PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D14

PROVIDER -
Harborside Healthcare-Reservoir
West Hartford, Connecticut

Provider No.: 07-5407

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Empire Medicare Services

DATE OF HEARING -
February 25, 2005

Cost Reporting Period Ended -
December 31, 1998

CASE NO.: 03-0176

INDEX

ISSUE:

Whether the Intermediary properly denied the Provider's new provider exemption request.

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. These limits on costs are referred to as routine cost limits (RCLs).

Because new providers may 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 (or the equivalent) for which it is certified for Medicare under present and previous ownership, for less than three full years." (emphasis added) 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:

The Reservoir (Provider) opened in West Hartford, Connecticut as a newly constructed facility on October 2, 1995, after the completion of the first phase of the construction project of a 75 bed skilled nursing facility under the ownership of Mr. Harold Moffie and Ms. Celia Moffie, father and daughter, and their associated business companies.[1] This first phase included the basement, the first floor, and the shell for the second floor of the facility. An initial complement of 30 skilled nursing facility beds were certified under the Medicare program on November 3, 1995.[2] There was 17,217 square feet of space on the second floor.[3] The walls on that floor were not insulated, nor was the vapor barrier or gypsum wall board installed.[4]

On November 21, 1996, CMS granted the Provider's request for an exemption to the Medicare skilled nursing facility routine cost limits as a new provider under the provisions of 42 C.F.R. §413.30(e)(2). At the time that the exemption was approved, 30 of the newly constructed beds were operational at the facility.[5] By the terms of the CMS approval and the Intermediary's November 21, 1996 Notice to the Provider, the exemption would expire at the end of September 30, 1999.[6]

In order to certify the remaining 45 skilled nursing facility beds to complete the second phase of the project, the Provider needed to obtain Certificate of Need (CON) rights for 45 beds and a CON approval of the capital expenditure required to complete the interior work on the second floor.[7] Bed rights needed to be obtained because the State of Connecticut had a moratorium prohibiting its Department of Social Services from accepting or approving CON applications for additional nursing home beds, with certain exceptions.[8]

The Provider entered into an agreement to acquire existing CON bed rights from two facilities, Carewell Convalescent (Carewell) and Fairlawn Convalescent (Fairlawn).[9] Both facilities ceased operations in 1996.[10] This acquisition resulted in the State of Connecticut Department of Social Services approving the transfer of CON rights for 41 beds from Carewell, and 4 beds from Fairlawn on April 6, 1997.

As part of the Connecticut CON proceedings, the allowance for the purchase of the CON bed rights was limited to $607,500 for the 45 beds.[11] The CON also approved the acquisition of movable equipment and the financing amount related to the completion of

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1 See Intermediary Exhibit I-63; Exhibit I-66; Exhibit I-67, page 180.
2 See Provider Exhibit P-7.
3 See Intermediary Exhibit I-67, page 180.
4 See Intermediary Exhibit I-67, page 180.
5 See Intermediary Exhibit I-39.
6 See Intermediary Exhibit I-3; Exhibit I-39.
7 See Provider Exhibit P-10.
8 See Intermediary Exhibit I-67, page 1. See Conn. Gen. Stat. §17-354(a).
9 Transcript (Tr.) 38 -39; Exhibit P-10.
10 Tr. 253.
11 See Provider Exhibit P-10, page 4.

the interior work on the second floor of the Provider,[12] which was limited to $1,192,500.[13] The Provider acquired only CON rights, and not any fixed assets or moveable equipment from either Carewell or Fairlawn.[14]

Carewell, the source of CON rights for 41 beds, was located in New Haven, Connecticut, which is 44 miles from West Hartford, where the Provider is located.[15] Fairlawn, the source of CON rights for 4 beds, was located in Norwich, Connecticut, which is 47 miles from West Hartford.[16] Carewell terminated its operation on November 15, 1996.[17] Fairlawn terminated its operation on May 10, 1996.[18]

Under Connecticut law a nursing facility license is only issued for the premises and persons named in the license application. It is not transferable or assignable; therefore, the licenses of the closed facilities could not, by law, be transferred to the Provider.[19] The Provider acquired only the intangible CON rights for 45 beds, and not any actual facility license for the 45 beds.[20]

By April of 1997 the Moffie family completed the build-out of the second floor space of the new facility. Based on the CON approval for the 45 beds, the Connecticut Department of Public Health issued a license to the Provider for an increase of nursing home beds, effective April 6, 1997, for a total of 75 beds.[21] Also, a Medicare Provider Tie-In Notice for an increase of SNF beds from 30 to 75[22] was issued via Form HCFA-2007 (Revised 2/82).[23] The Tie-In Notice brought the additional beds into the Provider's Medicare Provider Agreement for purposes of reimbursement of those beds for eligible days under the Medicare Program's Provider Reimbursement Manual HCFA Pub. 15-1, §2337, "Effective Date of Change in Bed Size And/Or Bed Designation."

Harborside Healthcare (Harborside), which is located in Boston, Massachusetts, acquired The Reservoir on December 12, 1997, from the Moffie family and their associated companies, pursuant to a Lease/Option to Purchase Agreement. At the time that Harborside acquired The Reservoir, it was being reimbursed by Medicare as a new provider with an exemption from the routine cost limits under 42 C.F.R. §413.30(e)(2) for 75 skilled beds. On The Reservoir's terminating cost report that was filed by the Moffies for the period ended December 11, 1997, it was paid under the exemption to the cost limits for all 75 Medicare certified beds.[24]

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12 See Exhibit P-10; Exhibit I-62.
13 See Intermediary Exhibit P-10, page 4; Exhibit I-67, page 4.
14 Tr. 39-40; Exhibit P-10.
15 Tr. 43.
16 Tr. 44.
17 Tr. 253.
18 Tr. 253.
19 Conn. Gen. Stat. Annotated, §19a-493.
20 Tr. 40; Exhibit P-10.
21 See Intermediary Exhibit I-63, page 2.
22 See Provider Exhibit P-8; Tr. 42.
23 See Provider Exhibit P-8.
24 Tr. 101.

In a May 17, 1998 letter to Blue Cross Blue Shield of Connecticut, Harborside requested that the exemption from the cost limits approved under the previous ownership of The Reservoir be retained through December 31, 1998,[25] because: (1) a portion of the three-year "new provider" exemption period remained for the period after Harborside Healthcare acquired The Reservoir on December 12, 1997, and (2) Harborside did not change the ongoing operation. Medicare continued to allow the new provider exemption in payments to the facility, as recognized in the original exemption request, through December 31, 1998.

At various times during the audit of Harborside's 1998 cost report in the summer of 2001, the Intermediary discussed items that it wished to review in connection with Harborside's exemption. After responding to the Intermediary's questions and requests for documentation in connection with settling the 1998 cost report, on September 14, 2001 Harborside submitted a completed Exhibit B – SNF Exemption Questions,[26] pursuant to the Intermediary's request. That Exhibit was issued by CMS as required by HCFA Pub. 15-1 §2533 "Request for Exemption From SNF Cost Limits,"[27] which was published in September, 1997, after the Moffies had built the second floor of the facility.

In a January 25, 2002 letter from the Intermediary (on behalf of CMS) to Harborside, the Intermediary requested information and documentation regarding eight separate items concerning the second floor beds in connection with the facility's request for the exemption on its December 31, 1998 cost report. The Intermediary's letter advised Harborside that if the cited documentation was not furnished within 45 days of the date of its letter, the exemption request "would remain denied."[28] On March 7, 2002 Harborside responded to the Intermediary's additional requests.[29] Exhibits P-6 through Exhibit P-18 are enclosures submitted with Harborside's March 7, 2002 response to the Intermediary's request for information and documentation.[30]

After several requests, the Intermediary determined that it had not received all of the documentation required by the PRM, namely: (1) documentation to support a change of ownership (CHOW) when Harborside purchased The Reservoir; (2) documentation of any request to expand The Reservoir from30 to 75 beds; (3) original CMS Form 671; and (4) original CON application or approval letter from the appropriate Connecticut state agency.[31]

CMS denied Reservoir's request to "fold in" the new provider exemption granted for the original 30 beds to the additional 45 beds whose bed rights were purchased on April 6, 1997 on the grounds that the Provider had failed to provide adequate documentation to supports its request. Furthermore, because the expansion of The Reservoir took place by means of the purchase of bed or CON rights, CMS took the position that a change of

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[25] See Provider Exhibit P-5.
[26] See Provider Exhibit P-3.
[27] See Intermediary Exhibit I-15.
[28] See Provider Exhibit P-4.
[29] See Provider Exhibit P-5
[30] See Intermediary's Exhibit I-7 contains this same documentation.
[31] See Intermediary Exhibit I-10.

ownership occurred according to HCFA Pub. 15-1 §§2533.1.H and 2533.1.E.2. CMS reviewed available documentation for both Carewell and Fairlawn and determined that because both had provided skilled nursing services within three years of the date of their CON rights being acquired by Reservoir, the exemptions previously approved for the 30 beds certified on October 12, 1995 would expire on April 6, 1997, the date that the "bed rights" to the 45 additional beds was approved by the State of Connecticut. In addition, CMS determined that for cost reporting periods beginning on and after April 6, 1997, none of the beds at The Reservoir would be exempt from the cost limits.[32]

The Provider appealed the Intermediary's denial to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 – 405.1841. The Provider was represented by Peter R. Leone, Esquire, of McDermott, Will & Emery L.L.P. The Intermediary was represented by Arthur E. Peabody, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law, regulations, Program Instructions, facts, parties' contentions and evidence submitted, the Board finds and concludes that the Provider is entitled to an exemption from the routine cost limits pursuant to 42 C.F.R. §413.30(e) for all 75 beds operating in 1998. This case involves two sub-issues: (1) the allowability of 45 newly constructed beds that resulted from the transfer of Certificate of Need (CON) bed rights from Carewell (41 beds) and Fairlawn (4 beds), and (2) the adequacy of documentation in the exception request.

Regarding the first sub-issue, the Board finds that the purchase of CON rights, in and of itself, does not constitute a change of ownership (CHOW) and does not affect the Provider's right to a new provider exemption. The Board observes that HCFA Pub. 15-1 §2604 addresses CMS' interpretation of the purchase of CON rights and its interface with the new provider exemption before 1997. There is some dispute over whether this Manual section is applicable to the Provider's situation due to timing. However, the Board finds this issue academic. Even if the Manual were applicable, the Board finds that imputing ownership based on the purchase of CON rights is inconsistent with the Medicare regulations.

This issue is clearly addressed in various U.S. Circuit Court decisions. In Ashtabula County Medical Center Skilled Nursing Facility v. Blue Cross and Blue Shield Association/Administar Federal, Inc., PRRB Dec. No. 2000-D70, June 29, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,516, decl'd rev., CMS Administrator, August 16, 2000, rev'd and reman'd, Ashtabula County Medical Center v. Thompson, CA 1:00CV1895 (N.D. Ohio, Feb. 8, 2002), 2002 U.S. Dist. Lexis 5499("Ashtabula") U.S. Court of Appeals, 6th Cir., Nos 02-3410/3425 dated 12/19/2003, the court found the Secretary's interpretation of the new provider regulation arbitrary, capricious, and erroneous with respect to the Secretary's position that the acquisition of bed rights from another provider is a completely different situation than when bed rights are acquired, for example, from a state authority. Under CMS' position, in the first situation the

[32] See Intermediary Exhibit I-10 at 3.

acquisition causes an immediate "lookback" into the services furnished by the relinquishing provider and the potential denial of a new provider exemption. In the second situation, there is no lookback and a new provider exemption is granted.

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 . . . . Ashtabula at ¶ 803,405. The Court found the Secretary's arguments regarding this matter, which essentially view state CON moratorium programs as evidence that additional beds are unnecessary for the efficient delivery of needed health care, to be unsupported and little more than conjecture. 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.

In Maryland General Hospital, Inc. v. Thompson (U.S. Court of Appeals, 4th Cir. October 9, 2002), (CCH Medicare & Medicaid Guide §301,188), the Court stated,

> 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 institution 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. See Gardebring v. Jenkins, 485 U.S. 415, 430 (1988) (explaining that a reviewing court should be "hesitant to substitute an alternative reading for the Secretary's [reading of his own regulation] unless that alternative reading is compelled by the regulation's plain language."); see also 5 U.S.C.A. §706(2)(A) (requiring a reviewing court to "set aside agency action, findings, and conclusions" that are "not in accordance with law.")

Regarding the adequacy of documentation to support the Provider's exception request, the Board observes that the Intermediary requested additional documentation on eight items which it believed needed further development. Harborside responded to all eight items but was unable to furnish all of the requested documentation because it was not available following Harborside's purchase of The Reservoir on December 12, 1997.

Ultimately, CMS' denial was based on lack of inadequate documentation for four items for which additional information had been requested. The first was that there was no documentation to support the change of ownership (CHOW) in December, 1997. The Board finds that Provider submitted Form HCFA-2007, Provider Tie-In Notice, for Harborside's acquisition of The Reservoir effective as of December 12, 1997 on March 7, 2002, and that this notice states that it is for a change of ownership effective as of December 12, 1997.[33] The Intermediary also was in possession of the Lease/Option to Purchase Reservoir and the Bill of Sale transferring ownership of Reservoir to Harborside as of December 12, 1997.[34] In addition, CMS' July 2, 2002 letter denying Harborside's exemption request notes that, "Harborside acquired the Reservoir on December 12, 1997, triggering the requirement for a re-evaluation of an approved exemption due to a change of ownership . . ."[35] Based on this evidence the Board finds that CMS had ample documentation of a CHOW whereby Harborside purchased The Reservoir from the Moffies on December 12, 1997.

Second, the Intermediary alleges that the Provider failed to submit documentation to support its request for an increase in bed size of 45 beds. The Board notes that the Moffie family, the Provider's prior owners, did not request an exemption for these additional 45 beds. However, it is undisputed that they had until November, 2003 to request an exemption. The Moffies failure is not relevant to the resolution of this issue. Moreover, DHHS' July 2, 2002 letter,[36] which identifies CMS' concern over insufficient documentation, actually discusses the source of the 45 beds, as it referenced the March 7, 2002 letter, from the Provider, which included the documentation, i.e., the tie-in notice and the related State of Connecticut letter supporting the change in bed size from 30 to 75 beds. Thus, the Board concludes that CMS had sufficient documentation to support this bed size change.

Third, the Intermediary requested the Provider's (the Moffies') original CMS Form 671 for the operation of the original 30 beds. That form is used by CMS to determine the cost reporting period selected by a nursing home.[37] The question is whether this document is critical in allowing the Provider's exemption request. The Board finds that it is not. Based on the record and testimony of the Provider's witness, there is other evidence that the Provider was an ongoing operation approved by both the State of Connecticut and Medicare, including a proper operating license from the state and certification of the facility by Medicare/Medicaid. All of these items are reasonable indications that the

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[33] See Provider Exhibits 5 and 18.
[34] See Intermediary Exhibit I-6.
[35] See Intermediary Exhibit I-7.
[36] See Intermediary Exhibit I-10.
[37] Tr. at 192, 201.

Provider was an ongoing business entity providing services to the Medicare, Medicaid and general patient population. Furthermore, the Board finds that the CMS Pub. 15-1 §2533 requirement for submitting HCFA 671 with the exception application was not issued until after the Provider's filing.

Finally, the Intermediary requested a copy of the Provider's CON application and approval letter for the additional 45 beds. The current owner of the Provider (Harborside) stated that these documents were completed by its prior owner (the Moffies) and Harborside did not have them. However, the Provider did provide the Intermediary with the "Agreed Settlement" between the Provider and the State of Connecticut for both the original 30 beds[38] and the additional 45 beds.[39] Although this document was not requested by the Intermediary, the Board finds that it contained all of the pertinent information that would have been included in the Intermediary's requested CON and CON approval letters.

In summary, regarding the four types of disputed or insufficient documentation alleged by the Intermediary, the Board finds that the Provider's submission of alternative documents was reasonable. The Provider has met the required provider burden of proof. The Board concludes that the Provider's exemption request should not have been rescinded by the Intermediary, and that the exemption should apply to all 75 beds through December 31, 1998.

DECISION AND ORDER:

The Provider's "New Provider" exemption was improperly rescinded. The Intermediary cannot consider the transfer of bed rights as a continuation of services from the previously operating facilities. Further, the Provider's submitted documentation to the Intermediary is reasonable and acceptable for determining the exemption eligibility of the Provider. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: January 25, 2006

Suzanne Cochran
Chairperson

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[38] See Provider Exhibit 9
[39] See Provider Exhibit 10.