PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2005-D46

PROVIDER
Evergreen Hospital Medical Center and SNF
Kirkland, Washington

Provider No.: 50-0124/50-5492

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Premera Blue Cross

DATE OF HEARING -
March 2, 2004

Cost Reporting Periods Ended -
December 31, 1995 - December 31, 1998

CASE NO.: 98-2583

INDEX

ISSUE:

Was the Provider entitled to a "new provider" exemption from Medicare's routine cost limits for its hospital-based skilled nursing facility (SNF)?

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. §1395(h), 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 proportion 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.

The statute, 42 U.S.C. §1395x(v)(i), authorizes the Secretary to establish prospective limits on provider costs that are reimbursed under Medicare. 44 Federal Register 31802 (June 1, 1979). 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 request relief from the costs 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.

Because new providers have difficulty meeting the applicable cost limits, HCFA provided an exemption from the costs 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 or its equivalent 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:

Evergreen Hospital Medical Center (Evergreen or Provider) is a hospital–skilled nursing facility (SNF) complex located in Kirkland, Washington. It was owned and operated by the King County Public Health District. The following facts relate to how the hospital-based SNF was established and are crucial to whether Evergreen is a "new provider" of SNF services.

To establish a nursing home, Evergreen was required under section 246-310-020 of the State of Washington's Administrative Code to obtain a certificate of need (CON). [1] A CON is a state requirement that particular categories of health care providers must meet in order to receive approval for building or remodeling new facilities, adding beds, programs or services, or purchasing new equipment. Washington State has had a CON for nursing homes since 1978.[2] In 1992, the CON was expanded to include hospital bed conversions, i.e., acute care facilities to SNFs.

Evergreen filed its CON application with the Washington State Department of Health in June of 1993.[3] In it, Evergreen stated its intention to obtain the rights to nursing home beds from an existing nursing home and to redistribute the beds to Evergreen to establish a nursing home on the campus of its institutional complex. Accordingly, Evergreen entered into an agreement with Pleasant Valley Health Services Corporation d/b/a Kirkland Convalescent Center (Kirkland) to purchase the right to operate 17 nursing home beds. On December 15, 1994, the State of Washington Department of Health approved the application and transferred ownership of the right to operate 17 nursing home beds from Kirkland Convalescent Center to Evergreen through the issuance of CON #1115.[4] On June 21, 1995, Evergreen began operating the nursing home located on the campus of the institutional complex. It was certified by Medicaid as a nursing facility on that date and was certified by Medicare as an SNF on July 19, 1995.

Evergreen submitted a request for an exemption from the routine care cost limits as a "new provider" under 42 C.F.R. §413.30(e), asserting that it rendered skilled services for the first time on June 22, 1995, and stating that skilled services had not been provided by the institution under past or present ownership for a period of more than three years.[5]

The Provider's Intermediary, Premera Blue Cross, recommended to CMS that the request be approved.[6] CMS denied the request on the grounds that Kirkland, the prior owner of the 17 beds, had participated in the Medicaid program as a nursing facility from March 31, 1974 through March 1, 1990, when it also became certified as an SNF in the Medicare program. Kirkland voluntarily sought decertification as a Medicare provider on September 12, 1990 but continued to participate in the Medicare program until December

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1 See Intermediary Exhibit I-7.
2 State Data Book on Long Term Care Program and Market Characteristics, HCFA Pub. No. 03354, August 1994.
3 See Intermediary Exhibit I-8.
4 See Intermediary Exhibits I-10, I-11 and I-12.
5 See Intermediary Exhibit I-13.
6 See Provider Exhibit P-3.

31, 1991. From January 1, 1992 through October 27, 1993, the date that Kirkland closed due to bankruptcy, the institution again participated as a dually certified long-term care facility under Medicare and Medicaid. Therefore, CMS concluded that Evergreen had operated as an SNF under previous ownership.

The Provider appealed this determination to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 – 405.1841. The Provider was represented by Stephen I. Pentz, Esquire, of Bennett, Bigelow & Leedom, P.S. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law and program instructions, the evidence and the parties' contentions, finds and concludes that CMS properly denied the Provider's request for a "new provider" exemption under 42 C.F.R. §413.30(e). The Board has held in several prior cases that acquisition of bed rights alone from an unrelated facility does not justify a conclusion that the "provider operated as the type of provider for which it is certified under Medicare . . . under . . . previous ownership . . ."[7] That is, Kirkland could not be considered a previous owner of Evergreen based solely on the transfer of bed rights. However, Evergreen is in the Ninth U.S. Circuit Court of Appeals. In Providence Health System-Washington v. Tommy G. Thompson, Secretary Department of Health and Human Services, No. 02-35912, 9th Cir, 12/17/2003 (Providence) that court made the following findings:

- The definition of a provider in 42 C.F.R. §413.30(c) is ambiguous. The Court found the Secretary's interpretation of that regulation reasonable and defers to that interpretation.

- Beds rights are an essential characteristic of providership.

- The sale of bed rights qualified as a change of ownership (CHOW) under Medicare Program Instruction CMS Pub. 15-1 §1500.7.

- The Secretary has broad authority to interpret his/her own regulations. Therefore, the Secretary can, through interpretation, determine that bed rights are a proper disposition of assets.

- HCFA Pub. 15-1 §2533 is an interpretive guideline issued in September 1997. It is not a new policy but merely restates a reading of old regulations.

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[7] See Larking Chase Nursing and Restorative Center v. Mutual of Omaha Insurance Co., PRRB Dec. 99-D8, November 24, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,647, and Maryland General Transitional Center v. Blue Cross Blue Shield Association/ Blue Cross and Blue Shield of Maryland, PRRB Dec. 99-D69, September 20, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,334, rev'd by CMS Adm. Dec., November 22, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,406, aff'd. PRRB Dec. U.S.D.C. of Maryland, No. WMN-00-221, June 27, 2001, Medicare and Medicaid Guide(CCH) ¶ 300,783.

- The Court's narrow interpretation to deny the Provider's request for a "new provider" exemption is reasonable in light of the State of Washington's de facto moratorium to limit SNF beds.

Because Evergreen acquired its bed rights from a facility that operated as an SNF, this case falls squarely within the Providence circumstances. Although the Board has ruled in favor of providers with similar fact patterns as exist in Evergreen's case, it defers to the Court's decision and analysis in the Providence case because Evergreen is in the Ninth Circuit.

The Provider argued that even if Kirkland's operating of an SNF could properly be considered, there was a break in service of twenty months that should be taken into account. Kirkland Hospital closed in October 1993 and Evergreen opened in June 1995. The Board finds that this twenty-month hiatus makes no difference. The regulatory requirement at §413.30(e) states, "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." Clearly, within the thirty-six month period preceding Evergreen's operation, Kirkland participated in the Medicare and Medicaid programs as a dually certified institution from January 1, 1992 through October, 1993, and during this period provided skilled care.

Based on the above analyses, the Board concludes that this Provider should not be granted a new provider exemption.

DECISION AND ORDER:

The Provider is not entitled to a new provider exemption under 42 C.F.R. §413.30(e). The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Martin W. Hoover, Jr., Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West

DATE: July 29, 2005

FOR THE BOARD:

Suzanne Cochran
Chairperson