PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D23

PROVIDER -
Jordan Hospital
Plymouth, Massachusetts

Provider No.: 22-0060

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Associated Hospital Services

DATE OF HEARING -
December 15, 2005

Cost Reporting Period Ended -
September 30, 1998

CASE NO.: 01-2214

INDEX

ISSUE:

Whether the Intermediary's denial of the application of Jordan Hospital for a new provider exemption from the routine cost limits for its provider-based skilled nursing facility was justified.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. 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 the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

At the close of its fiscal year, each provider submits a cost report to its intermediary showing the costs it incurred during the period and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and notifies the Provider in a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's determination may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The statute, 42 U.S.C. §1395 x(v)(1)(A), 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).

Because new providers have difficulty meeting the applicable cost limits, HCFA provided an exemption from the cost limits for approximately the first three years of operation. 44 Fed. Reg. 31802 (June 1, 1979). 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." An exemption expires at the end of the first cost reporting period beginning at least two years after the provider accepts its first patient. 42 C.F.R. §413.30(e).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Jordan Hospital (Provider) is a non-profit, general acute care hospital located in Plymouth, Massachusetts. The Provider opened the Peter Chapman Transitional Care Unit (PCTCU), a twenty-five bed hospital-based skilled nursing facility (HB-SNF), in December of 1995 to provide subacute care to patients who required a more sophisticated level of care than could be provided in a nursing home. The SNF was located in a former acute care ward on the third floor of the Provider's facility.

Massachusetts law required that providers obtain a Determination of Need (DON)[1] before constructing new facilities. The Massachusetts Department of Public Health (MDPH) imposed a moratorium on DON applications for new nursing facility beds in 1992. The MDPH developed an exception process to this moratorium under which a hospital could be granted a DON to open a new Level II SNF so long as it first arranged, by contract, for the closure of a Level III nursing home.[2] To take advantage of this exception, a hospital had to locate a nursing facility that was interested in closing its beds and apply to move the rights to operate that Level III facility.[3]

The Provider began this process on March 31, 1995 when it entered into a contract for services with Shirley Dionne, operator of Greenlawn Nursing Home.[4] The contract stated that Ms. Dionne wished to surrender her license to operate Greenlawn and that the Provider wished to obtain the right to operate a SNF. Under the contract, Ms. Dionne agreed to assist the Provider in obtaining from MDPH the right to operate a SNF. In exchange, the Provider agreed to pay Ms. Dionne $300,000. The contract stated that the Provider did not ". . . acquire any interest in the real estate, license, furnishings, equipment, receivables, notes or other assets of the Nursing Home" and that the Provider agreed to cooperate with the operator of the Nursing Home ". . . in the Hospital's efforts to obtain the right to operate a skilled nursing facility at its site as may be granted by the Department. . . ." By January 11, 1995, Greenlawn had transferred its last patient out of its facility. On March 2, 1995,[5] MDPH granted conditional approval to Greenlawn to suspend its license as of January 11, 1995. On May 4, 1995, the MDPH notified the Provider that the PCTCU was suitable to be licensed. MDPH extended the temporary suspension of Greenlawn's license until the Provider's facility was constructed and a license issued to PCTCU.

The Provider completed construction of a twenty-five bed hospital-based SNF in December of 1995. The first patient was admitted to the PCTCU on December 11, 1995, and CMS certified the PCTCU for Medicare participation effective December 15, 1995.

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[1] Per Provider Post-Hearing Brief, page 13, the DON is commonly referred to in other states as a Certificate of Need, or "CON."
[2] See, MDPH letter to CMS explaining this policy in a letter dated February 27, 1996, Exhibit P-8.
[3] See, Tr. at 75-77.
[4] See, Provider Position Paper, Exhibit P-13.
[5] See, Provider Position Paper, Exhibit P-12.

In July 1996, the Massachusetts legislature established an alternative basis for the issuance of DONs. Under the 1996 Mass. Acts ch. 203 § 31, any hospital which was issued a DON under the previous process would have its prior DON superseded and replaced by authorization under the 1996 DON Act. Accordingly, on September 20, 1996, the MDPH superseded the prior licensure that PCTCU had obtained and operated under since December of 1995, and replaced it with a DON under the 1996 DON Act.[6] This new DON was made effective retroactive to December 8, 1995.[7]

On June 17, 1997, the Provider applied to its fiscal intermediary at the time, C&S Administrative Services, for a new provider exemption to the Medicare RCLs for the PCTCU pursuant to 42 C.F.R. §413.30(e). In July of 1997, the Provider was assigned a new intermediary, and its initial application was returned by C&S Administrative Services. On December 31, 1997, the Provider resubmitted its application to its new intermediary, Associated Hospital Services (Intermediary).

By letter dated July 15, 1998, the Intermediary communicated to the Provider CMS' denial of the Provider's request for a new provider exemption. CMS stated that ". . . Jordan (the Provider) does not qualify for a new provider exemption because its distinct part unit has operated in a manner equivalent to a SNF, under past or present ownership, as evidenced by the fact that it provided skilled nursing and rehabilitative serves as a nursing facility (NF) for three or more years under past ownership prior to its current Medicare certification."[8] In summary, CMS' letter alleged the following: 1.) Jordan Hospital purchased Greeenlawn Nursing Home, including its bed rights and DON rights, thereby triggering a review of the services furnished by Greenlawn during the three-year "look-back" period; 2.) Greenlawn provided skilled nursing and rehabilitative services in a manner equivalent to a SNF during the three year look-back period; and 3.) PCTCU and Greenlawn served the same inpatient population. The CMS letter concluded that the Provider did not qualify for a new provider exemption as a new provider or as a relocated provider.

The NPR for the Provider's FYE 9/30/98 cost report was issued by the Intermediary on September 25, 2000, and the Provider filed a timely appeal of that NPR on March 22, 2001. The Provider added the RCL issue to the open appeal on April 7, 2005. The amount of Medicare funds in controversy for 1998 is approximately $825,155.

The Provider appealed the adjustment to the 1998 cost report to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835 - 405.1841. The Provider was represented by Barbara Straub Williams, Esquire, of Powers, Pyles, Sutter & Verville, PC. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

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[6] See, also Tr. at 67-69. The Provider's witness testified that the new state statute superseded the previous practice of transferring of beds.
[7] See, Provider Position Paper, Exhibit P-16.
[8] See, Provider Position Paper, Exhibit P-23.

JURISDICTIONAL CHALLENGE:

The Intermediary contends that although the Provider appealed the 1998 cost report adjustment, it has also requested relief for cost reporting periods ended September 30, 1996 and September 30, 1997. The Intermediary asserts that the Board lacks jurisdiction over the Provider's request related to the FY 1996 and FY 1997 cost reporting periods because the Provider did not appeal the NPR for the cost reporting period ended September 30, 1996; although the Provider did file an appeal of the NPR for the cost reporting period ended September 30, 1997, that appeal (Case No. 00-0762) was closed in June 2001. In addition, the Provider also failed to appeal the initial CMS denial of its new provider exemption dated July 15, 1998.

The Intermediary argues that for cost reporting years ended September 30, 1996 and September 30, 1997, the Provider is well beyond the 180-day period in which an appeal can be filed. See, 42 C.F.R §405.1811. Since the Provider does not have appeals pending for the September 30, 1996 or September 30, 1997 cost reporting periods, there is no vehicle for the Board to reverse the denial of the new provider exemption request for those cost reporting periods. In addition, there is no open appeal to which the issue can be added. In these circumstances, only the cost year ended September 30, 1998 is at issue in this appeal.

The Provider asserts that it filed a timely and valid appeal of the September 30, 1998 cost report in accordance with the requirements of 42 U.S.C. §1395oo(a). The Provider argues that once it has complied with the prerequisites of subsection (a), subsection (d) of the statute grants the Board broad authority to decide issues raised at a hearing that are related to the Provider's cost reports:

> A decision by the Board shall be based upon the record made at such hearing . . . and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such a cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

42. U.S.C. §1395oo(d). Similarly, the Provider asserts that the Medicare regulations define the scope of the Board's authority to encompass matters "not considered in the intermediary's determination." 42 C.F.R. §405.1869.

The Provider argues that the central issue in this case is whether the Provider is entitled to an exemption from the routine cost limits as a new provider. If the Board agrees that the Provider has established, by substantial evidence presented in the record and at hearing, that it is entitled to a new provider exemption, then it is entitled to that exemption for all

three years that are covered by its exemption application. A decision by the Board with respect to any of these years would, therefore, comply with the substantial evidence limitation that Congress placed on the Board's authority.

The Provider also argues that the Board has accepted jurisdiction over multiple years of a new provider exemption application, even though the provider only appealed a single cost year. The Provider cites St. Elizabeth's Medical Center of Boston v. BlueCross BlueShield Association/Associated Hospital Service of Maine, PRRB Case. No. 98-0489, PRRB Dec. No. 2002-D49 in which the Board granted jurisdiction for a fiscal year 1998 cost reporting period when the Provider had instituted an appeal only for its 1997 cost year. The Provider also adds that this decision was upheld by the D.C. Circuit Court.

The Board majority finds that it has jurisdiction over the three cost reporting periods covered under a new provider exemption, which includes FYs 1996, 1997 and 1998. The Board majority finds that the new provider exemption regulation unambiguously applies to multiple years as it ". . . expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient." 42 C.F.R. §413.30(e). Therefore, if it is determined in any one year that the Provider meets the requirements to be granted a new provider exemption, the exemption is deemed granted for all applicable years. The amount of reimbursement in controversy for 1996 is $644,807, and for 1997 it is $799,848.[9]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The Board finds that the Provider is entitled to an exemption from the routine cost limits pursuant to 42 C.F.R. §413.30(e). The Board notes that the exception process for obtaining a DON in the State of Massachusetts in 1995 required a provider to find another entity willing to close so that the "rights to operate" could be transferred. The Provider contracted with another facility to close, and made payment to that facility for its closure, in order to obtain bed rights to open the PCTCU, as this was the only available avenue for the Provider to obtain a license to operate during the relevant time period. The Board concludes that the purchase of the "rights to operate" does not, in itself, constitute a change of ownership (CHOW) and does not affect the Provider's right to a new provider exemption.

This issue is addressed in various other PRRB decisions and in U.S. District and Circuit Court decisions. Most recently, the Board addressed a very similar issue regarding the purchase of CON bed rights in Harborside Healthcare-Reservoir v. Blue Cross and Blue Shield Association/Empire Medicare Services.[10] In that case the Board found that ". . . the purchase of bed rights, in and of itself, does not constitutes a change of ownership (CHOW) and does not affect the [p]rovider's right to a new provider exception;" also that

[9] See, Provider Position Paper, Exhibit P-1.
[10] PRRB Dec No. 2006-D14, January 25, 2006, Medicare and Medicaid Guide (CCH) ¶81,462.

". . . imputing ownership based on the purchase of CON rights is inconsistent with the Medicare regulations." In its decision, the Board rejected the intermediary's contention that the transfer of bed rights constituted a ". . . continuation of services from the previously operating facility." In Ashtabula County Medical Center v. Thompson[11] the District Court found that the Secretary's interpretation of the new provider exemption regulation was arbitrary, capricious and erroneous. In that case, the Secretary manintained that when a provider acquires CON bed rights from an unrelated party, a CHOW has occurred;[12] and when a CHOW occurs, there must be a "look back" to determine whether the relinquishing provider had operated for more than three years.

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. . . ." The Court found as ". . . little more than a generous amount of conjecture and guesswork . . ." the Secretary's argument that the existence of state CON moratorium programs can be interpreted as a finding by the state that additional beds are unnecessary for the efficient delivery of needed health care services.[13] 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.

Ashtabula at 897.

The Fourth Circuit also held that the term "provider" in the new provider exemption regulation unambiguously refers to an institution, not a single asset such as a CON. In Maryland General Hospital, Inc. v. Thompson, 308 F.3d 340 (4th Cir. 2002), the hospital obtained permission from the State of Maryland to open a new SNF by acquiring state operating rights, but nothing else, from pre-existing SNFs. The Secretary contended that prior ownership of SNF bed rights could be treated as prior ownership of the SNF because the term "provider" as used in 42 C.F.R §413.30(e) is ambiguous. The Fourth Circuit rejected this assertion, observing that in the Medicare program, "provider of services" means specified types of health care institutions – including, for example, hospitals, home health agencies, and SNFs. The Court further noted that PRM §2604.1 repeatedly characterizes a "provider" as an "institution" engaged in providing skilled

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[11] Ashtabula County Medical Center v. Thompson, 191 F. Supp. 2d 884, 897 (N.D. Ohio 2002), aff'd 352 F. 3d 1090 (6th Cir. 2003).

[12] Id. at 890.

[13] Id. at 895.

nursing services.[14] Thus, the Court ruled, the Secretary erred in treating prior ownership of operating rights as prior ownership of the "provider":

> 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 instituition 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.

Maryland General at 347.

Additionally, the Board finds that the instant case is unique when compared to similar cases heard on this issue. The Provider claims that it followed the DON exception process in place in the State of Massachusetts in 1995 by negotiating with a Level III facility that was willing to close so its bed rights could be transferred to Jordan Hospital and a new Level II hospital-based SNF could be established. However, due to a subsequent, retroactive change in Massachusetts law in July 1996,[15] the approval of the DON the Provider secured through this process was suspended and replaced by a new DON as if the beds rights surrendered by the close facility first reverted to the state and were then reissued to the Provider. By virtue of this retroactive change in Massachusetts law, the Provider argues, and the Board agrees, that any question as to whether the Provider "purchased" the closed facility becomes moot. The new DON issued on September 20, 1996 retroactively replaced the prior DON.

The Board finds that the statute change that had the effect of granting the Provider operating rights directly from the state distinguishes this case from others in which the Secretary's interpretation has been upheld. For example in South Shore Hospital, Inc v. Thompson, 308 F.3d 91, (1st Cir. 2002),[16] the First Circuit granted deference to the Secretary's interpretation of the term "provider," as it found that the term, as used in 42 C.F.R. §413.30(e), was "manifestly ambiguous." The Court explained that the precise issue in that case, like the present case, turned on the meanings of "previous ownership," "provider," and "institution", none of which are unambiguous. However in South Shore, the provider did not present factual evidence that a change in state statute altered the

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[14] Id. at 344.
[15] See, Provider Position Paper, Exhibit P-10 – 1996 MASS Acts Ch. 203 §31.
[16] See, Intermediary Position Paper, Exhibit I-20.

entity from which the Provider received its DON. In the instant case the Board finds that the 1996 change in Massachusetts' statute resulted in a new DON being issued by the state on September 20, 1996 that superseded the DON granted as a result of the transfer of beds from Greenlawn. Consequently, there was no "previous owner" of the DON. Accordingly, the South Shore decision, although issued in the First Circuit, is not controlling here.

DECISION AND ORDER:

The Intermediary improperly denied Jordan Hospital a new provider exemption from the routine cost limits for its provider-based skilled nursing facility. The Board majority also finds that the exemption is granted for the FY 1996, 1997 and 1998 cost reporting periods by operation of law.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S. (Dissenting as to jurisdiction)
Elaine Crews Powell, C.P.A. (Dissenting as to jurisdiction)
Anjali Mulchandani-West
Yvette C. Hayes

DATE: February 28, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson

Dissenting Opinion of Elaine Crews Powell and Gary B. Blodgett

Jordan Hospital applied for a new provider exemption on June 17, 1997 and again on Dec. 31, 1997. CMS denied the requests on June 22, 1998; the hospital was notified of the denial on July 15, 1998; and the hospital was informed that it had 180 days from July 15, 1998 to appeal CMS' determination. However, the hospital did not appeal the denial within that timeframe.

Subsequently, Jordan Hospital timely appealed its 1998 cost report period from an NPR dated September 25, 2000 and met the requirements for Board jurisdiction. In April 2005 it added the issue of CMS' denial of its new provider exemption request to its pending 1998 appeal, and at that time, the Board majority also accepted jurisdiction over the hospital's 1996 and 1997 cost reports, finding that when an exemption is granted under 42 C.F.R. §413.30(e), it applies to multiple years. The majority concluded that when a provider is granted a new provider exemption for any one year, the exemption is deemed granted for all applicable years. For the reasons discussed below, we respectfully dissent.

It is undisputed that the Provider never appealed CMS' July 15, 1998 denial of its new provider exemption request until April 2005, when the Provider added the new provider exemption denial to its pending PRRB case for FYE 09/30/98. It's also undisputed that as of April 2005, the Provider did not have an appeal pending before the Board for either 1996 or 1997.

We find that individual cost report appeals are specific to the cost reporting year in dispute. Had the Provider wished to protect its appeal rights relative to CMS' denial of its new provider exemption for fiscal years 1996 and 1997, it should have filed an appeal for those years from the notice it received regarding CMS' denial. When the Provider failed to timely appeal the denial (which is a final determination that can be appealed to the Board), it missed its opportunity to have fiscal years 1996 and 1997 covered in the three years envisioned by the new provider exemption regulation. Therefore, the Provider is precluded from simply appending 1996 and 1997 to its 1998 individual cost report appeal, as the 1998 appeal is specific to fiscal year 1998 only.

Since the Provider failed to timely appeal CMS' denial of its request for a new provider exemption for fiscal years 1996 and 1997, we find that the Board does not have jurisdiction over the 1996 and 1997 cost reporting periods.

Based on the merits of the case, we concur with the Board majority's decision that the Provider is entitled to a new provider exemption for FYE 09/30/98.

Elaine Crews Powell, C.P.A. Gary B. Blodgett, D.D.S.