PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D80

PROVIDER -Kingwood Hospital
Michigan City, Indiana

Provider No. 15-4033

vs.

INTERMEDIARY -
Anthem Blue Cross and Blue Shield

DATE OF HEARING-
July 22, 1998

Cost Reporting Period Ended -
May 31, 1990

CASE NO. 93-0054

INDEX

ISSUE:

Was the issue relating to denial of new provider exemption proper and should the Provider's base year be changed from fiscal year 1984 to 1990?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Kingwood Hospital (" Provider") is an 89-bed facility located in Michigan City, Indiana. The Provider was recertified to participate in the Medicare program as a free-standing psychiatric hospital with an effective date of June 1, 1989. Immediately prior to the Provider's June 1, 1989, recertification, the Provider operated as a general, short-term acute care hospital with a distinct part psychiatric unit. The Provider's distinct part psychiatric unit had been certified to participate in the Medicare program with an effective date of January 1, 1984.

The Provider was first certified to participate in the Medicare program on April 4, 1968 as a general, short-term acute care hospital.[1] As a general, short-term acute care hospital, the Provider operated 89 medical/surgical beds. The Provider operated as a general, short-term acute care hospital through December 31, 1983.

Effective January 1, 1984, the Provider received approval to operate a PPS-exempt psychiatric unit.[2] Thus, the Provider became certified to participate in the Medicare program as a general, short-term acute care hospital with a distinct part psychiatric unit. The Provider converted 36 of the medical/surgical beds to psychiatric beds on this date.

The 36-bed distinct part psychiatric unit expanded to 58 beds on September 22, 1985, with an effective date of January 1, 1986.[3] January 1 was the beginning of the fiscal year subsequent to the expansion of the distinct part psychiatric unit. The distinct part psychiatric unit remained at 58 beds through May 31, 1989. The Provider sought Medicare certification as a psychiatric hospital. The Provider was reclassified for participation in the Medicare program from a general, short-term acute care hospital with a distinct part psychiatric unit to a free-standing psychiatric hospital. This reclassification became effective June 1, 1989. Consequently, the remaining 31 medical/surgical beds of the 89 total beds were converted to psychiatric beds.[4]

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1 Intermediary Exhibit I-1.

2 Intermediary Exhibit I-2.

3 Intermediary Exhibit I-3.

4 Id.

During review of the Provider's fiscal year ended May 31, 1990 cost report, Anthem Blue Cross and Blue Shield ("Intermediary") applied the TEFRA rate of ceiling increase to the operating costs.[5] The Notice of Program Reimbursement (NPR) for the fiscal year ended May 31, 1990 cost report was issued September 30, 1992.

The Provider filed a request with the Intermediary for an exemption as a new hospital on October 8, 1992.[6] The Intermediary subsequently forwarded the Provider's request to the Health Care Financing Administration ("HCFA") recommending that the Provider's request for an exemption as a new hospital be rejected. HCFA issued its determination with respect to the Provider's request on March 29, 1993.[7] HCFA determined that the Provider was not entitled to an exemption from the TEFRA rate of increase ceiling as a new hospital as described in 42 C.F.R.
§ 413.40(f)(1) because it had been operating as an inpatient psychiatric hospital for almost three years prior to its reclassification/recertification as a free standing psychiatric hospital. As a result, the hospital exemption did not apply because the hospital had changed the basis of its certification but continued to provide the same type of services.

On April 27,1993 the Provider appealed HCFA's determination to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The amount of Medicare reimbursement in controversy is approximately $362, 436.

The Provider was represented by Patric Hooper, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary is represented by James R. Grimes, Associate Counsel, of the Blue Cross and Blue Shield Association.

When approval was given by the Board to hear this case "On-the-Record", the Provider submitted an additional argument that, even if it is not entitled to an exemption from the TEFRA limits as a new provider, its base year should be changed from fiscal year 1984 to fiscal year 1990.[8]
Since submitting its original position paper, the Provider points out that there was a second HCFA determination made with respect to the application of the TEFRA limits to its 1990 cost report. Subsequent to HCFA's determination on March 29, 1993 denying the Provider's

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5 Intermediary Exhibit I-4.

6 Intermediary Exhibit I-5.

7 Intermediary Exhibit I-6.

8 Both the Provider and the Intermediary submitted supplemental position papers briefing this additional issue.

request for an exemption as a new provider, on April 27,1993, the Provider requested an exception pursuant to 42 C.F.R. § 413.40(e). HCFA made a determination on August 11, 1995,[9] granting a limited adjustment to the TEFRA limits for increased routine and additional ancillary services for the Provider's 1990 cost reporting period. However, in addition to HCFA again refusing to grant the Provider a new hospital exemption, HCFA refused to change the Provider's TEFRA base year from the 1984 fiscal year to the 1990 fiscal year, as requested by the Provider as an alternative to treating it as a new provider.

Issue 1: New Provider Exemption

PROVIDER'S CONTENTIONS:

The Provider argues that the literal language of the regulation requires HCFA to grant a new hospital exemption to the TEFRA limits for a provider when there is a change in the "type of hospital for which HCFA granted it approval to participate in the Medicare program". 42 C.F.R. § 413.40(f)(1).

The Provider refers to the governing Medicare regulation, 42 C.F.R. § 413.40(f)(1), which reads
as follows:

> [n]ew hospitals that request and receive an exemption from HCFA are not subject to the rate of increase ceiling imposed under this section. For purposes of this section, a new hospital is a provider of inpatient hospital services that has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership, or both, for less than three full years.

42 C.F.R. § 413.40(f)(1).

The Provider contends that the Secretary, through HCFA, is interpreting the language of the regulation more restrictively. The Provider points to HCFA's exemption denial letter[10] which states in part that the new hospital exemption under 42 C.F.R. § 413.40(f)(1) "[d]oes not apply to hospitals that change their Medicare certification but continue to provide the same type of service". The Provider asserts that subsequent to the fiscal year at issue, HCFA amended the regulation to incorporate the more restrictive interpretation. See 42 C.F.R. § 413.40(f) [1992].

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9 See HCFA letter dated August 11, 1995 attached to Provider Supplemental Position Paper.

10 Intermediary Exhibit I-6.

The Provider points out that the interpretation of the governing regulation has been the subject of two recent court cases which have upheld the Secretary's interpretation under the facts of those two cases. The Provider contends that when the cases are closely analyzed, the critical facts of the two court cases can be distinguished from those here.

In Memorial Rehabilitation Hospital of Santa Barbara v. Shalala, 65 F.3d 134 (9th Cir. 1995) Medicare & Medicaid Guide (CCH) ¶ 43,572, ("Memorial"),[11] the Court of Appeals for the Ninth Circuit concluded that the Secretary properly denied a new hospital exemption because the facts giving rise to the request essentially involved nothing more than a change of ownership of the provider, which does not trigger new provider status. In that case, the Secretary and the Court emphasized that the hospital had been operated exclusively as a rehabilitation hospital prior to January 1, 1982, and continued to be operated exclusively as a rehabilitation hospital after January 1, 1982, when it underwent a change of ownership. According to the Court, as long as Memorial Rehabilitation Hospital provided and was certified for the same type of services as previously provided by the previous owner (Santa Barbara County), Memorial can be deemed, under the language of the regulation, the "same type of provider." Id. at Page 45,731. The Court supported the Secretary's finding that the transaction "was basically a change of ownership from the county to the foundation," based on the facts that (1) Memorial Rehabilitation Hospital continued to offer the same type of service for the same number of beds as the county had, and (2) both entities were licensed and certified under the Medicare program for long-term rehabilitation services. The Court emphasized that the new owner "continued to provide identical rehabilitation services," following the change of ownership. Id. at Page 45,732. Thus, no "material changes" in the inpatient services occurred at the hospital before and after January 1, 1982, the requested effective date for new hospital status.

The Provider contends that it is not relying on a change of ownership or change in the Medicare certification of the hospital to try to obtain an exemption as a new hospital. The Provider argues that unlike the situation in Memorial, there was a material change in its certification, licensure and services provided before and after the fiscal year at issue. The Provider maintains that it changed from providing short-term acute care hospital services and psychiatric hospital services to providing psychiatric hospital services only. (emphasis added).

Therefore, the Provider contends that it is entitled to an exemption as a new hospital under § 413.40(f)(1) because there was, in fact, a change in the type of services provided. The Provider contends that unlike the situation in Memorial, it did not continue to provide the same type of services after May 30, 1989, the end of its previous certification as a short-term

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[11] Provider Exhibit P-1.

hospital.

The Provider also points to a more recent case supporting the Secretary's interpretation of the governing regulation. In SSM Rehabilitation Institute v. Shalala, 68 F.3d 266 (8th Cir. 1995), Medicare & Medicare Guide (CCH) ¶ 43,685 ("SSM"),[12] the provider argued that a change in its Medicare certification from a long-term hospital to a rehabilitation hospital, in and of itself, triggered a new hospital exemption. The hospital provided rehabilitation services while it was certified as a long-term care hospital and continued to do so when it became certified as a rehabilitation hospital. Because of this fact, the Secretary concluded that SSM was not a new hospital upon the change of its certification. The Secretary stated "because [the provider] had provided comprehensive rehabilitation services for more than three years prior to its certification as a rehabilitation hospital," it was not entitled to an exemption as a new hospital. Id. at 46,664.

The United States Court of Appeals for the Eighth Circuit upheld the Secretary's interpretation of the governing regulation and concluded that SSM was not entitled to a new hospital exemption "solely by reason of recertification." Id. at 46,665. The Court concluded that the Secretary was within her discretion in concluding that SSM did not qualify for a new hospital exemption because SSM provided the same services before and after its recertification. (emphasis added).

The Provider contends that the situation in SSM is very different from the instant case. The Provider asserts it furnished short-term general acute care services and psychiatric services prior to June 1, 1989 and it furnished psychiatric services exclusively as of June 1, 1989.[13] (Emphasis added). Therefore, the Provider argues that the Secretary's interpretation of the regulation, which requires a change in the type of services to be granted an exemption, is satisfied here.

The Provider contends that under circumstances very similar to this case, the Secretary, through HCFA, granted a new hospital exemption to a Texas hospital.[14] The Provider notes that the Texas hospital had added general acute care services to its existing free standing rehabilitation facility and thus became certified as a general short-term hospital with a distinct part rehabilitation unit. The Provider maintains that HCFA granted the Texas hospital a new provider exemption because according to HCFA, applying a rate of increase ceiling for a free-

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[12] Provider Exhibit P-2.

[13] Provider Position Paper at 6.

[14] See Provider Position Paper Exhibit P-3. Exhibit refers to a Texas hospital that was granted a new base period by HCFA for establishing the TEFRA limitation in a distinct part rehabilitation unit. (emphasis added).

standing rehabilitation hospital to a distinct part rehabilitation unit of a general acute care hospital "would not be appropriate."

The Provider contends that when its psychiatric unit was only a distinct part of the general short-term hospital, Medicare reimbursement for the entire hospital was different from reimbursement for services furnished after the change in certification and the termination of the short-term hospital services. The Provider further contends that a change in the methodology in determining Medicare's share of the costs occurred as a result of its recertification as a free-standing psychiatric hospital and the change in acute care services, a situation similar to that with the Texas hospital.

The Provider argues that agency consistency requires that HCFA follow the reasoning it applied in the case of the Texas hospital to the facts of this case. The Provider contends that there is no meaningful distinction between the situation in the instant case and the situation in the Texas

hospital. In both cases, the furnishing of short-term acute care services changed along with the change in Medicare certification.

The Provider contends that even if the Secretary's restrictive interpretation of the governing regulations adopted, as was the case in Memorial and SSM, it qualifies for new hospital status here because the types of services furnished before and after June 1, 1989, were different. Therefore, the Provider requests the Board to order the Intermediary to grant an exemption from the TEFRA rate of increase ceiling on the grounds that it qualifies as a new hospital under the governing regulation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that after the Provider's distinct part psychiatric unit was certified for 36 beds in 1984, it expanded very rapidly. The distinct part psychiatric unit expanded to 58 beds on September 22, 1985 and these beds became Medicare certified on January 1, 1986. See Intermediary Exhibit I-3. The Intermediary asserts that the Provider has actually operated a distinct part psychiatric unit with 79 beds since September 1986 even though these additional 21 beds did not obtain Medicare approval for certification until the whole unit was reclassified on June 1, 1989. Id.

The Intermediary illustrates as follows the Provider's distinct part psychiatric unit's expansion in operations since its certification date of January 1, 1984. (See Intermediary Position Paper at 8.)

Dates	Total Beds	Med/Surg Beds	Psych Beds	Percent Psyc Beds

01/84 - 09/85	89	53	36	40.4%
09/85 - 09/86	89	31	58	65.7%
09/86 - 06/89	89	10	79	88.8%
06/89 -	89	0	89	100%

The Intermediary points out that the Provider's submitted and settled cost reports for the fiscal years ended December 31, 1984, through May 31, 1990, support the Provider's expansion of its distinct part psychiatric unit's operations.[15] The Intermediary notes that the cost reports reflect the number of beds split between the medical/surgical area and the psychiatric area based on the Provider's operations.

Based on the above, the Intermediary rejects the Provider's argument that it qualifies for a new hospital exemption because the types of services furnished before and after June 1, 1989 were different. The Intermediary contends the Provider has operated an inpatient distinct part psychiatric unit since 1984, and has offered inpatient psychiatric services for over 5 years prior to its reclassification/recertification as a free standing psychiatric hospital effective June 1, 1989.[16] In addition, the Intermediary points out that the Provider has operated almost ninety (90) percent of its total beds for psychiatric services for three (3) full years during this time and for more than two (2) years prior to its reclassification/recertification from a distinct part psychiatric unit to a free-standing psychiatric hospital. The Intermediary maintains that based on the Provider's distinct part psychiatric unit's operations prior to its reclassification/recertification, the Provider clearly does not meet the definition of a new hospital as described in 42 C.F.R.
§ 413.40(f)(1)(I).[17] This section states in part:

> a new hospital is a Provider of hospital inpatient services that --
>
> (A) has operated as the type of hospital for which HCFA granted its approval to participate in the Medicare program, under present or previous ownership (or both), for less than two full years; and
>
> (B) has provided the type of hospital inpatient services for which HCFA

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15 Intermediary Exhibit I-8.

16 Intermediary Position Paper at 9.

17 Intermediary Exhibit I-9.

> granted its approval to participate in the Medicare program, for less than two years.

42 C.F.R. § 413.40(f)(1)(I) (Emphasis in original).

In its March 29, 1993, letter[18] denying the Provider's request for an exemption to the TEFRA rate of increase ceiling as a new hospital, HCFA stated:

> . . .[t]he new hospital exemption does not apply to hospitals that change the basis of their certification but continue to provide the same type of service.

Id.

The Intermediary argues that the Provider is not changing the type of service offered. The Provider offered inpatient psychiatric services prior to its reclassification/recertification and continues to offer inpatient psychiatric services after the reclassification/recertification.

The Intermediary contends it is clear based on the Provider's operations that the type of services offered did not change prior to or after the reclassification/recertification. The Intermediary points out that at the time of the Provider's request to change the hospital's status, the Provider operated only 10 beds in the general, short-term acute care area out of the 89 total beds for the hospital. With the expansion of the distinct part psychiatric unit, the Provider was phasing out or eliminating the general, short-term acute care services offered.

The Intermediary asserts that based on the Provider's expansion of the distinct part psychiatric unit, the Provider had no choice but to request the change in the hospital's status.

In summary, the Intermediary contends that based on the Provider's operations prior to the reclassification/recertification from a general, short-term acute care hospital with a distinct part psychiatric unit to a free-standing psychiatric hospital, the Provider does not meet the definition of a new hospital as defined in 42 C.F.R. § 413.40(f)(1)(I). Therefore, the Provider is not entitled to a new hospital exemption from the TEFRA rate of increase ceiling. Accordingly, the Intermediary's adjustment and HCFA's determination should be affirmed.

Issue 2: New Base Year

PROVIDER'S CONTENTIONS:

The Provider maintains that the governing Medicare regulation, 42 C.F.R. § 413.40(b),

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[18] Intermediary Exhibit I-6.

defines those cost reporting periods which should be subject to the TEFRA rate of increase ceiling. The Provider also maintains that in June 1992, HCFA proposed a revision to 42 C.F.R. § 413.40 to address various issues, including the requirements to qualify for a new hospital under § 413.40(f). At the same time, the Provider contends that HCFA also proposed to revise § 413.40(b)(1) to "clarify" that when a hospital with a distinct part unit, such as a general acute care hospital with a psychiatric subunit, becomes a free-standing hospital, such as a free-standing psychiatric hospital, the hospital's TEFRA base year is to be the first full twelve-month cost reporting period effective with the revised Medicare certification.[19]

The Provider refers 57 Fed. Reg. 23660 (June 4, 1992) (Provider Exhibit P-1 at column 1) in which HCFA states as follows:

> [h]owever, we also recognize that it would not be appropriate to subject these types of hospitals or distinct part units to the ceiling that applied before the hospital's reorganization. Therefore, when the operational structure of a hospital or distinct unit changes (that is, a free-standing rehabilitation hospital becomes a distinct part unit or vice versa), we are proposing to revise Section 413.40(b)(1) to clarify that the base period would be the first full twelve-month cost reporting period effective with the revised Medicare certification.

Id.

The Provider contends that when this provision is applied to the facts of this case, it becomes obvious that its 1990 cost reporting period must be used as the TEFRA base period for the application of the TEFRA rate of increase ceiling to its cost reports following its new certification as a free-standing psychiatric hospital. The Provider notes that fiscal year ending May 31, 1990 is the first full twelve-month cost reporting period effective with the revised Medicare certification, June 1, 1989.

The Provider points out that the proposed clarification of the regulations was adopted by HCFA on September 1, 1992, when § 413.40(b) was revised to incorporate the above clarifying language. See 57 Fed. Reg. at 39802 and 39829 (September 1, 1992) , included in Provider Exhibit P-1. It is the Provider's position that because the revision was deemed by HCFA, itself, to constitute a clarification, rather than a change in existing policy, the clarification is applicable retrospectively as well as prospectively.[20] The Provider argues that this should be contrasted with the other revisions added to § 413.40 in 1992 pertaining to

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[19] See pages 23659-23660 of the June 4, 1992 Federal Register, included as an attachment in Provider Exhibit P-1.

[20] Provider Supplemental Position Paper at 3.

qualifying for a new hospital exemption, which changed Medicare policy and thus were made effective prospectively only for Medicare certifications occurring on or after October 1, 1992. (emphasis in original).

The Provider contends that the language of the revised regulation pertaining to a change in a provider's base year upon a change in certification of the type that occurred here is consistent with then-existing HCFA policy and is thus applicable to pre- 1992 fiscal years, as illustrated by Provider Exhibit P-3. The Provider explains that its Exhibit P-3 is a determination by HCFA in 1992 for a 1990 cost reporting period, that confirms when a free-standing rehabilitation hospital changes its certification to a general acute care hospital with a distinct part rehabilitation unit, or vice versa, it is not appropriate to apply the same TEFRA base year that was applicable to the previously certified free-standing rehabilitation hospital.

The Provider asserts that according to HCFA, in such a situation, the first twelve-month cost reporting period following the recertification must be used as the TEFRA base year due to the fact that Medicare's methodology for determining the provider's reimbursement changes completely when a hospital's certification is changed from a free-standing PPS-exempt hospital to a general acute care hospital, which is subject to the prospective payment system (except for an exempt subunit.)

The Provider contends that when it was certified as a general acute care hospital with a psychiatric subunit, it was subject to reimbursement under the Medicare prospective payment system except for those services furnished in the psychiatric subunit. Once it became certified as a free-standing psychiatric hospital, the entire hospital was exempt from reimbursement under the prospective payment system and was subject to the reasonable cost reimbursement system. The Provider further contends that it is this precise type of change in the methodology for determining Medicare's share of the costs of the different levels of patient care which requires a change in the TEFRA base year even if the “overall financial structure” of the hospital does not change materially. See Provider Exhibit P-3.

The Provider asserts that the HCFA determination in its Exhibit P-3 was done under virtually identical circumstances to those in this case. Based on this determination, the Provider believes that the only conclusion that can be drawn is that the 1990 fiscal year must be treated as the TEFRA base year and thus the TEFRA rate of increase ceiling should not have been applied to its 1990 fiscal year.

Based on the above, the Provider requests the Board to grant its request for relief from the application of the TEFRA rate of increase ceiling for the 1990 fiscal year even if the Board decides that it should not be exempt from the TEFRA limits as a new provider.

INTERMEDIARY’S CONTENTIONS:

The Intermediary explains that the Provider has submitted an additional argument that, even if it is not entitled to an exemption from the TEFRA limits as a new provider, its base year should be changed from fiscal year 1984 to fiscal year 1990. The Intermediary notes that the Provider relies on revisions to 42 C.F.R. § 413.40 adopted on September 1, 1992.[21] The Intermediary points out that the revisions sought to clarify application of the new hospital exemption in cases where reorganization or changes to the basis of participation in the Medicare Program occurs while a provider continues to provide the same services before and after the reorganization. The language found in the proposed revision indicates that a provider that has undergone such a reorganization should not be entitled to a new provider exemption because the provider would not experience many of the difficulties faced by a new provider in the market. However, the language does indicate such a provider should not be limited to the same rate of increase ceiling applied before the reorganization because there could be cost distortions resulting from the change in the organization of the facility's operation. The revision then permits a change in base period to the first full 12 month cost reporting period effective with the revised Medicare certification.

The Intermediary does not believe the instructions contained in the revisions to § 413.40 in any way effect the outcome of this case. The Intermediary believes the purpose of the clarification to § 413.40(b)(1) is to recognize that providers who reorganize through a change of the basis of participation would, in that first cost reporting year after the change, have different cost experiences. In this case, while the recertification of the Provider as a free standing psychiatric

hospital took place in 1989, the Intermediary points out that the Provider had been acting as a psychiatric hospital for some time.

The Intermediary explains that the change from an acute care hospital with a psychiatric sub-unit had taken place gradually over several years. The Intermediary points out that prior to 1984, the Provider operated as a general acute care hospital with 89 medical/surgical beds. In 1984, the Provider established the psychiatric unit with 36 beds, leaving 58 medical/surgical beds. In 1986, 58 of the Provider's 89 beds or 65% of its beds were in the psychiatric unit.[22] The Intermediary also notes that there is some indication that the psychiatric unit was expanded to 79 beds (or 88.76% of the beds) in 1986.[23]

The Intermediary contends it is clear that any effect that the change in organization might have on the cost experience of the Provider would have taken place long before the

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21 Intermediary Exhibit I-10.

22 See Intermediary Position Paper at 8.

23 See Intermediary Exhibit I-3.

recertification effective in 1989. Further, in 1984, the Provider's over-all utilization was less than 50% while its utilization in the psychiatric unit was over 90%.

The utilization pattern in subsequent years was as follows:

	1985	1986	1987	1988
Routine	35%	52%	48%	11%
Psychiatric	90%	78%	77%	89%

Intermediary Exhibit I-11

It is the Intermediary's position that the recertification would not have resulted in a distortion in costs since most of the Provider's cost would have been generated from its psychiatric unit anyway. Finally, the Intermediary also points out that there were no major changes in expenses or cost centers between 1989 and 1990.[24]

The Intermediary points out that in HCFA's correspondence dated August 11, 1995,[25] after the revisions to § 413.40 discussed above, HCFA again indicated that "a reassignment of the base period from FY 1984 to FY 1990 is not warranted." Id. The Intermediary contends that determination was supported by the fact that the percentage of beds in the psychiatric unit compared to the total beds indicated the Provider had for some years been focusing on providing psychiatric services. In addition, its overall occupancy compared to the occupancy in the psychiatric unit established that the Provider had not experienced changes in structure in the year of recertification. Finally, HCFA stated ". . . the adjustment process effectively addresses the distortions created by changes in patient care and services." Id.

It is the Intermediary's position that the Provider did not experience distortions in its costs that would affect the comparability of cost reporting periods as a result of the recertification that took place in 1989. Therefore, there is no justification for a new provider exemption or a change in the base year as asserted by the Provider.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS :

1. Law- 42 U.S.C.

   § 1395(v)(1)(A) - Reasonable Cost

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[24] See Intermediary Exhibit I-12.

[25] Intermediary Exhibit I-13.

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 413.40 et seq	-	Limitations on Reimbursable Costs

3. Cases:

Memorial Rehabilitation Hospital of Santa Barbara v.Shalala, 65 F.3d 134 (9th Cir. 1995) Medicare & Medicaid Guide (CCH) ¶ 43,572.

SSM Rehabilitation Institute v. Shalala, 68 F.3d 266 (8th Cir. 1995), Medicare & Medicare Guide (CCH) ¶ 43,685.

4. Other:

57 Fed. Reg. 23659-23660 (June 4, 1992).

57 Fed. Reg. at 39802 and 39829 (September 1, 1992).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts and parties' contentions, finds and concludes as follows:

Issue No. 1 - New Provider Exemption

The Board finds and concludes that HCFA properly denied the Provider's request for an exemption to the TEFRA limits as a new provider. The Board finds the Provider does not qualify as a new provider pursuant to 42 C.F.R. § 413.40(f)(1).

Medicare regulation 42 C.F.R. § 413.40(f)(1) explains that:

> [n]ew hospitals that request and receive an exemption from HCFA are not subject to the rate of increase ceiling imposed under this section. For purposes of this section, a new hospital is a provider of inpatient hospital services that has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership, or both, for less than three full years.

Id. (emphasis added.)

The Board finds that the Provider was primarily operating as a provider of psychiatric services for over five years prior to its recertification as a free standing psychiatric hospital. The Board also finds that the Provider had used a majority of its beds (eighty-nine percent) for psychiatric services during the three years preceding its recertification on June 1, 1989.[26] The Board notes that the Provider began increasing its psychiatric beds in 1984 and continued this increase until all beds were converted to psychiatric beds on June 1, 1989. The Board finds no convincing evidence in the record that the Provider was primarily providing acute care inpatient services, i.e. "a provider of inpatient services that has operated as the type of hospital for which HCFA granted it approval to participate in the Medicare program, under present or previous ownership, or both, for less than three full years." 42 C.F.R. § 413.40(f)(1).

The Board finds that recertification and licensure change in and of itself, will not warrant an exemption as a new provider.

The Board has reviewed the Provider's Exhibit P-3, regarding HCFA's approval of a new base period for a Texas hospital. The Board finds that after its review, the facts in the Texas case can be distinguished from the facts in the current issue.

Issue No. 2 - New Base Year

The Board finds and concludes that HCFA properly denied the Provider's request to change its base year from 1984 to 1990. The Provider's request was based on a revision to the regulations at 42 C.F.R. § 413.40(b)(1) in 1992. The Board finds the Provider does not qualify for a base year change.

The Board has searched the regulations in effect for the subject cost reporting year (FYE 1990) for specific cites related to a provider changing its base year. The Board finds that although there was not a specific subsection[27] related to the assignment of a new base period, there was an adjustment process in § 413.40 to address distortions in costs between the base year and other years. The Board refers to 42 C.F.R. § 413.40(h), Adjustments, which states, in part:

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[26] Intermediary Exhibit I-8.

[27] The Board notes that in the following year, HCFA revised the regulation in §413.40 to include a specific subsection on assigning new base periods. This revision, however, was effective for cost reporting periods beginning on or after April 1, 1990. See 42 C.F.R.
§ 413.40(j)[1990].

(1) Comparability of Cost Reporting Periods

(i) HCFA may adjust the amount of the operating costs considered in establishing cost per case for one or more cost reporting periods, including both periods subject to ceiling and the hospital's base period, to take into account factors that could result in a significant distortion in the operating costs of inpatient hospital services.

42 C.F.R. § 413.40(h)(1)

The Board notes that in Intermediary Exhibit I-14, HCFA granted the Provider an adjustment to the rate of increase. The Board notes that the Provider's request[28] for an exception was based on increased costs in the current year that were not included in its base year.

The Provider argued that in 1992, HCFA proposed a revision to § 413.40 (b)(1) to "clarify" that when a hospital with a distinct part unit, such as a general acute care hospital with a psychiatric subunit, becomes a free-standing hospital, such as a free-standing psychiatric hospital, the hospital's TEFRA base year is to be the first full twelve-month cost reporting period effective with the revised Medicare certification.

The Board finds that there was a proposed and final rule to 42 C.F.R. § 413.40 and it was effective on October 1, 1992. (emphasis added). The following was added to subsection (b)(1), regarding the establishment of a base year for "Cost reporting periods subject to the rate of increase ceiling". The added language, states, in part:

> [w]hen the operational structure of a hospital or distinct unit changes (that is, a free-standing hospital becomes a distinct part unit or vice versa), the base period would be the first full 12-month cost reporting period effective with the revised Medicare certification classification.

42 C.F.R. § 413.40(b)(1)[1992].

The Board also notes HCFA referred to the above addition as a clarification in its comments in the Proposed Rule[29] to the revision of § 413.40. The Board rejects the Provider's argument that because HCFA referred to the above as a clarification, it is automatically retroactive and mandates a base year change. The Board is of the opinion that although this "clarification" may allow for a retroactive application, it does not mandate a retroactive application. (emphasis added).

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[28] Intermediary Exhibit I-13.

[29] See 57 Fed. Reg. 23660 (June 4, 1992) at Provider Exhibit P-1.

As noted above, there was an adjustment process in place in the subject year to address distortions in costs between the base year and other years. Therefore, the Board concludes that, although a recertification of the Provider took place on 1989, this recertification did not cause the Provider to experience distortions in its costs that would require a base year change. The distortions that did occur between the base year and the current year were due to increased and added services. These distortions were effectively addressed through the adjustment process described above.

DECISION AND ORDER:

Issue No. 1 - New Provider Exemption

The Provider is not entitled to a "new provider" exemption from the TEFRA operating cost limits. The HCFA denial letter is affirmed.

Issue No. 2 - New Base Year

A reassignment of the Provider's base period from FY 1984 to FY 1990 is not warranted. The HCFA denial letter is affirmed.

Board Members Participating:

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

Date of Decision: August 08, 1997

FOR THE BOARD:

Irvin W. Kues
Chairman