and not before June 2005 did it suggest that a review of such records might be helpful.

Turning to jurisdiction, the Provider pointed out that the Board did determine that it had jurisdiction over FY 1998, at the close of the hearing, when it also informed CMS that it could submit a motion for reconsideration, which was never done. The Provider also noted that, contrary to CMS' claim, it did request that the exemption apply to FY 1998, for in its original request for an exemption, the Provider, nearly quoting from §413.30(e), wrote that it "'under[stood] that the exemption expires at the end of our first cost reporting period beginning two years after accepting our first patient.'"[16] The letter also contained the date the Provider's first patient was admitted and the month its cost reporting period ended. Thus, the Provider was clearly seeking the full multi-year application of the regulation. Moreover, the Provider's request for hearing expressly referenced both cost years.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments are included in the record and have been considered.

Since its inception in 1966, Medicare's reimbursement of health care providers was governed by § 1861(v)(1)(A) of the Act. Section 1871(v)(1)(A), provides that, "reasonable cost shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." However, the Secretary has also been granted authority under § 1861(v)(1)(A) of the Act to establish:

> limits on the direct and indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title...

[16] The Provider cited to Intermediary Exhibit No. I-1.

Implementing § 1861(v)(1)(A) of the Act, the Secretary has promulgated the regulation at 42 CFR 413.30 which sets forth the general rules under which CMS may establish payment limits on the reasonable costs of providers. The regulation further establishes rules which govern exemptions from and exceptions to limits on cost reimbursement in order to address the special needs of certain situations and certain providers. In this case, the Provider requested an exemption from the cost limits for new providers. This exemption is set forth in the regulation at section 413.30(e), which reads:

> 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 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.

In this case, the issue is whether the Provider was operating 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." When determining whether a SNF provider has operated as a SNF or its equivalent for three years, CMS looks at the services of the institution as a whole prior to certification.

Notably, the U.S. Court of Appeals for the District of Columbia recently rendered St. Elizabeth's v. Thompson, supra. In St. Elizabeth's a SNF had requested a new provider exemption after purchasing operating rights from a Medicaid nursing facility (NF). CMS determined that, under the law, both NFs and SNFs are required to provide the same fundamental range of services, i.e., nursing and specialized rehabilitative services meeting a certain standard. Thus, CMS found that the Provider was not a "new provider" for purposes of the §413.30(e) exemption. However, on review, the Court of Appeals found that the record did not show that the NF was "primarily engaged"[17] in providing skilled nursing or rehabilitative services. Thus, the Court reversed CMS' determination that the NF was a SNF or equivalent.

[17] The Act defines a SNF at §1819(a)(1) as an institution which: "is 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, and is not primarily for the care and treatment of mental diseases." 42 CFR 409.33 of the regulations also set forth examples of skilled nursing and rehabilitative services.

The Administrator continues to maintain the validity of CMS policy set forth in the CMS determination litigated in St. Elizabeth's.[18] However, under §1878(f)(1), the District of Columbia is a judicial district in which the Provider may file suit and, thus St. Elizabeth's is binding case law here. Accordingly, the Administrator finds it proper to remand the instant case to CMS to apply the Court's criteria in St. Elizabeth's to the particular facts of this Provider's exemption request[19] and to determine whether the Provider's request for a new provider exemption should be allowed under the St. Elizabeth's criteria.[20] This remand is limited to the facts, circumstances, and cost years presented in this specific case.

Accordingly, the Administrator orders:

THAT the decision of the Provider Reimbursement Review Board be vacated;

THAT this case be remanded to CMS to apply the Court's criteria in St. Elizabeth's Medical Center of Boston v. Thompson to the Provider's exemption request;

THAT a CMS decision on the Provider's exemption request will be rendered as expeditiously as possible; and

---

[18] Admr. Dec. 2002-D49.

[19] The Administrator notes that both CMS and the Provider characterized the Provider's twenty beds as former "hospital" or "medical/surgical" beds. However, the State of Rhode Island's certificate of approval for the creation of the Provider required that "the hospital de-license 15 rehabilitation beds at the Providence Unit and 5 medical/surgical beds at the Fatima Unit and that the … licensed capacity of the nursing facility not exceed 20 beds." [Emphasis added.] See Intermediary Exhibit No. I-55 at 648.

[20] The Administrator finds that the Provider properly requested that the exemption apply to both FYEs 09/30/97 and 09/30/98; thus, a CMS determination would apply to both cost years. See Intermediary Exhibit No. I-1. Moreover, the Administrator notes that the Provider appealed pursuant to the FYE 09/30/97, but that NPRs for years subsequent to FYE 09/30/97 had not been issued at the time of the Provider's request for hearing. See Revised List of Issues signed August 8, 2000.

THAT a CMS decision on the Provider's exemption request pursuant to the criteria set forth in St. Elizabeth will follow the provisions of 42 CFR 413.30(c).

Date: 7/13/05

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare and Medicaid Services