PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D40

PROVIDER - Milwaukee Subacute and Rehabilitation Center
Milwaukee, Wisconsin

DATE OF HEARING-
January 6, 1998

Provider No. 52-5569

Cost Reporting Period Ended - December 31, 1995

vs.

INTERMEDIARY -
United Government Services

CASE NO. 96-2419

INDEX

ISSUE:

Should the Provider be granted a "new provider" exemption from the routine cost limits in accordance with 42 C.F.R. § 413.30(e)?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Milwaukee Subacute and Rehabilitation Center ("Provider") is a 20-bed skilled nursing facility ("SNF") located on the campus of Sinai Medical Center, an acute care hospital located in Milwaukee, Wisconsin.[1] The Provider began operations on April 7, 1995, after Paragon Health Network, Inc.,[2] a parent organization, obtained approval from the Wisconsin Department of Health and Social Services to transfer Certificate of Need ("CON") rights for 35 beds from one of its other facilities, Shores Transitional Care and Rehabilitation Center ("Shores"), to the Sinai Medical Center location.[3]

On June 20, 1995, the Provider submitted a request to become exempt from Medicare's routine service cost limits on the basis of being a "new provider" in accordance with 42 C.F.R.
§ 413.30(e)(2).[4] United Government Services ("Intermediary") forwarded the Provider's request to the Health Care Financing Administration ("HCFA") for review. On February 14, 1996, HCFA denied the Provider's request concluding that the Provider was not "new" since it had been an integral component of Shores, which had been in existence for many years. HCFA also noted that Medicare's Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2604.1 allows for an exemption where a provider that is not new relocates, and the normal patient population can no longer be expected to be served at the new location. However, HCFA also concluded that the Provider did not qualify for an exemption based upon this provision because the primary service area and population served did not substantively change.[5]

On August 9, 1996, the Provider appealed HCFA's denial to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and has met the

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1 Initially the Provider was a 35-bed facility. See Provider's Position Paper at 1 and Provider's Post-Hearing Brief at 1. Transcript ("Tr.") at 45.

2 Paragon Health Network, Inc. was previously known as GranCare, Inc.

3 Provider's Post-Hearing Brief at 1-2.

4 Exhibit I-1.

5 Exhibit I-3.

jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is approximately $500,000.

The Provider was represented by Glenn P. Hendrix, Esquire, of Arnall Golden & Gregory, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it is entitled to an exemption from Medicare's routine service cost limits because it qualifies as a "new provider" in accordance with 42 C.F.R. § 413.30(e) which states, in part:

> [e]xemptions from the limits imposed under this section may be granted in the following circumstances: . . . 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.

42 C.F.R. § 413.30(e).

The Provider contends that it is, in fact, a new provider. It began operations on April 7, 1995, and first became certified to participate in Medicare on May 26, 1995.[6] Accordingly, the Provider asserts it had operated for less than three full years when filing its request.

The Provider contends that HCFA's denial pursuant to 42 C.F.R. § 413.30(e) is based upon the erroneous premise that it had been an integral component of Shores and that it had only relocated from Shores. The Provider asserts that the only thing that had transferred from Shores were the CON rights for 35 beds. The Intermediary's witness conceded that the "only link" the Provider had with Shores was the transfer of these "paper beds."[7]

The Provider argues that it was "new" in every sense of the word; it had a new facility, a new location, and new personnel. Additionally, it had no patients or referral relationships, and it did not inherit any name recognition or goodwill from Shores. The Provider proclaims that it was indeed started "from scratch."[8]

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6 Provider's Post-Hearing Brief at 1.

7 Tr. at 234-235.

8 Tr. at 36.

The Provider also argues that HCFA's denial based upon the transfer of CON rights elevates form over substance since at least ten states do not even have a CON program.[9] The Intermediary's witness conceded that if the Provider and Shores were located in one of those other states the link between the two facilities, transferred CON rights, would not exist and the Provider would not have been denied an exemption.[10] Accordingly, the Provider argues that it should not be penalized because it does business in Wisconsin and not, for example, in the State of Arizona which has no CON program.

The Provider explains that the exemption is intended to compensate "new providers that [are] building up their referral systems and case loads. These new firms . . . experience higher costs per patient for a brief period." Homemakers North Shore, Inc. v. Bowen, 832 F.2d 408, 410 (7th Cir. 1987).[11] Accordingly, the Provider asserts that a facility's need for such compensation does not depend on whether it was developed in Wisconsin as opposed to Arizona, or whether or not a CON was a prerequisite to becoming licensed. The Provider asserts that the purpose of the new provider exemption is served by granting its request. Specifically, it commenced operations without any residents, referral relationships with physicians and hospital discharge planners, or name recognition or goodwill in the SNF market. A low census, combined with high start-up costs, has resulted in high costs per patient day, precisely the reasons the new provider exemption was established.[12] Between April and December 1995, the Provider's occupancy rate averaged 27.9 percent while the mean occupancy rate for nursing facilities in southeastern Wisconsin was 92 percent.[13]

The Provider also contends that it is not a relocated pre-existing facility pursuant to HCFA Pub. 15-1 § 2604.1, that was cited by HCFA as the basis for its denial.[14] The manual provides that a change in "geographic location" of an "institution" does not "in itself" result in classification as a new provider. Rather, a "provider seeking such new provider status must

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9 Tr. at 165 and 207. Exhibits P-6 and P-7.

10 Tr. at 208-210.

11 Provider's Post-Hearing Brief at 7. See also San Diego Physicians & Surgeons Hospital v. Ætna Life Insurance Co., PRRB Dec. No. 91-D6, November 15, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,966, rev'd. HCFA Admin., January 12, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,007. Exhibit P-4.

12 Tr. at 80 and 215.

13 Tr. at 45-46. Provider's Post-Hearing Brief at 4.

14 Exhibit P-8.

apply to the intermediary and demonstrate that in the new location a substantially different inpatient population is being served."[15]

The Provider argues that it is entitled to a new provider exemption regardless of whether or not it is serving a "substantially different inpatient population" than Shores. The "different inpatient population" requirement of HCFA Pub. 15-1 § 2604.1 applies only where an entire institution relocates. In that instance, a facility should not be granted an exemption if it moves to a new building, but takes with it its referral sources, community goodwill, residents, staff, equipment and inventory. The relocated facility is simply the continuation of an ongoing business, notwithstanding its new address. Likewise, a facility should not be considered a new provider if it simply adds new beds to an already existing facility.[16] However, the manual provision should not bar an exemption where the new facility has not inherited referral sources, goodwill, residents, equipment or inventory from a pre-existing institution, but merely received "paper beds" in the form of CON rights for a portion of the pre-existing institution's bed capacity. In this situation, the new facility is not a "relocated" provider (i.e. an ongoing business with a new address), but rather a start-up enterprise deserving of an exemption.

The Provider contends that even if it were properly considered a relocated facility pursuant to HCFA Pub. 15-1 § 2604.1, it is still entitled to an exemption because it does, in fact, serve a "substantially different inpatient population" than Shores. As stated in HCFA Pub. 15-1 § 2604.1:

> . . . a provider which relocates may be granted new provider status where the normal inpatient population can no longer be expected to be served at the new location. The distance moved from the old location will be considered but will not be the determining factor in granting new provider status. For example, a specialty hospital may move a considerable distance and still care for generally the same inpatient population, while the relocation of a general hospital a relatively short distance within a metropolitan area may greatly affect the inpatient population served. A provider seeking such new provider status must apply to the intermediary and demonstrate that in the new location a substantially different inpatient population is being served.

HCFA Pub. 15-1 § 2604.1.

With respect to the instant case, the Provider asserts that hospital referral data confirms that it serves a substantially different inpatient population than Shores. Although both facilities are located in the same metropolitan area, there is virtually no overlap in their referral sources.

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[15] Id.

[16] Provider's Post-Hearing Brief at 11. Tr. at 122.

Sinai Samaritan Hospital is the source of 89 percent of the Provider's admissions, while Shores drew only 4 percent of its patients from that hospital even prior to the Provider's opening.[17]

The Provider maintains that resident home addresses are not the proper focus to determine populations served because very few residents are admitted directly from their homes. Nevertheless, in response to HCFA testimony regarding this matter, the Provider asserts that residents' address zip codes of its patients and of Shores' patients support a finding that the two facilities serve different populations.[18] Almost 77 percent of the Provider's residents had home addresses in an area comprising just eighteen zip codes. Only 28 percent of Shores' residents had home addresses in this same area.[19]

Furthermore, the Provider asserts that even though it is located only seven miles from Shores, the two facilities are in vastly different economic strata. Shores is located in Milwaukee's affluent northern suburbs. In fact, it is located in the wealthiest zip code area in Milwaukee. Conversely, the Provider is located in Milwaukee's inner city in one of the poorest zip code areas in the state.[20]

The Provider also argues that HCFA's decision not to grant new provider status based upon HCFA Pub. 15-1 § 2604.1, is misplaced. HCFA did not deem the provision to allow an exemption because both the Provider and Shores are located in, and draw their patients from, an area designated by the Wisconsin Department of Health and Social Services as Health Service Area ("HSA") number ("No.") 2. However, HCFA's witness, who concluded that the Provider and Shores serve the same population, had no knowledge of Wisconsin or Milwaukee health care markets, nor did she speak with anyone (including the local staff of the Intermediary) having such knowledge. At the hearing the witness testified that her "knowledge of local health care market conditions in Milwaukee really begins and ends with the boundaries" of HSA No.2. The witness also testified that she did not know the criteria that were used by the State of Wisconsin to establish the boundaries of HSA No. 2. She simply assumed that HSA No.2 constituted a single, homogeneous market for long-term health care services. The witness opined that each of the 49 SNFs in the City of Milwaukee, home to approximately 750,000 people, serve the same population, which ignores "the real world of present day socio-health care delivery." Englewood Community Hospital-SNF v.

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17 Tr. at 98. Exhibits P-16 - P-18.

18 Provider's Post-Hearing Brief at Footnote 3. Tr. at 205.

19 Exhibit P-20.

20 Provider's Post Hearing Brief at 4.

Mutual of Omaha, PRRB Dec. No. 98-Dl3, Dec. 11, 1997.[21]

In contrast, the Provider asserts that its witness' testimony confirms the fact that it serves a significantly different population than Shores. Initially, the Provider explains that its witness is uniquely qualified to testify on the SNF market in southeastern Wisconsin. The witness is the National Director of Long-Term Care Services for an international accounting and consulting firm, as well as a life long resident of Milwaukee.[22] The witness and his firm have worked with four of the five major SNF chains in Wisconsin, and he has performed numerous feasibility studies and analyses of the market for post-acute services in HSA No.2.[23]

With respect to actual testimony, the Provider argues unequivocally that it does not serve the same population as Shores.[24] The fact that the two facilities are both located in HSA No.2 and draw their residents from this area does not mean they serve the same population. HSA No.2 is 80 miles across and comprises seven counties and a major metropolitan area of over one million people. Moreover, there are 122 nursing facilities in HSA No.2, and many of these facilities fill specific geographic or patient care niches and have distinct referral sources.[25] As recognized in HCFA Pub. 15-1 § 2604. 1, "a relatively short distance within a metropolitan area may greatly affect the inpatient population served."

Finally, the Provider contends that revised manual instructions issued by HCFA in September 1997, HCFA Pub. 15-1 § 2533.1, reprinted Medicare & Medicaid Guide (CCH) ¶ 7544K,[26] do not apply in the instant case because they are not effective until periods beginning after October 19, 1997.[27]

The Provider asserts, however, that although the revised manual instructions are not directly applicable to this appeal, they nevertheless provide a revealing contrast to HCFA Pub. 15-1 § 2604.1. Specifically, HCFA Pub. 15-1 § 2533.1(B)(3) states:

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21 Tr. at 196-200, and 229.

22 Tr. at 56.

23 Tr. at 58, 83-84, and 102-103.

24 Provider's Post-Hearing Brief at 13.

25 Tr. at 86-87.

26 Provider's Post-Hearing Brief at 15. Exhibit P-13.

27 The Provider originally requested an exemption from the routine service cost limits from May 26, 1995 to December 31, 1997. However, the Provider now seeks an exemption only through October 19, 1997, as a result of HCFA Pub. 15-1 § 2533.1. See Provider Position Paper at Footnote 3.

> [a]n institution or institutional complex that has undergone a change in location may be granted new provider status when the normal inpatient population can no longer be expected to be served at the new location. In this case, the institution or institutional complex must demonstrate that in the new location a substantially different inpatient population is being served. This includes those institutions or institutional complexes that are established in whole or in part through the purchase, reallocation, or leasing of long term care beds (operating or nonoperating) from an existing institution or institutional complex (operating or closed). The normal inpatient population is defined as the health service area (HSA) for long term care facilities, or its equivalent, as designated by the State planning agency or local planning authority in which the institution or institutional complex is located. If an institution or institutional complex relocates within the same HSA for long term facilities, or its equivalent, it will not qualify for a new provider exemption, as the population normally served would continue to be expected to be served at the new location. To demonstrate a substantial change in the population served, an institution or institutional complex must show that 50 percent or more of its admissions (all payers) are from a different HSA. . . .

HCFA Pub. 15-1 § 2533.1(B)(3) (emphasis added).

Thus, the Provider maintains that the new manual provision, which did not become effective until October 1997, adopts the same position taken by HCFA in denying its request for new provider status. Specifically, under the new provision HCFA determines whether the pre-existing facility and the relocated facility serve the same population based upon a single simplistic criterion, i.e., whether the two facilities are located within the same HSA for long term care facilities, or its equivalent, as designated by the State planning agency or local planning authority. The Provider asserts, however, that this rule is very different from the standard set forth in HCFA Pub. 15-1
§ 2604.1. The latter provision recognizes that "a relatively short distance within a metropolitan area may greatly affect the inpatient population served." Under the rigid approach set forth in the new provision, however, if the two facilities are located within the same HSA, it does not matter whether the populations served by the two facilities are vastly different. The Provider concludes that HCFA is applying new policy retroactively, and that it clearly satisfies the standards for a new provider exemption to the routine service cost limits set forth in HCFA Pub. 15-1 § 2604.1.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA's denial of the Provider's request for an exemption to the routine service cost limits on the basis of being a "new provider" is proper. The Provider does not qualify for a new provider exemption based upon the provisions of 42 C.F.R. § 413.30(e) or HCFA Pub. 15-1 § 2604.1.

Medicare regulation 42 C.F.R. § 413.30(e) provides, in part, that an exemption to the cost limits may be granted to a provider 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." In the instant case, the Provider does not meet this requirement since it was a portion (35 beds) of an already existing SNF that was just relocated.[28] Prior to relocation, the Provider was an integral portion of Shores which is a 111 bed SNF that was certified to participate in Medicare on March 7, 1979.[29] The continuous operation of the 35 beds is evidenced by the transfer of CON rights from Shores to the Provider's location.[30]

The Intermediary asserts that its position is supported by the "real world" events involved in this case. Specifically, establishing SNF operations in the Sinai Samaritan Medical Center ("Sinai") location was not done to meet a need for SNF services. Rather, it was a decision to increase GranCare's market share of SNF business in the Milwaukee area. GranCare was getting a small percentage of referrals from Sinai. It also had excess bed capacity at Shores that could be moved without disturbing Shore's patient operations. Therefore, to better compete for Sinai's referral business, GranCare relocated the beds. The Intermediary asserts that Sinai was not in need of additional SNF capacity for which to refer patients, but welcomed GranCare as a tenant paying rent on a piece of its building that was not being used. The Intermediary concludes that the new provider exemption contained in 42 C.F.R. § 413.30(e)(2) is not intended to apply in a situation where a relocation is made to obtain referrals.[31]

The Intermediary also contends that the Provider is not entitled to an exemption based upon HCFA Pub. 15-1 § 2604.1, because the transfer of beds to the Sinai location has not resulted in substantive change in the population that it serves. Medicare instructions at HCFA Pub. 15-1
§ 2604.1 provide, in part, that:

> . . . a provider which relocates may be granted new provider status where the normal inpatient population can no longer be expected to be served at the new location . . . A provider seeking such new provider status must . . . demonstrate that in the new location a substantially different inpatient population is being served.

HCFA Pub. 15-1 § 2604.1.

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28 Intermediary's Position Paper at 4.

29 Intermediary's Position Paper at 2.

30 Id. Tr. at 170.

31 Tr. at 182 and 247-249.

The Intermediary contends that an analysis of data submitted by the Provider shows that both the Provider and Shores are located in the same HSA. The data also shows that practically 100 percent of the Provider's admissions came from the same cities and towns as all of Shores' admissions.[32] Approximately 70 to 80 percent of the patients admitted to both facilities had Milwaukee addresses.

Finally, the Intermediary rejects the Provider's argument that HCFA Pub. 15-1 § 2533.1 contains totally new policy that HCFA applied retroactively in denying its request. Initially, the Intermediary asserts that HCFA Pub. 15-1 § 2533.1(B)(3), which generally provides that a provider will not qualify for a new provider exemption if it relocates (in whole or in part) within the same HSA, did not exist when HCFA made its decision. The manual section was issued in September 1997,[33] while HCFA's decision denying the Provider's request was issued in February 1996.[34] Furthermore, the Intermediary asserts that HCFA Pub. 15-1 § 2533.1(B)(3) is effectively a clarification of policy which had been in existence. Specifically, HCFA had always recognized partial provider relocations, and the normal inpatient population served had been recognized to be patients residing within a particular HSA.[35]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Regulations - 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.30(e)	-	Limitations on Reimbursable Costs. Exemptions

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2533.1	-	Requests Regarding New Provider Exemption

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32 Tr. at 174-175. Intermediary's Position Paper at 5.

33 Exhibit P-13.

34 Exhibit I-3.

35 Tr. at 177-179.

§ 2604.1 - Definitions. New Provider

4. Case Law:

Homemakers North Shore, Inc. v. Bowen, 832 F.2d 408, 410 (7th Cir. 1987).

San Diego Physicians & Surgeons Hospital v. Ætna Life Insurance Co., PRRB Dec. No. 91-D6, November 15, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,966, rev'd. HCFA Admin., January 12, 1991, Medicare & Medicaid Guide (CCH) ¶ 39,007.

Englewood Community Hospital-SNF v. Mutual of Omaha, PRRB Dec. No. 98-Dl3, Dec. 11, 1997.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, and testimony elicited at the hearing, finds and concludes that HCFA properly denied the Provider's request for an exemption to the routine service cost limits. The Provider does not qualify as a new provider pursuant to 42 C.F.R. § 413.30(e) or HCFA Pub. 15-1 § 2604.1.

Medicare regulation 42 C.F.R. § 413.30(e) explains that a new provider may be granted an exemption to the routine service cost limits. The regulation defines a "new provider" as one 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." (Emphasis added.)

With respect to the instant case, the Board finds that the Provider was established by the transfer of CON rights for 35 beds from the Shores facility to a new location within the campus of the Sinai Medical Center. The Board also finds that this type of transaction constitutes a relocation of a portion of a pre-existing facility as opposed to the establishment of a facility that had never before existed. As such, the Board is compelled to view the previous owner's operation to determine whether or not the Provider meets the regulatory requirement of having not operated for more than three full years as the type of provider for which it is certified.

In this regard, the Board finds that Shores had been operating as a 111 bed Medicare certified SNF that provided skilled nursing and rehabilitative services since March 7, 1979, prior to the transfer. Therefore, the Board concludes that the Provider is not eligible for the new provider exemption provided by 42 C.F.R. § 413.30(e) because it had operated under previous ownership for more than three years as the same type of provider for which it became certified.

The Board acknowledges the Provider's argument that its only "link" to Shores is the transfer of CON rights, and that it essentially started from "scratch" in a new location with new staff and no patients or referral sources. However, the Board rejects the Provider's argument that having its request denied on the basis of transferred CON rights elevates form over substance, adding that if it were located in a state without a CON program that its request would not have been denied.
Factually, the Provider is located in Wisconsin, a state with a CON program, as well as a moratorium on the establishment of new health care facilities. The Provider, in order to establish itself and begin operations, had to obtain the licensure rights to existing patient beds from an existing provider. While the Board cannot speculate regarding events that may or may not occur in a state without a CON program, the Board notes that 4 out of every 5 states have a CON program or moratorium or both. The purpose of these programs is clearly to limit the growth of new health care facilities and the Provider was required to live within the restriction of its state's CON program.

The Board also finds that a provider which does not qualify as a new provider in accordance with 42 C.F.R. § 413.30(e) may still be granted new provider status and obtain an exemption to the routine service cost limits. Program instructions at HCFA Pub. 15-1 § 2604.1 state, in part, that a relocated provider, as in the instant case, may be granted new provider status "where the normal inpatient population can no longer be expected to be served at the new location." In order to be granted new provider status in accordance with this provision a provider must demonstrate that a "substantially different inpatient population is being served . . ." Id.

Based upon analyses of patient source data placed into evidence, the Board finds, however, that the Provider is not serving a substantially different population than it served when it was part of Shores. Data submitted by the Provider and analyzed by HCFA shows that in 1995, practically 100 percent of the Provider's admissions came from the same cities and towns as Shores'admissions.[36] In particular, the vast majority of admissions to each facility were from Milwaukee. While the Board recognizes that Milwaukee is a large area which could represent different populations, the Board finds support for its finding in patient zip code data also submitted by the Provider.[37] This data shows that the Provider's patient workload consisted of 82 admissions representing patients from 28 different zip codes. Similarly, the data shows that Shores admitted patients from all but 4 of these same zip codes. With respect to the 4 zip codes not represented in Shores' patient workload, the Board notes that the Provider drew only 8 of its admissions from them. Similarly, the data shows that 77 of the Provider's admissions, or 93 percent of its total admissions, were drawn from only 16 different zip codes. In comparison, Shores drew 200 admissions from these 16 zip codes or approximately 47 percent of its total admissions.

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[36] Exhibit I-12.

[37] Exhibit P-20

Finally, the Board rejects the Provider's argument that HCFA Pub. 15-1 § 2604.1 pertains only to entire facilities that relocate as opposed to portions of facilities that relocate. The Intermediary's witness identified at least one other situation in Wisconsin where a partially located facility applied for and received new provider status pursuant to HCFA Pub. 15-1 § 2604.1. Likewise, the Board rejects the Provider's argument that it serves a "significantly different population" based upon patient referral sources. The Board does not find that referral sources, in and of themselves, provide a clear indication of any particular patient population being served.

DECISION AND ORDER:

The Provider is not entitled to a new provider exemption to the routine service cost limits in accordance with 42 C.F.R. § 413.30(e) or HCFA Pub. 15-1 § 2604.1. HCFA's denial of the Provider's request for an exemption is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: April 14, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman