# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D26

**PROVIDER** –
Rogue Valley Medical Center
Medford, OR

Provider No.: 38-0018

**vs.**

**INTERMEDIARY –**
BlueCross BlueShield Association/
Medicare Northwest

**DATE OF HEARING** –
September 2, 2004

Cost Reporting Periods Ended -
September 30, 1995; September 30, 1996;
September 30, 1997 and September 30, 1998

**CASE NO.:** 97-2174

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ISSUES:

Does the Board have jurisdiction over a new provider exemption appeal filed within 180 days of the exemption determination?

Does the Board have jurisdiction over multiple fiscal years in a new provider exemption or must the Provider file an exemption request for each cost reporting period?

Was the Health Care Financing Administration's (HCFA) denial of the Provider's request for an exemption as a new provider proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND**:**

This dispute arises under the Federal Medicare program administered by the Centers for Medicare and Medicaid Services ((CMS), formerly the Health Care Financing Administration (HCFA)). The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. CMS is the agency of the Department of Health and Human Services responsible for administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies know as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law, regulations and interpretative guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20-413.24.

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 proportion of those costs allocated to Medicare. 42 C.F.R. §412.20. 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. §1395(1)(A), permits the Secretary to establish limits on provider costs recognized as reasonable under the Medicare program. These limits on costs are referred to as routine cost limits (RCLs). The Medicare regulation at 42 C.F.R. §413.30(c) permits providers to obtain relief from the cost limits by requesting a reclassification, exception or exemption. A provider has 180 days from the issuance of the NPR to request an adjustment to the cost limits.

New Provider Exemptions:

The regulation permits "new providers" (facilities that have been in operation less than three years) to carry forward to succeeding cost reporting periods certain costs which are not reimbursed because of cost limits established under the statute and regulation.

Because new providers have difficulty operating under 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 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:

Rogue Valley Medical Center (Provider) is an acute care hospital located in Medford, Oregon. On April 13, 1995, the Provider opened an 18-bed Medicare certified, hospital-based skilled nursing facility (SNF). The Provider requested a new provider exemption, and HCFA denied the request on November 6, 1996.[1] HCFA concluded that the Provider's SNF was established by the relocation of 10 beds from Hearthstone Manor (Hearthstone), which is located across the street from the Provider, and that the relocation was in accordance with the transfer of site approved by the State of Oregon. Hearthstone was found to be the equivalent provider and, upon relocation of the beds, the population served and the service area did not change substantially.

The Provider and Hearthstone are both owned by Asante Health System.[2] The Provider undertook a separate licensing process for its SNF and did not assume Hearthstone's provider number. Further, the Provider and Hearthstone filed separate cost reports and were not required to file change of ownership forms with HCFA at the time of the transfer of beds.[3] Although the Provider had considered having Hearthstone operate the hospital's SNF, in the end, the Provider decided to open its own, separately licensed SNF.[4]

PARTIES' CONTENTIONS

Jurisdiction

The Intermediary asserts that the Provider must file an appeal of its new provider exemption determination within 180 days of the NPR issued on September 24, 1997. Since the appeal was filed before the issuance of the NPR, the Intermediary believes that the appeal was a protective filing, not a legitimate appeal under the statute and regulations. Since there was no appeal of the NPR, the Intermediary contends that the Board lacks jurisdiction over the appeal. Further, the Intermediary argues that the Board's acceptance of jurisdiction over the fiscal year ends (FYEs) 1996-1998 is flawed, because a provider must seek an exemption for each cost reporting period to which the exemption is applicable under the provisions of the Provider Reimbursement Manual (PRM) (HCFA Pub. 15-1) §2531.1 and 42 C.F.R. §413.30.

[1] Provider Position Paper, Ex. P-1
[2] Tr. at 40.
[3] Tr. at 47-50.
[4] Tr. at 57-58.

The Provider refutes these arguments by noting that PRM §2537 advises providers that they are "entitled to a formal appeal under [42 C.F.R. §405.1801 et seq.] on the issue of the provider's . . . request for . . . exemptions." See also, 42 C.F.R. §413.30(c). The Provider also asserts that if its exemption request had been granted, the regulation requires that it be applied to multiple cost reporting periods. 42 C.F.R. §413.30(e).

Denial of Exemption Request

The Provider asserts that it qualifies as a new provider because it meets the regulatory requirement that it is a "provider of inpatient services that has operated as the type of provider (or the equivalent ) for which it is certified under present and previous ownership for less than three years." 42 C.F.R. §413.30(e). The Provider notes that when it opened its hospital-based SNF, it did so with a new license, and that the de-licensing of 10 beds by Hearthstone Manor is not a relocation of beds. The Provider also argues that this is not a transfer of site that would have required approval by the State of Oregon for licensure.

The Intermediary asserts that the reallocation or relocation of beds constituted a change of ownership under the Medicare program guidelines. As a result of this reallocation or relocation, the Provider was not entitled to a new provider exemption because the facility changed owners and had operated as a SNF in the previous three years.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law, parties' contentions and evidence presented, finds and concludes that it has jurisdiction over the appeal; however, the Provider is not entitled to a new provider exemption.

Jurisdiction:

The Intermediary's argument that an exemption determination is not a final determination that can be appealed to the Board is incorrect. Its position reflects earlier HCFA policy that an NPR is the only final decision that can be appealed to the Board. That policy was overturned by a decision of the Federal courts, in Washington Hospital Center v. Bowen, 795 F.2d 139 (D.C. Cir. 1986) (Washington Hospital Center).

When the Secretary published the final rules for the exemption and exception process, it modified the provisions of 42 C.F.R. §405.460(c) (recodified as 42 C.F.R. §413.30(c)) to state that the time required for HCFA to review an exception shall be considered good cause for granting an exception of the time to limit to apply for a Board review of the NPR. 44 Fed. Reg. 31802, 31804 (June 1, 1979). This change to the proposed rule was made because comments from providers indicated that the NPR limiting providers to the routine cost limit started the 180-day appeal period, and the appeal period could be partially or totally expired before HCFA issued a decision on the exemption. Id. at 31803.

At the time this regulation was implemented, HCFA believed that the only document that could be considered a final determination was an NPR. See, Health Care Financing Administration Ruling 84-1, Medicare and Medicaid Guide (CCH), ¶ 33,990 (May 29, 1984) (only an NPR determines the "total amount of payment due the hospital" as required by the regulations for PRRB review). However, in Washington Hospital Center the Court found that the Secretary's position that an NPR is the only final determination that could be appealed to the Board was inconsistent with the statutory scheme. Id. at 149-150. In light of the Circuit court decision, the Board finds that the new provider exemption determination is a final determination as defined in 42 C.F.R. §405.1801, and the appeal of this determination was timely.

Further, the Board finds that the new provider exemption determination covers multiple fiscal year ends. The regulation, 42 C.F.R. §413.30(e), states that when a new provider exemption is granted, 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." This is further reflected in the PRM, which details how to determine when a facility "accepts its first patient." See also, 44 Fed. Reg. 31802 (June 1, 1979) (the exemption is retained for approximately the first three years of the provider's existence).

Entitlement to a New Provider Exemption:

It is undisputed that Asante Health System owned the Provider and Hearthstone Manor at the time of the application by the Provider for the SNF license. Hearthstone Manor was licensed as both an intermediate care facility and a skilled nursing facility. The Provider's witness referred to the Provider and Hearthstone, each of which had its own Medicare provider number, as "divisions" of the same company. Consequently, the origin of the SNF beds is immaterial; the same corporate owner was already providing SNF services at the time its hospital-based SNF was licensed, which is the threshold inquiry for determining whether an exemption should be granted. The fact that the provider numbers for the two facilities are different is immaterial. Finally, since the Provider does not meet the threshold test for entitlement to a new provider exemption, the Board does not need to address the other arguments of the parties.

DECISION AND ORDER:

The Board finds that HCFA's denial of the new provider exemption was correct. CMS' decision is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Martin W. Hoover, Jr., Esq.
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FOR THE BOARD:

DATE: March 15, 2005

Suzanne Cochran, Esq.
Chairperson