CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Covenant Shores Health Center **Provider**	**Provider Reimbursement for Cost Reporting Periods Ending: 01/31/98 and 01/31/99**
vs.	
Blue Cross Blue Shield Association/ AdminStar Federal Illinois **Intermediary**	**Review of: PRRB Dec. No. 2005-D44 Dated: June 10, 2005**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(l) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). Comments were received from the CMS' Center for Medicare Management (CMM) requesting that the Board's decision be reversed. The parties were then notified of the Administrator's intention to review the Board's decision. No other comments were received. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue is whether CMS' denial of the Provider's request for an exemption to the routine cost limits (RCLs) for skilled nursing facilities (SNFs) as a new provider was proper.

The Board held that CMS' denial of the Provider's request for an exemption to the SNF RCLs was improper and determined that the Provider's request should be granted on the merits. The Board found that the only issue for its consideration was the adequacy of the information supplied by the Provider to support the use/non-use of the beds purchased from Wesley Home during the period from purchase until the

Provider placed the bed in use. The Board examined the Provider's initial submission and found that it was improperly processed between the original and subsequent intermediaries. The Board noted that neither intermediary listed anything that the Provider failed to supply and, in fact, the new intermediary gave the Provider a favorable recommendation when it forwarded the request to CMS. The Board further noted that CMS' subsequent request for additional information were matters of interpretation rather than completeness. The Board further found that the Provider's original submission included persuasive evidence that the beds were not in use for the period at issue. Moreover, the Board stated that where, as in this case, an exemption request is complete, the 45-day rule was not applicable and a request for additional clarification does not disqualify the Provider. The Board concluded that the evidence presented in the Provider's original application was sufficient to establish that the beds were not in use during the period at issue. Thus, the Board held that the Provider's request should be granted on the merits.

SUMMARY OF COMMENTS

The Center for Medicare Management (CMM) commented, requesting that the Board's decision be reversed. CMM contended that the Board lacked jurisdiction for the fiscal year ending (FYE) January 31, 1998 because the request for hearing was not timely filed. With respect to CMS' denial, CMM maintained that the Provider failed to provide documentation to support its request with the timeframe provided for at Section 2531.1B.4 of the Provider Reimbursement Manual (PRM).

CMM argued that the Board incorrectly found that the Provider's original request was complete and that the request should be granted on the merits for the cost years in dispute. CMM noted that the Provider purchased its certificate of need (CON) from Wesley Home and that such a purchase is a change of ownership. Under the relevant PRM provisions, where a change of ownership occurs, CMS must determine if there is a break in service between the purchase of the beds and the resumption of operations that exceeds three years. Further, if the period is less than three years, the entire operation of the prior owner is considered and, CMS must determine how the institution has operated under past and present ownership.

In this case, CMM argued that the Provider's first request only referenced the purchase of bed allocation rights from Wesley Home. However, no documentation was submitted regarding the closing date of the transaction; what happened with the licensed beds between closing, approval of the CON, and the date of reopening; and the prior owner's operation. Thus, CMS requested additional documentation be submitted within 45 days. However, the Provider failed to provide such

documentation within the timeframe. CMM maintained that, after the 45th day had passed, the Provider submitted a draft document, characterized by the Board as an estimated timeline, which did not address the issues raised by CMS. Further, CMM argued that the draft document was not considered as it was untimely filed.

DISCUSSION

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

Regarding the matters in dispute before the Board, from the beginning of the Medicare program, Medicare reimbursed hospitals and other health care providers on the basis of reasonable costs of covered services. Section 186l(v)(l)(A) of the Act defines "reasonable cost" as the "cost actually incurred," excluding amounts not necessary to the efficient provision of health care. Section 223 of the Social Security Act of 1972 amended section 1861(v)(l)(A) to authorize the Secretary to set prospective limits on the costs reimbursement by Medicare.[1] These limits are referred to as the "223 limits" or "routine cost limits" (RCL), and were based on the costs necessary in the efficient delivery of services. Beginning in 1974, the Secretary published routine cost limits in the Federal Register. These "routine cost limits" initially covered only inpatient general routine operating costs.

In 1982, in an effort to further curb hospital cost increases and encourage greater efficiency, Congress established broader cost limits than those authorized under section 1861(v)(l)(A), the existing routine cost limits. The Tax Equity and Fiscal Responsibility Act (TEFRA) added section 1886(a) to the Act, which expanded the existing cost limits to include ancillary services operating costs and special care unit operating costs in addition to routine operating costs. Pursuant to section 1886(1)(A)(ii) of the Act, these expanded cost limits, referred to as the "inpatient operating cost limits," applied to cost reporting periods beginning after October 1, 1982.

Relevant to this case, exceptions and exemptions to the "routine cost limits" or RCLs were promulgated at 42 CFR 413.30. The regulation at 42 CFR 413.30 provides for exemptions to the RCLs if certain criteria are met. Specifically, the regulation at 42 CFR 413.30(e)(2) provides that a provider may request an

[1] Pub. Law 92-603.

exemption to the RCLs if it meets the criteria of a new provider. In order to qualify for an exemption as a new provider, the provider must have operated as the type of provider, or its equivalent for which it is certified for Medicare, under present and prior ownership for less than three full years.

With respect to the process for filing an exemption request, the regulation at 42 CFR 413.30(c) explains that:

> The providers' request must be made to its fiscal intermediary within 180 days of the date of the intermediary's notice of program reimbursement. The intermediary makes a recommendation on the provider's request to CMS [formerly HCFA] which makes the decision. CMS responds within 180 days from the date CMS receives the request from the Intermediary. The intermediary notifies the provider of CMS' decision ....

Consistent with the regulation, sections 2531 and 2533 of Provider Reimbursement Manual set forth the instructions and documentation requirements for providers seeking exemptions from the SNF routine cost limits. These instructions include the process for submission of such requests and the documentation requirements and time limits for submissions.

In this case, CMS denied the Provider's request for an exemption to the RCLs for SNFs as a new provider. Specifically, CMS determined that the Provider's application was incomplete and that the Provider failed to timely respond to CMS' request for additional information. The Board, however, found that the Provider had submitted a complete application and that CMS' subsequent request for additional information were matters of interpretation rather than completeness. Viewing the record as whole, the Administrator finds that under the narrow circumstances in this case, the Provider met the completeness requirement. However, the Administrator also finds that the Board erroneously ruled on the merits of the Provider's request for an exemption. Since CMS had not rendered a final determination on the merits of the Provider's request, the Board is without authority to rule on such matters. Thus, the Administrator hereby vacates the Board's decision on the merits of the Provider's request for an exemption to the RCLs for SNFs as a new provider, and remands this case to CMS for a final determination.

Accordingly, the Administrator orders:

THAT the decision of the Provider Reimbursement Review Board as to the merits of the Provider's RCL request be vacated;

THAT this case is remanded to CMS for a determination on the Provider's application for an exemption to the SNF RCLs based on the entire record which was before the Board and the Administrator;

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

THAT a CMS decision on the Provider's exemption request will follow the provisions of 42 CFR 413.30(c).

Date: 8/11/05

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