PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D36

PROVIDER –
Select Medical 2002-2003 Freestanding
"New Hospital" Capital-Related Costs Groups

Provider Nos.: Various

vs.

INTERMEDIARY -
Wisconsin Physicians Service
(formerly Mutual of Omaha Insurance Co.)

DATE OF HEARING -
March 12, 2007

Cost Reporting Periods Ended -
Various

CASE NOs.: 06-1080G and 06-1081G

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ISSUE:

Whether the Intermediary's adjustments to the Providers' reimbursable capital cost after denying "new hospital" status was proper.

MEDICARE STATUTORY AND REGULATORY GENERAL 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 or Medicare administrative contractors (MACs) determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary or MAC showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary or MAC 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 or MAC'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. §§405.1835-405.1837.

Under Medicare Part A, participating institutions are reimbursed either their actual costs of providing services or pursuant to a formula that is based on a preset payment per discharge for various types of diagnoses under a prospective payment system (PPS). Long-term care hospitals (LTCHs) were among the group of hospitals that were excluded from hospital inpatient PPS, including the prospective payment system for capital related costs (Capital PPS) when it was implemented in 1994. However, since 2002, LTCHs have also been subject to a discharge-based PPS system for reimbursement of their operating and capital costs. 42 C.F.R. §412.500.

To qualify as an LTCH, a hospital must first demonstrate an average Medicare inpatient length of stay greater than 25 days over a minimum six-month period. 42 C.F.R. §412.23(e). During the initial period, Providers seeking LTCH certification are paid as general acute care hospitals and thus are subject to PPS and Capital PPS.

For purposes of payment under LTCH PPS, 42 C.F.R. §412.23(e)(4), a new LTCH is defined as:

> . . . a provider of inpatient hospital services that meets the qualifying criteria in paragraphs (e)(1) and (e)(2) of this section and, under present or previous ownership (or both), its first cost reporting period as a LTCH begins on or after October 1, 2002.

In the Preamble to the proposed and final rules establishing a PPS for Medicare payment of inpatient hospital services furnished by a LTCH, the determination of each LTCH's payment for capital-related costs was based on the estimated payments that would have been made under the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA) methodology. The Preamble states, in part:

> . . . Medicare allowable capital costs are paid on a reasonable cost basis. Thus, each LTCH's payment for capital-related costs would be taken directly from the cost report and updated for inflation. . . .

For cost reporting periods beginning on or after October 1, 2002, "new hospitals" are eligible to be reimbursed for two years at eighty-five (85%) of their allowable Medicare inpatient hospital capital-related costs, rather than being paid under Capital PPS. 42 C.F.R. §412.304(c)(2). After the two year exemption period, the provider is no longer considered "new" and the standard federal rate per discharge applies. For purposes of capital PPS reimbursement, 42 C.F.R. §412.300(b) defines a "new hospital" as follows:

> (b) ***Definition*** For purposes of this subpart, a new hospital means a hospital that has operated (under previous or present ownership) for less than 2 years. The following hospitals are not new hospitals:
>
> > (1) A hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.
> > (2) A hospital that closes and subsequently reopens.
> >
> > (3) A hospital that has been in operation for more than 2 years but has participated in the Medicare program for less than 2 years.
> >
> > (4) A hospital that changes it status from a hospital that is excluded from the prospective payment systems to a hospital that is subject to the capital prospective payment systems.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Select Medical Corporation ("Select") operates over ninety (90) LTCHs in twenty-five (25) states. The LTCHs operate under detailed Medicare program regulatory standards as separately-licensed and certified hospitals. All of the Providers in group appeal number 06-1080G are freestanding hospitals because the LTCHs do not operate within the same

buildings or on the same campus as another hospital (commonly refered to as the "host" hospital). In contrast, all of the Providers in group appeal number 06-1081G are hospitals within hospitals (HIHs), as that term is used by Medicare. The Intermediary for the Providers is Wisconsin Physicians Services formerly Mutual of Omaha.

After signing a lease agreement for the space, each of the Providers' LTCHs underwent extensive renovations to the space occupied by the LTCH before the LTCH began admitting patients. This development process required, among other things, the drafting and approval of architectural plans, site preparation, demolition, construction, and detailed finishing efforts. Equipment was purchased for the LTCH as well. The Providers paid significant capital costs associated with these renovations and equipment, relative to the size of each Provider's hospital and the number of beds.

Each LTCH then obtained the necessary state and federal approvals. The LTCH submitted applications for a hospital operating license from the state and a hospital provider agreement with the Medicare program and the state Medicaid program, if applicable. The state survey agency completed one or more surveys of the LTCH. The state licensing agency issued a hospital license to the LTCH. The Medicare program then assigned a hospital provider number to the LTCH pursuant to a Medicare provider agreement.

The Providers' cost reports at issue in these group appeals cover the required start-up period for LTCH certification following each hospital's initiation of operations. Each of these cost reports has a fiscal year end (FYE) in 2002 or 2003. See Exhibits P-1 and P-2. Each Provider began operating as a Medicare-certified LTCH the day after its respective FYE in these appeals.

The Providers' cost reports for the years in question claimed capital cost reimbursement as a "new hospital," thereby requesting 85% of the Providers' allowable Medicare capital costs rather than being paid under the Capital PPS. Each of the Providers indicated on their respective cost reports that they were new hospitals for purposes of capital cost reimbursement and that the Capital PPS rate was inapplicable. The Intermediary issued NPRs to the Providers with adjustments eliminating the "new hospital" designation, which reduced the Providers' capital cost reimbursement to the lower Capital PPS rate.

The Providers appealed the adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Providers were represented by Jason Healy, Esq. of Reed Smith LLP. The Intermediary was represented by Terry Gouger, Supervisor Cost Report Appeals of Wisconsin Physicians Service.[1]

PARTIES' STIPULATIONS:

The Providers and the Intermediary have stipulated to the following facts:

[1] Formerly Mutual of Omaha Insurance Company.

1. The issue in these appeals is whether the Providers' hospitals were "new hospitals" as that term is defined at 42 C.F.R. §412.300(b) for capital cost reimbursement during their start-up cost reporting periods.
2. All of the Providers' LTCHs in PRRB case number 06-1080G operate as free-standing hospitals because they are not co-located with another hospital (i.e., they do not have a "host" hospital).
3. All of the Providers' LTCHs in PRRB case number 06-1081G operate as hospitals-within-hospitals ("HIHs"), as defined at 42 C.F.R. §412.22(e), because they are co-located with another hospital (i.e., they have a "host" hospital).
4. None of the Providers' LTCHs were operated as separate and distinct hospitals prior to the cost reporting periods at issue in these appeals.
5. All of the Providers' LTCHs were licensed by the states and certified by Medicare as separate and distinct hospitals just prior to the start of the cost reporting periods at issue in these appeals.
6. For PRRB case number 06-1080G, all of the buildings where the Providers lease space were operated by a hospital for more than 2 years prior to but not immediately preceding, the lease arrangement.
7. For PRRB case number 06-1081G, all of the buildings where the Providers lease space were operated by the host hospital for more than 2 years prior to the lease arrangement.

PROVIDERS' CONTENTIONS:

The Providers contend that their LTCHs clearly qualified as "new hospitals" under the plain language of 42 C.F.R. §412.300(b) as that term is defined by Medicare for purposes of capital PPS. The Providers argue that because each of the LTCHs had been operating for substantially less than two years by the end of the cost reporting periods at issue, they meet the criteria of a "new hospital" under the regulation. The Providers also contend that none of the four exceptions in the regulation at 42 C.F.R. §412.300(b)(1)-(4) apply to the LTCHs because they were not existing hospitals that (1) built new or replacement facilities or moved to a new space, (2) closed and then reopened, (3) operated for more than two years, or (4) changed their status from a PPS-exempt hospital to a hospital subject to capital PPS.

The Providers contend that although each LTCH is leasing space that was utilized as a hospital in the past, each LTCH has operated from the outset as a separate and independent hospital, fully consistent with Medicare requirements for such arrangements. Each LTCH also had to separately comply with all state and federal licensure, certification, regulatory, reimbursement and contractual requirements applicable to hospital institutions. The Providers also contend that the regulatory and operational differences between LTCHs and general acute care hospitals, particularly the specialized services and highly acute patient population of a LTCH, illustrate the vast distinction between each LTCH and its host hospital. The Providers assert that these factors demonstrate their independence from the "host" hospitals or any other hospital which operated from the leased space, and therefore the "new hospital" regulation is applicable for the LTCHs.

The Providers maintain that each LTCH underwent a substantial development process just as any other type of new hospital would. As the Providers explained, this process included the design, demolition, construction, finishing, equipment installation, inspection, licensing and Medicare certification of each LTCH. In addition, none of the LTCHs claimed capital costs related to the "host" hospitals original construction. The Providers maintain that the Intermediary improperly focused on the co-location of the LTCHs within "host" hospitals or in locations that may have housed other healthcare operations in the past as the basis for concluding the Providers ineligible for "new hospital" status, thereby ignoring each LTCH's new capital asset base.

The Providers argue that applying the "new hospital" designation to the LTCHs is consistent with CMS' objectives in designing the two-year exemption for Capital PPS. CMS explained that payments based on the federal capital rate might be insufficient to enable new providers that have not received reasonable cost payments in the past to recover their reasonable capital costs and thus provided special protection during their initial period of operation. Specifically, CMS explained it provided for the special treatment of new hospitals because they have no historic asset base; or have initial capital expenditures that may reasonably exceed their PPS per-discharge-based rate for such cost; or generally have low initial patient utilization; and\or have not had an opportunity to accrue the type of capital cost reserve that an established hospital could have developed. The Providers contend that each of them demonstrated these shortfalls in their start-up periods, and are precisely the type of hospitals that CMS sought to protect by promulgating the two-year exemption in question.

Finally, the regulations at 42 C.F.R. §412.304(b) provided that "[f]or cost reporting periods beginning on or after October 1, 1991 and before October 1, 2001, the capital payment [would be] . . . determined under §412.324 through §412.348. In particular, 42 C.F.R. §412.324(b) provided that new hospitals would be paid 85 percent of their allowable Medicare inpatient hospital-related costs for their first two full cost reporting years. In addition, the regulation at 42 C.F.R. §412.304(c)(2) extended the two-year new hospital exemption to all cost reporting periods beginning on or after October 1, 2002. The Providers argue that CMS had the authority to retroactively apply the 2002 rule to new hospitals certified from October 1, 2001 through September 30, 2002, but that it chose not to do so. The Providers assert that although, in general, CMS cannot promulgate retroactive rulemaking, it is permissible if based on express authorization from the legislature[2], or if a particular situation calls for an exception.[3] The Providers assert that the facts in this case avoid the Supreme Court's presumption against retroactive rulemaking and that an exemption to the prohibition against retroactive rulemaking may apply. The Providers also argue that this regulation could be deemed "secondarily" retroactive, which they describe as concerning past events but having a primarily future effect. The Providers ask the Board to find that since the payments to the LTCHs were not made until after October 1, 2002, the rule pertaining to FY 2002 was only secondarily retroactive because it simply looked to past facts to determine the payment due after October 1, 2002. They argue that the Board could then find that the

[2] Bowen v. Georgetown University Hosp., 488 U.S. 204, 222 (Scalia, J., concurring).
[3] Id. at 215.

FY 2002 rule could be deemed applicable to new hospitals with cost reporting periods beginning on or after October 1, 2001, rather than October 1, 2002.[4]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that all of the LTCHs in both case nos: 06-1080G and 06-1081G involve facilities leased from entities that operated hospitals in the leased space for at least two years preceding the lease agreements. The Providers in case no. 06-1081G operate within another acute care hospital, known as a "host" hospital, in an arrangement known as a "hospital-within-hospitals." The Providers in case no. 06-1080G operate as freestanding hospitals, but leased space from hospitals that had also utilized the space and physical assets for hospital services.[5] In each case the Providers executed lease agreements with their respective hosts or hospitals to renovate space and upon completion of the renovations, the State Agency surveyed the renovated space and certified the Providers as Medicare certified acute care hospitals. Each of the LTCHs operated as acute care hospitals for approximately six months, the minimum time necessary to demonstrate that they met the length of stay requirements. However, in each case, the "host" hospital or lessor hospital operated in the leased space for more than two years prior to the execution of the lease agreements.

42 C.F.R. §412.300(b) defines a new hospital as:

> For purposes of this subpart, a new hospital means a hospital that has operated (under previous or present ownership) for less than two years.

The Intermediary defines a "hospital" as an institution that provides medical care for sick or injured people. As the lessor of each facility had operated as a hospital for two years or more in the space that was leased by the Providers, the execution of a lease agreement merely changed who operated the hospital or that particular portion of the hospital. The regulation identifies specific examples of situations that are not considered new hospitals and among them is "[a] hospital that builds new or replacement facilities at the same or another location *even if coincidental with a change of ownership, a change in management, or a lease arragement*. 42 C.F.R. §412.300(b)(1) (emphasis added). The Intermediary contends this example speaks directly to the case at hand as the Providers built new or replacement facilities (as renovated) at the same location, coincidental with a lease arrangement.

The Intermediary also argues that the regulation does not provide an exception for a hospital that is providing a different type of service from its predecessor. The regulation specifically provides that a hospital is not new if it changes its status from a hospital that is excluded from the prospective payment system to a hospital that is subject to the capital prospective payment system. See 42 C.F.R. §412.300(b)(4).

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[4]Provider's Revised Position Paper, pages 35-36.
[5]See Stipulations 2 and 6 and Intermediary Position Paper, pages 8-9.

The Intermediary further argues that the Providers not only fail to meet the plain meaning of a "new hospital" per the regulations at 42 C.F.R. §1412.300(b), but also do not meet the intent of the "new hospital" exemption. In the June 4, 1992 Federal Register, CMS stated:

> We believe that it is essential to maintain the integrity of the capital prospective payment system by allowing only truly new providers of hospital care to qualify for the new hospital exemption. The exemption is intended to protect hospitals that come under the capital prospective payment system without a historic asset base and need special consideration for their original plant and equipment costs during their initial years of operation. Therefore, we are proposing to clarify that the new hospital exemption under the capital prospective payment system would not apply to a facility that opens as an acute care hospital if that hospital has operated in the past under current or previous ownership and has a historic asset base.

57 Federal Register 23618 (June 4, 1992) (Exhibit I-1 CN: 06-1080G)

CMS provided additional clarification in the Federal Register dated September 1, 1992:[6]

> Further, we believe it is appropriate to restrict the new hospital exemption under the capital prospective payment system to new entrants into the hospital field that do not have a historic asset base. . . . Consistent with the need to provide neutral incentives, the proposed changes in the new hospital definition clarify that existing hospitals that move, realign, or replace physical assets from which they operate will not qualify as a new hospital regardless of the mode through which such capital changes are effected.
>
> * * * * *
>
> Regardless of whether new patient care services, staff, patient demographics or other operational factors are involved or even form the basis for a substantial change in hospital assets, the determining factor in deciding whether a hospital is new for purposes of making capital payments should be directly related to a hospital's assets rather than its operations.

57 Federal Register 39746 (Exhibit I-11 CN: 06-1080G)

The Providers admit that although they are claiming capital costs related to the renovations (i.e. depreciation expense for the leasehold improvements) and the equipment needed to operate their hospitals, significant areas of the space leased did not have to be

[6] See Intermediary's Exhibit I-4 at 2-3.

renovated. The Providers pay as part of their lease payments for the "historic assets" of the hospitals from which they are leasing the space. This is in direct contrast to the intent of the regulations, as the Providers are paying the lessor hospitals for its assets. Therefore, the "host" facility and the Providers would both be reimbursed for the historical capital costs of the leased space under Providers' theory.

The Intermediary also argues that while the Providers were able to demonstrate that their Medicare costs exceeded their Medicare reimbursement[7], the Providers have not documented that the excess cost was due to exceptionally high capital costs. In fact, the majority of the Providers' costs (and thus the losses) are due to operating costs which are not relevant to this appeal. In addition, the Providers are paying significant rent payments to the lessor hospitals which encompass both the physical plant which was already constructed as well as equipment leased from the lessor.[8] Therefore to contend that the Providers' facilities are entitled to the same "new hospital exemption" as newly built facilities when their capital costs incurred were limited to renovations and the costs related to the bricks and mortar of the facilities were already claimed by the lessor hospitals should be further subsidized by those facilities is simply disingenuous.

The regulation at 42 C.F.R. §489.18(a)(4), states [t]he lease of all or part of a facility constitutes a change of ownership of the leased portion." The Intermediary argues that the execution of the lease agreement between the host facility and the Provider constituted a change of ownership (CHOW) for the portion of the facility leased and operated by the Providers. The Provider counters that these transaction do not constitute a CHOW, because none of the "hallmarks" of a CHOW took place.[9]

Finally, even if the Board does decide that the Providers meet the criteria for "new hospitals" for capital cost reimbursement, the regulations do not allow for cost reimbursement for capital expenditures for cost reporting periods which began prior to October 1, 2002. Therefore each of the Providers in case no. 06-1081G and one of the two Providers in case no. 06-1080G, would not be eligible based upon the express prohibitions of the regulation. CMS specifically stated, "While we are making this change effective for cost reporting periods beginning on or after October 1, 2002, we are not making this change effective for any periods prior to that date because doing so would constitute retroactive rulemaking."[10] In Bowen v. Georgetown University Hospital, 488 U.S. 204 (1988), the U.S. Supreme Court held that retroactivity is not favored in the law and that ". . . even where some substantial justification for retroactive rulemaking is presented, courts should be reluctant to find such authority absent an express statutory grant."[11] As there was no statutory grant to allow retroactive rulemaking, the Intermediary contends the regulation cannot be applied to cost reporting periods beginning prior to October 1, 2002.

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[7] Exhibits P-11 and P-12.
[8] Transcript 61-64.
[9] See Provider's Final Position Paper at 12 (FY 2003).
[10] 67 Fed. Reg. 49981, 50102.
[11] See, Intermediary's Exhibit I-23 at 4.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds as follows:

The issue before the Board is whether the Providers' were "new hospitals," as defined at 42 C.F.R. §412.300(b), for capital cost reimbursement during their start-up cost reporting periods, and are, therefore, eligible to receive 85% of their allowable Medicare inpatient hospital capital-related costs for their first two years of operations. The Parties have stipulated that both of the Providers' LTCHs in PRRB case number 06-1080G operate as free-standing hospitals because they are not co-located with another hospital (i.e., they do not have a "host" hospital) and that each of the Providers' LTCHs in PRRB case number 06-1081G operate as hospitals-within-hospitals, as defined at 42 C.F.R. §412.22(e) because they are co-located with another hospital (i.e., they have a "host" hospital). The parties have also stipulated that all of the buildings where the Providers lease space were operated by another hospital or the host hospital for more than two years prior to the lease arrangement.

The Board finds that the regulation defining a "new hospital" for capital PPS purposes at 42 C.F.R. §412.300(b) is ambiguous, in that it is not clear if the term "hospital" means the individual physical assets, as the Intermediary suggests, or the business entity as a whole, which would include both bricks and mortar and the operations. The Board finds significant that the term "hospital" is used in 42 C.F.R. §412.300(b) rather than the term "provider" which is used in other exemption regulations. For example, the Skilled Nursing Facility (SNF) exemption regulation at 42 C.F.R. §413.30(d) defines a new SNF as ". . . a *provider* of inpatient services that has operated as a SNF (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than 3 full years." (emphasis added). The Board also finds significant that this regulation which defines a new hospital explicitly states its purpose at 42 C.F.R. §412.300(a) as establishing a reimbursement methodology for inpatient hospitals "capital-related costs," which are defined in §412.302 and includes physical assets.

Accordingly while we recognize the ambiguity of the regulations, we rely to a great extent on 42 C.F.R. §412.300(a) which requires, at the very least, an analysis of the physical assets. The parties have stipulated that all of the buildings where the Providers lease space were operated by another hospital or host hospital for more than 2 years prior to the lease arrangement. Therefore, the bricks and mortar of those facilities were established and presumably the original costs associated with the space claimed for Medicare reimbursement during the years in which a hospital operated out of the space.

While none of the examples under 42 C.F.R. §412.300(b) specifically address the factual circumstances at issue in these cases, such examples are consistent with the principle expressed by the Intermediary that the exemption to receive cost reimbursement for the capital-related costs should be limited only to assets for which the Medicare program has

not previously made payment under the reasonable cost principles. We find additional support for the Intermediary's arguments in the August 1, 2002 Federal Register:[12]

> This payment provision was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals. These hospitals may not have sufficient occupancy in those initial 2 years and may have incurred significant capital startup costs, so that capital prospective payment system payments may not be sufficient. (emphasis added)

We find that the intent of the regulations is to prohibit the cost reimbursement treatment under the exemption for hospital's facility costs that have been reimbursed in the proceeding two years. Therefore, the Board finds that applying the exemption where each lessor hospital operated as a hospital for more than two years prior to the execution of the lease agreements in the same space that the Providers were later located violates the intent of the regulation. We conclude the Providers in this case are not "new hospitals" under 42 C.F.R. §412.300(b).

Even if the Providers could be considered "new hospitals" under 42 C.F.R §412.300(b), the regulation does not permit the exemption to be applied to providers with cost reporting periods which began prior to October 1, 2002. On the contrary, the regulation is explicit as to which cost years the regulation applies, and the Board has no authority to retroactively apply the regulation to earlier years.

DECISION AND ORDER

The Intermediary properly disallowed the Providers' new hospital status. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A. (Dissenting)
Keith E. Braganza, C.P.A. (Dissenting)
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

[12] Exhibit I-5, Federal Register, Page 50101, Section B. *New Hospitals.*

DATE: August 19, 2009

Dissenting Opinion of
Keith E. Braganza and Michael D. Richards

As stipulated by the parties, the issue in this case is whether the Providers were "new hospitals", as that term is defined at 42 C.F.R. §412.300(b), for capital cost reimbursement during their startup cost reporting periods.

The Statute

Before analyzing the regulation or attempting to determine whether it is ambiguous, it is useful to review the underlying statute. 42 U.S.C. §1395ww(a) addresses payments to hospitals for inpatient services, including limitations on payment. A section of the statute which addresses exceptions to those payment limitations is 42 U.S.C. §1395ww(a)(2). That section states:

> The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account –
>
> (A) the special needs of sole community hospitals, of new hospitals, or risk based health maintenance organizations, and of hospitals which provide atypical services or essential community services, and to take into account extraordinary circumstances beyond the hospital's control, medical and paramedical education costs, significantly fluctuating population in the service area of the hospital, and unusual labor costs.
>
> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title, and
>
> (C) a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services.

Based on the language above, the intent of the statute was clearly to provide relief based on a hospital's special needs or on extraordinary circumstances beyond a hospital's control. The statute specifically mentions the special needs of new hospitals. In the context of this case, the intent of the statute is perfectly clear – it is to provide an exception or adjustment to the payment limitations based on the special needs of a new hospital. There is no ambiguity with regard to that intent.

The Regulation

The regulation 42 C.F.R. §412.300(b) states:

> *Definition*. For purposes of this subpart, a new hospital means a hospital that has operated (under previous or present ownership) for less than 2 years. The following hospitals are not new hospitals.
>
> (1) A hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement.
>
> (2) A hospital that closes and subsequently reopens.
>
> (3) A hospital that has been in operation for more than two years but has participated in the Medicare program for less than 2 years.
>
> (4) A hospital that changes its status from a hospital that is excluded from the prospective payment systems to a hospital that is subject to the capital prospective payment systems.

Per the regulation, the above exceptions appear to be an exhaustive list of hospitals that are not new hospitals. The Provider's circumstances meet none of the situations listed above. Therefore, based on the language of the regulation, the Provider meets the definition of a new hospital.

The primary definition is clear – a new hospital is one that has operated (under previous or present ownership) for less than 2 years. Of the situations described (of hospitals that are not new hospitals), none specifically address the factual circumstances at issue in this case. Nevertheless, it is significant that for each example of a hospital that is not a new hospital, the special needs of a new hospital would be absent. Consider the following:

(1) "A hospital that builds new or replacement facilities . . ." In this example the hospital would have a base of patients to draw upon and there would be existing relationships with physicians. Such a hospital should not have the initial low occupancy (i.e., the special needs) of a completely new hospital, and so an adjustment to payment limits would not be warranted.
(2) "A hospital that closes and subsequently reopens." In this example too, the fact that the hospital was previously in operation should make startup costs lower and also make it easier to "ramp up" to average occupancy in less than 2 years. Hence there would be no need for an exception or adjustment to the limits.

Likewise, in examples (3) and (4) above, the special needs of a completely new hospital would be absent, or at least minimized, so that an exception to payment limits would not be necessary.

The language of the regulation is **not** ambiguous and is consistent with the underlying statute. (The majority finds the language of the regulation ambiguous, but interestingly, it states "…none of the examples under 42 C.F.R. §412.300(b) specifically address the factual circumstances at issue in these cases.")

Relevant Facts of the Case

The complete facts of this case are contained in the record. The relevant points include the following:

1. Select Medical Corporation ("Select") designed its hospitals, leased space, made extensive renovations, purchased equipment and began admitting patients. The Providers went through all the steps necessary to become licensed and certified by the state and federal agencies, including: complying with state and federal fire codes, meeting infection control standards, and passing state licensure and Medicare surveys. Each LTCH has a license separate from that of the host hospital and is a separately-certified Medicare provider.

2. Each LTCH is an independent hospital, separate and distinct from the host hospital. The LTCHs are not units of their host hospitals. They are organizationally and functionally independent. Each Provider LTCH has a separate CEO and a separate medical staff.

3. LTCHs are different from acute care hospitals. As stated by MedPAC, "LTCHs provide post-acute care to a small number of medically complex patients who are more stable than patients in an intensive care unit (ICU) but may still have unresolved underlying complex medical conditions." MedPAC "Report to Congress: New Approaches in Medicare," June 2004, pg. 125. These are not the same services that short-term acute care hospitals provide. The Provider LTCHs do not care for the same patients as the host hospital and do not use the same staff or the same assets.

4. None of the Provider LTCHs obtained either licensed beds or bed rights by transfer from the host hospital. (Some bed equipment may have been provided, but that is irrelevant to the issue in this case).

Analysis

The regulation is clear on its face and therefore, dispositive. The Providers are new hospitals separate and distinct from the host hospitals, none of the exceptions to the definition of "new hospital' apply to the Providers and none of the Providers' LTCHs were previously operated. The Providers therefore qualify as new hospitals under 42 C.F.R. §412.300(b).

The majority focuses on the word "hospital" and, since another exemption regulation uses the word "provider," concludes that the term "hospital" is defined as its individual physical assets. We respectfully disagree. In the context of the statute and regulations, the word "hospital" is more than just physical assets. 42 U.S.C. §1395ww is titled "Payments to hospitals for inpatient hospital services." Clearly the payment is made to the entity or provider. The majority cites 42 C.F.R. §413.30(d) as defining a new SNF as a "provider" and concludes that the term "hospital" in 412.300(b) must therefore pertain to physical assets. However, §413 (of which 413.30(d) is a subset) is itself titled, "Principles of reasonable cost reimbursement; . . . prospectively determined payment rates for skilled nursing facilities." The meaning of "skilled nursing facilities" in that title must mean the entities or providers.

Assuming arguendo that there is a basis for the majority's determination that the word "hospital" means individual physical assets, it uses that determination to conclude that 42 C.F.R. §412.300(a) requires an analysis of the physical assets. The title of 42 C.F.R. §412.300(a) is "*Purpose*" and that purpose relates to the establishment of a system of prospective payment for capital-related costs as required by 42 U.S.C. §1395ww(g)(1)(A). It does not require an analysis of physical assets. For this case the relevant regulation is 42 C.F.R. §412.300(b), titled "*Definition*", which addresses the definition of a new hospital. 42 C.F.R. §412.300(a) is not pertinent.

Finally, the majority accepts the principle expressed by the Intermediary that, "the exemption to receive cost reimbursement for the capital-related costs should be limited only to assets for which the Medicare program has not previously made payment under the reasonable cost principles." In our opinion, based on the language of the statute and regulation, there is absolutely nothing that supports this principle.

The majority finds support for the Intermediary argument in the August 1, 2002 Federal Register, p. 50101, which states:

> This payment provision was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of <u>newly</u> built hospitals. These hospitals may not have sufficient occupancy in those initial two years

> and may have incurred significant capital startup costs, so that capital prospective payment system payments may not be sufficient.

The majority and the Intermediary place an undue emphasis on "newly." In this case that emphasis is irrelevant because the LTCHs were in fact newly built. There was first a design phase, then demolition where existing furnishings and equipment were removed, a construction phase where new plumbing, sprinklers, electrical, lighting, heating, ventilation and air conditioning were addressed, followed by a finishing phase where flooring, ceiling tile, railings, workstations, equipment, etc. were added. The Providers had to comply with the various building codes for each phase.

The above language in the Federal Register is nevertheless relevant in conveying the intent of the statute and regulation. Consider the same language with different words emphasized:

> This payment provision was implemented to provide special protection to new hospitals during the transition period in response to concerns that prospective payments under a DRG system may not be adequate initially to cover the capital costs of newly built hospitals. These hospitals may not have sufficient occupancy in those initial two years and may have incurred significant capital startup costs, so that capital prospective payment system payments may not be sufficient.

Based on the emphasis as placed above, the intent of the regulation should be clear. Furthermore, the words emphasized above are consistent with the "special needs" referenced in the statute.

After citing the language from the Federal Register, the majority goes on to find "that the intent of the regulations is to prohibit the cost reimbursement treatment under the exemption for hospitals' facility costs that have been reimbursed in the preceding two years." We disagree. Neither the statute nor the regulation makes any mention or reference to costs that had been reimbursed in the preceding two years. And in our opinion, the intent of the regulation, as is clear in the underlying statute, differs from that as expressed in the majority interpretation.

It appears that the Intermediary's adjustment and analysis is based on its failure to recognize that a LTCH is completely different from a short term acute care hospital. As it states on p. 23 of its position paper, for a hospital to be considered as new, "the assets must not have been utilized in any hospital setting for more than two years." It also states on p. 7 that, "To be considered new, a Provider must be both newly certified for Medicare and acquiring an asset base that has been utilized for providing hospital care for less than two years at any time from a source that has not provided patient care for more than two years." There is no support for those statements in either the statute or the regulations, but the majority appears to have accepted them.

Consistent with the Board majority, we find the application of the new provider exemption to PPS capital is effective for cost reporting periods beginning on or after October 1, 2002 as stated in 67 Fed. Reg. 49981, 50182.

Findings and Conclusion

Because the LTCHs are completely different from short term acute care hospitals, they would have the same special needs as new hospitals with regard to payments for capital. They would experience the challenges unique to any startup operation, namely, incurrence of high non-recurring startup costs and initial low occupancy. Furthermore, none of the Providers had operated as an LTCH for more than two years. Based on the statute and the regulation, the Providers are entitled to the exemption for new hospitals for cost reports beginning on or after October 1, 2002.

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