PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D49

PROVIDER –
St. Elizabeth's Medical Center
Boston, Massachusetts

Provider No. 22-0036

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
Associated Hospital Service of Maine

DATE OF HEARING -
January 30-31, 2001

Cost Reporting Period Ended
September 30, 1997

CASE NO. 98-0489

INDEX

ISSUE:

Was the Intermediary's adjustment (denial) of the transitional care unit new provider exemption proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Elizabeth's Medical Center ("Provider") is a non-profit, general acute care hospital located in Boston, Massachusetts. On October 28, 1996, the Provider opened a 26-bed transitional care unit ("TCU") that was certified on October 31, 1996, as a skilled nursing facility ("SNF") eligible to receive payments under the Medicare Program.[1] On January 15, 1997, the Provider submitted on behalf of the TCU a request for a new provider exemption to Medicare's routine service cost limits for SNFs.[2] The Centers for Medicare and Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), reviewed the Provider's request and, by letter dated June 18, 1997, notified C&S Administrative Services for Medicare ("Intermediary") that the Provider's request was denied.[3] In pertinent part, CMS stated:

> [w]e have reviewed the information submitted with the request of Saint Elizabeth's Medical Center Transitional Care Unit (SE), Provider Number 22-5713, for an exemption to the Medicare skilled nursing facility routine service cost limits. SE is seeking an exemption as a new provider under the regulations at 42 C.F.R. [§] 413.30(e).
>
> A new provider exemption would be granted to those providers of inpatient services that have operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and/or previous ownership, for less than 3 full years. In this regulation [42 C.F.R. § 413.30(e)] the phrase ". . . has operated as the type of provider . . ." refers to whether or not, prior to certification, the institution or institutional complex engaged in providing residents skilled nursing care and related services for residents who required medical or nursing care, or rehabilitation services for the rehabilitation of injured disabled, or sick persons as identified in 42 C.F.R. § 409.33(b) and (c), and did not primarily care and treat residents with mental diseases. Therefore, an exemption is granted based upon the functioning of the entire institution or institutional complex, not just the Medicare certified distinct part . . . . The key to understanding HCFA's regulations and policy concerning new provider exemptions is recognizing that we look at the operation of the institution

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1 Provider Position Paper at 1.

2 Provider Position Paper at 12. Exhibit P-25.

3 On July 1, 1997, Blue Cross and Blue Shield of Maine, Inc., operating as Associated Hospital Service of Maine, replaced C&S Administrative Services for Medicare as the Provider's Intermediary.

or institutional complex under both "past and present ownership" exclusive of specific provider numbers, names, location, etc., since these are subject to change, to determine if and when skilled nursing and/or rehabilitative services were performed.

In addition, the Omnibus Budget Reconciliation Act of 1987 included the Nursing Home Reform provisions that regulate the certification of long-term care (LTC) facilities under the Medicare and Medicaid programs. These provisions became effective for services rendered on or after October 1, 1990. Congress' intent in adopting these provisions was to establish uniform certification standards for all Medicare and Medicaid LTC facilities. The result is that both Medicare SNFs and Medicaid nursing facilities (NFs) are required to provide, directly or under arrangements, the same basic range of services. . . . This range of services includes those nursing services and specialized rehabilitative services needed to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being. Therefore, the range of services for which a Medicaid NF must provide to be certified includes the same types of services as are offered in a SNF that is certified for Medicare. Consequently, a NF, operating as of October 1, 1990, is considered an equivalent provider of skilled nursing or rehabilitative services, by meeting the requirements for certification, effective October 1, 1990, specified in the regulations at 42 C.F.R. Part 483; Subpart B, Requirements for Long-Term Care Facilities.

Given this context, SE became Medicare certified October 31, 1996. However, SE was established due to the purchase and relocation of 29 long-term care beds from an existing long-term care institution known as Friel Nursing Home. Friel Nursing Home, Provider Number 22E098, was certified to participate in the Medicaid program on March 31, 1974. It operated as a NF since October 1, 1990 providing skilled nursing and rehabilitative services for three full years prior to its closure and subsequent relocation to 736 Cambridge Street, 7th Floor, West Wing, Seton Building, Boston, Massachusetts on October 28, 1996. These services included, but were not exclusive of, care of pressure ulcers, subcutaneous and intramuscular injections, as well as rehabilitative services to include occupational therapy, physical therapy and speech pathology. This information was retrieved from the Friel Nursing Home's self-reported resident census reports from its December 1, 1992, January 31, 1994, February 21, 1995 and April 16, 1996 survey and certification as reported in the On-Line Survey and Certification and Reporting System (OSCAR). Therefore, there has been no change in the type of services rendered at either location. This relocation was in accordance with the transfer of site approved by the Massachusetts Department of Public Health, Determination of Need Program based upon the transfer of ownership of Friel Nursing Home to St. Elizabeth's Medical center, assuming relocation of the long-term care facility to the campus of St. Elizabeth Medical Center in accordance with section 31, Chapter 203 of the Acts of 1996.

Section 2604.1 of HCFA Pub. 15-1 allows for an exemption based upon a relocation whereby the normal inpatient population can no longer be expected to be served at the new location. The service area identified by the State includes all of greater Boston, or HSA IV. When we reviewed the first year of admissions for SE, we found that Brighton, Lincoln, Watertown, Newtonville, Charlestown, Brookline, Quincy, Boston (including South Boston), Roslindale, Walpole, Dorchester, Cambridge, Wayland, Waltham, Bedford, Newton Center, Allston, Littleton, Arlington, Billerica, Newton, Weymouth, Concord, Chestnut Hill, Revere, Maynard, Needham, Framingham, Westwood, Natick, Roxbury, Belmont, Somerville, Winchester, and Dedham are all included in this service area. Patients from this service area constituted 89% of all admissions to SE in the first four months of operation.

Consequently, the population served at Friel Nursing Home, which also came from, and was included in, HSA IV, (it was located in Quincy, Massachusetts) can continue to be expected to be serviced at the new location, thereby eliminating the possibility of an exemption for SE based upon the provisions in Section 2604.1 of HCFA Pub 15-1.

Accordingly, the provider does not qualify for a new provider exemption because;

1. SE was established due to the purchase and relocation of 29 long-term care beds from an existing long-term institution known as Friel Nursing Home. This relocation was in accordance with the transfer of site approved by the Massachusetts Department of Public Health, Determination of Need Program based upon the transfer of ownership of Friel Nursing Home to St. Elizabeth's Medical Center, assuming relocation of the long-term care facility to the campus of St. Elizabeth Medical Center in accordance with section 31, Chapter 203 of the Acts of 1996.

2. Friel Nursing Home, Provider Number 22E098, was certified to participate in the Medicaid program on March 31, 1974. It operated as a NF since October 1, 1990 and it provided skilled nursing and rehabilitative services for three full years prior to its closure and relocation to SE. Therefore, [it] is considered to be an equivalent provider.

3. Upon relocation, the population served did not substantially change, nor was there a change in the primary service area.

HCFA Letter, June 18, 1997.[4]

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[4] Exhibit P-26.

On December 17, 1997, the Provider appealed CMS' denial to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $900,000.

The Provider was represented by Mark A. Borreliz, Esq., of Choate, Hall & Stewart. The Intermediary was represented by Eileen Bradley, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that CMS' denial of its request for a new provider exemption to the SNF routine service cost limits is improper. The Provider asserts that its TCU was not established through the purchase and relocation of long-term care beds from Friel Nursing Home ("Friel"). Moreover, even assuming that it had purchased and relocated beds from Friel, which it did not, the Provider asserts that Friel did not operate as the same type of provider or equivalent as its TCU pursuant to 42 C.F.R. § 413.30(e), nor did it serve the same inpatient population pursuant to Medicare's Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2604.1.[5]

The Provider contends that it facilitated the closure of Friel in order to comply with Massachusetts State law. However, that compliance does not represent a "relocation" of Friel to the Provider.[6] The Provider asserts that Friel never had any interest in the TCU. And, even though its agreement with Friel enabled Friel to close and surrender its license to the Commonwealth of Massachusetts ("Commonwealth"), the Provider acquired nothing from Friel. Neither Friel nor any other nursing facility provided the TCU with beds, patients, staff, equipment, referral sources, or goodwill. The TCU did not even acquire its operating rights from Friel. As discussed immediately below, because of passage of the 1996 Mass. Acts, ch. 203, § 31 ("1996 DON Act"), the TCU acquired its operating rights directly from the Commonwealth. In contrast, see South Shore Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/C&S Administrative Services, PRRB Dec. No. 99-D38, April 21, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,182, decl'd rev., HCFA Admin., June 23, 1999, rev'd and reman'd, South Shore Transitional Care Center v. Thompson, Civil Action No. 99-11611-JLT (D.C. MA January 3, 2002), Medicare and Medicaid Guide (CCH) 2002-1 ¶ 300,934 ("South Shore"), where the Board observed that the provider, a Massachusetts hospital that opened a SNF in February 1995, "purchased . . . DON rights directly from [a nursing facility]."

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[5] Provider Position Paper at 13.

[6] Provider Position Paper at 15. Provider Post Hearing Brief at 19. Transcript ("Tr.") at 88 and 174-177.

The Provider explains that Massachusetts' regulations on the establishment of new SNFs derive from an imbalance in the supply of long-term care that existed in the early 1990s.[7] There was, on one hand, a surplus of older "Level III" nursing homes that were not permitted to provide continuous skilled nursing care to patients who had just been discharged from a hospital and were in need of full-time nursing and rehabilitation services. There was, on the other hand, a shortage of more sophisticated "Level II" SNFs that could provide such services. The Massachusetts Department of Public Health ("DPH") addressed this situation in the mid-1990s by establishing: (1) a moratorium on the issuance of new "determinations of need" ("DONs") (105 C.M.R. § 100.302(D)), which are a prerequisite to licensure of any nursing facility in Massachusetts (M.G.L. c. 111, § 25C), and (2) an exception to the moratorium pursuant to which a hospital wishing to open a new Level II SNF could obtain a DON so long as it first arranged, by contract, for the closure of a Level III nursing home.[8] The Provider notes that the DPH Commissioner explained this policy to the Director of CMS' Office of Chronic Care and Insurance Policy in a letter dated February 27, 1996.[9]

The Provider continues by explaining that the moratorium exception could be made to fit within the existing structure of Massachusetts' DON regulations under the fiction that the hospital was acquiring an intangible operating right of the facility slated for closure. The hospital would apply to DPH under 105 C.M.R. § 100.720 for approval of a transfer of site of operating rights for long-term care beds, and DPH, carrying out the fiction of transfer, could grant an approval (which, under the cited regulation, "shall constitute a determination of need for the purpose of original licensure").[10]

In late July 1996, however, the Massachusetts legislature established, as an independent basis for the issuance of DONs (and, therefore, for licensure), the very act of contracting for the closure of a nursing home. The legislature replaced the exception to DPH's DON moratorium with a statute that provides:

> [t]he department of public health is hereby directed to issue a determination of need [for the establishment or expansion of a skilled nursing facility] to any hospital . . . that can demonstrate the following:
>
> > (1) a binding contractual commitment with a nursing home . . . that results in the nursing home's surrender of its license;
> >
> > (2) that such license holder has ceased operation of its facility;

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7 Provider Position Paper at 5.

8 See Exhibits P-7 and P-8.

9 Exhibit P-9.

10 Exhibit P-10.

> (3) that the hospital has developed a hospital based skilled nursing facility and meets the qualifications for licensure and Medicare certification; and
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> (4) that the hospital agrees to be responsible for all overpayments owed to the division of medical assistance by the nursing facility which surrenders its license.

1996 DON Act.[11]

Under this legislation a hospital desiring to establish a SNF does not actually acquire operating rights from another facility; instead, although the hospital still must arrange for a nursing home to close, the hospital receives the operating rights and the underlying DON for its new SNF directly from DPH.[12]

Respectively, the Provider asserts that except for the accident of DPH and the Massachusetts legislature choosing to link hospital-based SNF licenses to the closure of less-sophisticated nursing homes elsewhere, preconditioning one on the other, CMS would not have had any pretext for portraying Friel as a "previous owner" of the TCU or for characterizing the transaction between the Provider and Friel as a "relocation."[13] Clearly, the linkage required between hospital-based TCUs and Level III nursing homes by the 1996 DON Act does not constitute an ownership connection or a transfer of rights.[14]

The Provider acknowledges but rejects the argument that CMS does not abide by DPH's interpretation of Massachusetts law. According to CMS, and contrary to statements made by DPH officials, the Provider purchased a DON from Friel.[15] The Provider explains, however, that CMS' interpretation of its own rules may be entitled to great deference, Thomas Jefferson University v. Shalala, 512 U.S. 504, 512 (1994), but no such deference applies when CMS construes state law. Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 844 (1984) (deference to a federal agency's construction of a statute is appropriate only where the agency is entrusted with administration of the statute). On this principle, federal agencies have refrained from arrogating to themselves the interpretive prerogatives of state authorities. See e.g., In re Oregon System of Higher Education, Dkt. No. 92-25-SP, Final Decision at 22, 1993 WL 452646 at 11 (Educ. Appeals Bd., April 5, 1993) ("[i]t is a well settled maxim of federalism that Federal tribunals should defer to a state's interpretation of its own

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[11] Exhibit P-11.

[12] Id.

[13] Provider Position Paper at 16.

[14] Provider Post Hearing Brief at 30.

[15] Provider Post Hearing Brief at 21.

laws").

The Provider contends, therefore, the fact that the TCU did not operate on the basis of a DON or DON-like rights purchased from another entity, pursuant to state law, distinguishes this case from others in which the Board affirmed CMS' denial of new provider exemption requests. Clearly, the Board's prior decisions affirming CMS' denial of new provider exemption requests in Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,224, decl'd rev., HCFA Admin., June 8, 1998; Mercy St. Teresa Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D64, June 16, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,006, decl'd rev., HCFA Admin., August 7, 1998, aff'd, Case No. C-1-98-547 (S.D. Ohio June 16, 1999); and, Larkin Chase Nursing and Restorative Center v. Mutual of Omaha Insurance Co., PRRB Dec. No. 99-D8, November 24, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,145, decl'd rev., HCFA Admin., January 15, 1999, should have no bearing on the Board's consideration of the Provider's appeal because each of these decisions involved a facility that acquired its operating rights directly from a preexisting facility.[16] The Provider, by contrast, received the DON for its TCU directly from the Commonwealth not from any preexisting provider. Unlike the business entities involved in the aforementioned cases, the Provider never had any other DON rights to establish a SNF. Because the TCU is not in anyway the outgrowth of a related nursing facility, there is no prior ownership that should cloud its entitlement to a new provider exemption and justify comparisons such as those made in these other cases.

The Provider contends that receipt of its DON rights also did not give rise to a change of ownership ("CHOW") as argued by the Intermediary.[17] CMS' proposition that the TCU was previously owned by Friel glossed over several fallacies. First, CMS' State Operations Manual ("HCFA Pub. 15-7") § 3210.1 states:" [t]here can be no CHOW . . . if there is no functioning enterprise in existence." Notably, Friel had ceased to function by the time its transaction with the Provider closed, and Friel was not certified to participate in the Medicare program. Second, even if an asset transfer had occurred within the meaning of HCFA Pub. 15-1 § 1500.7, it does not necessarily mean that the facility has undergone a change of ownership. Nonetheless, CMS' representative stated: "[b]ecause we found a change of ownership [under HCFA Pub. 15-1 § 1500.7] we then looked to the operation of Friel Nursing Home. (Tr. at 623, 629). Third, CMS' decision to rely upon HCFA Pub. 15-1 § 1500.7 to determine that the TCU is a successor to Friel is unreasonable. By its own terms, HCFA Pub. 15-1 § 1500.7 is intended to identify events that require a participating Medicare provider to file a terminating cost report. The manual provision specifically states: "[t]he described events are not intended to define changes of ownership for purposes of determining . . . the continuation of the provider agreement. And fourth, CMS' reliance upon HCFA Pub. 15-1 § 1500.7 is made even less reasonable by the fact that CMS has published vastly more elaborate CHOW guidance. Specifically, Medicare's Part A Intermediary Manual, Part 4 ("HCFA Pub. 13-4") §§ 4500-4502.14, provide that a CHOW for both

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[16] Provider Position Paper at 17. Provider Post Hearing Brief at Footnote 9.

[17] Provider Post Hearing Brief at 25.

certification and reimbursement purposes can arise from a transfer of assets. Significantly, however, it limits such events to: "a purchase of all or substantially all of a corporation's tangible assets. HCFA Pub. 13-4 § 4502.2.

Also regarding this matter, the Provider respectfully submits that the Board's decision in South Shore wrongly applied the CHOW rules to the new provider exemption request in that case, and for the same reasons the CHOW rules should not apply in this case.[18] Specifically, the provider in South Shore opened a new hospital-based SNF pursuant to the exceptions in DPH's moratorium on the issuance of new DON rights. The provider satisfied the moratorium exception by acquiring the DON rights of a Level III facility, Prospect Hill Manor, that had gone into receivership and closed. A majority of the Board determined that the transaction with Prospect Hill Manor was a CHOW and, therefore, that Prospect Hill Manor was a previous owner of the provider's new SNF. In fact, neither the provider in South Shore nor the Provider at hand acquired a DON as a result of a CHOW, and CMS' CHOW rules should not have any bearing on the Provider's new provider exemption request.

The Provider asserts that the purpose of the CHOW regulation is to identify those situations in which an "existing [Medicare] provider agreement" will be assigned automatically to a new owner. 42 C.F.R. § 489.18(c). Manual instructions further elaborate that a CHOW triggers a provider's obligation to file a final Medicare cost report. See HCFA Pub. 15-1 § 1500. Under the CHOW regulation and the related manual provisions, a CHOW occurs upon:

> (1) certain changes in the composition of a partnership (42 C.F.R. § 489.18(a)(l); HCFA Pub. 15-1 § 1500.1);
>
> (2) the transfer of title and property of an unincorporated sole proprietorship (42 C.F.R. § 489.18(a)(2); HCFA Pub. 15-1 § 1500.2);
>
> (3) the "merger" or "consolidation" of a corporation (42 C.F.R. § 489.18(a)(3); HCFA Pub. 15-1 § 1500.3);
>
> (4) the leasing "of all or part of a provider facility" (42 C.F.R. § 489.18(a)(4); HCFA Pub. 15-1 § 1500.4);
>
> (5) the transfer of a provider from one government entity to another (HCFA Pub. 15-1 § 1500.5);
>
> (6) the "donation of all or part of a provider's facility" (HCFA Pub. 15-1 § 1500.6);

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[18] Provider Position Paper at 17.

(7) "[d]isposition of all or some portion of a provider's facility or assets (used to render patient care) through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity" (HCFA Pub. 15-
1 § 1500.7); or

(8) a bankruptcy filing by a provider (HCFA Pub. 15-1 § 1500.8).

Accordingly, the Provider asserts that the CHOW rules have no place in this case because Friel, like Prospect Hill Manor, was never certified under Medicare and never had an "existing provider agreement." 42 C.F.R. § 489.18(c). Neither did Friel or Prospect Hill Manor ever have an obligation to file a Medicare cost report let alone a final Medicare cost report. Consequently, the CHOW rules should have no bearing on the transaction between Friel and the Provider.

The Provider also asserts that even if the CHOW rules were applied in this case the result should not be a finding that a CHOW occurred. None of the eight events that can constitute a CHOW happened here. First, Friel was not a partnership or a sole proprietorship; the Provider did not lease anything from Friel; neither Friel nor the Provider is, or was, affiliated with the government; Friel did not donate anything to the Provider; and, Friel did not file for bankruptcy protection. Second, although Friel and the Provider are both corporations, no merger or consolidation between them ever occurred. Finally, the transaction between the Provider and Friel did not constitute the "disposition . . . of a provider's . . . assets (used to render patient care)" within the meaning of HCFA Pub. 15-1 § 1500.7. Again, Friel was not a participating provider in the Medicare program, so there were no "provider's assets" to be acquired.

Furthermore, the Provider never received any assets from Friel. The only contemplated consideration -- an intangible operating right -- was expressly superseded by the 1996 DON Act, under which the Provider's operating rights emanated purely from the Commonwealth. And finally, even if contrary to fact the Provider was considered to have acquired operating rights for the TCU from Friel, such an intangible right to operate beds is not an asset used to render patient care. Rather, it is simply the nursing facility equivalent of a driver's license. Patient care is delivered by trained personnel utilizing supplies and specialized equipment, none of which the Provider acquired from Friel. The Provider built, furnished, equipped and staffed its own new facility, and it provides patient care without reliance on any assets disposed of by Friel.

CMS' application of the CHOW rules to transactions such as the Provider's acquisition of Friel appears to rely upon HCFA Pub. 15-1 § 2533.1, that did not go into effect until September 1997, long after the Provider submitted its new provider exemption request. See HCFA Transmittal No. 400.[19] In this manual instruction CMS states that it will

[19] Exhibit P-5.

consider a CHOW to have taken place even if one of the entities involved in the transaction did not participate in Medicare, as follows:

> [f]or purposes of determining new provider status, these [CHOW] transactions apply to entities currently participating in Medicare, as well as to those nonparticipating entities such as, a Medicaid certified nursing facility or a nursing home not certified for Medicare.
> HCFA Pub. 15-1 § 2533.1.E.1.[20]

This manual provision conflicts, however, with the CHOW rules which apply only to transactions between Medicare providers. Notably, application of these CHOW rules to the transaction between the Provider and Friel has no legal basis since HCFA Pub. 15-1 § 2533.1 was not in effect when the Provider lodged its new provider exemption request, and because Friel never was a Medicare provider.

The Provider notes that this new manual provision further elaborates that CMS will deem a CHOW to have occurred if "an institution . . . purchases the right to operate (i.e., a certificate of need) long-term care beds from an existing institution . . . (be it open or closed), that has or is rendering skilled nursing or rehabilitative services to establish . . . a long-term care facility." HCFA Pub. 15-1 § 2533.1.E.l.b. This policy, adopted months after CMS denied the Provider's new provider exemption, was not until then a part of CMS' interpretation of 42 C.F.R. § 413.30, and cannot be retroactively applied to the Provider.

Notwithstanding, the Provider contends that its TCU is entitled to new provider status based upon comparisons of its level of care and patient base to that of Friel.[21]

The Provider asserts that its TCU does not operate as the same type of provider as Friel. As noted, Friel provided long-term care to persons who did not require skilled nursing services. Friel was licensed as a Level III intermediate care facility and was certified as a Medicaid NF. Friel was not Medicare certified or licensed to provide continuous skilled nursing services. To the extent Friel provided nursing services characterized by CMS as "skilled," it did so only on an episodic basis. In contrast, the TCU is licensed to/and actually provides continuous skilled nursing services to its patients who require such care.

The Provider maintains that CMS' conclusion that Friel's status as a NF means that it was the same type of provider as the TCU is unfounded for three reasons. First, the fact that Friel, as a condition of certification as a Medicaid NF, had to be capable of providing a full range of nursing services begs the question actually put by 42 C.F.R. § 413.30(e); the correct inquiry under the regulation is whether Friel "operated as the [equivalent] type

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[20] Exhibit P-34.

[21] Provider Position Paper at 21.

of provider . . . for which [the TCU] is certified for Medicare," that is, as a SNF. (emphasis added).

What it means to operate as a SNF is not left to CMS' improvisation but is governed instead by statutory definition. According to 42 U.S.C. § 1395i-3(a), a SNF, among other things:

> (1) is primarily engaged in providing to residents-
>
> (A) skilled nursing care and related services for residents who require medical or nursing care, or
>
> (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons . . .

42 U.S.C. § 1395i-3(a) (emphasis added).[22]

NFs do not satisfy this requirement. Friel, for example, although it had a theoretical ability to provide skilled nursing care, and may in fact have done so on isolated occasions, was "primarily" engaged in giving its patients maintenance care. Friel never was "primarily" engaged in giving skilled nursing care or rehabilitation services to its patients. CMS suggests no way of reconciling this definitional clash; indeed, CMS' decision completely ignores this seemingly fundamental feature of the law.[23]

Second, CMS' conditions of participation for long-term care facilities draw material distinctions between Medicaid NFs and Medicare SNFs. For example, the supposedly "uniform" requirement that long-term care facilities maintain licensed nurse coverage around the clock (42 C.F.R. § 483.30(b)) actually can be waived completely for a NF when the conditions set forth in 42 C.F.R. § 483.30(c) are satisfied. By contrast, CMS' regulations do not permit a Medicare SNF ever to maintain licensed nurse coverage for less than 24 hours per day. 42 C.F.R. § 483.30(a). Similarly, while a SNF may have the registered nurse coverage requirement reduced only to 40 hours per week (42 C.F.R. § 483.30(d)), a NF again may have the requirement completely waived. Furthermore, in the case of Medicaid NFs but not Medicare SNFs, any required physician task may, at the option of the state, be performed instead by a nurse practitioner, clinical nurse specialist, or physician assistant. 42 C.F.R. § 483.40(f). The fact that a facility is certified by Medicaid as a NF thus only begins the inquiry into whether it operates in the same manner as a SNF. As the certification rules implicitly recognize and accommodate, the actual operations of a Medicaid NF may so differ from the operations of a SNF as to relieve the NF from having to comply with standards applicable to providers primarily engaged in rendering skilled nursing care.

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[22] Exhibit P-36.

[23] Provider Post Hearing Brief at 35. Tr. at 62, 256, 281, 491 and 637.

The Intermediary argues that Friel must be regarded as a SNF because the Omnibus Budget Reconciliation Act of 1987 ("OBRA") required that Medicaid-certified nursing facilities, such as Friel, be certified to provide skilled nursing services.[24] However, this argument is misguided. Pursuant to 42 C.F.R. § 413.30(e), if the applicant for an exemption is a SNF, the question is not whether the applicant's previous owner was "certified" to provider some skilled services; rather, the regulation mandates that CMS ask whether the previous owner "operated" as a SNF or the equivalent. Under the statutory definition of SNF, an institution does not operate as a SNF merely by being "certified" to provide skilled services.

And third, CMS' reliance on any past instance of skilled nursing service to determine the SNF-equivalent nature of a Medicaid NF is inconsistent with Medicare's required mode of analysis for characterizing the nature of care a facility provides. For example, on May 12, 1998, CMS issued regulations implementing a prospective payment system for SNFs. 63 Fed. Reg. 26252, 26283-85 May 12, 1998.[25] These rules set forth a sophisticated stratification system for classifying SNF patients into one of 44 Resource Utilization Groups ("RUGs") to which different payment rates apply. Only 26 of the 44 RUGs are presumptively reimbursable under the Medicare program. SNF residents classified into one of the 18 other RUGs are presumed not to meet the statutory criteria for SNF level of care, regardless of whether skilled services are actually furnished to the resident, absent an individual factual determination to the contrary under the SNF coverage rules of 42 C.F.R. §§ 409.30 and 409.35. Under 42 C.F.R. § 409.34, in order for a patient's stay to qualify as a SNF stay, skilled nursing services "must be needed and provided 7 days a week." The incidental or isolated administration of a skilled service is not enough to qualify the stay for SNF reimbursement.

Similarly, in the context of deciding whether a hospital stay is excluded from Medicare coverage as a custodial care stay or instead constitutes a covered skilled care admission, the fact that the patient might receive some skilled services in the course of the stay is not determinative. To the contrary, CMS' rules require an analysis that takes the larger reality into account. Under Medicare's Hospital Manual, ("HCFA Pub.10") § 261.1.B.2, one must look to the primary purpose of the care furnished:

> [i]f the primary purpose of the total care provided an individual is to assist him in meeting the activities of daily living, the custodial care exclusion applies and no payment can be made under the program for any of the care furnished him. However, if the skilled services furnished the patient are the primary purpose for the total care provided, the custodial care exclusion does not apply and payment may be made for services covered under the program.

Id. (Emphases added.)

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[24] Provider Post Hearing Brief at 37. Tr. at 42 and 791.

[25] Exhibit P-39.

The Provider explains that it would be anomalous to hold that the furnishing of skilled nursing services to an individual patient, while insufficient on its own to make the patient's stay a skilled nursing stay, nonetheless suffices to make the provider as a whole the equivalent of a skilled nursing provider. Under this self-contradictory approach, a provider could be deemed to have operated as a SNF without ever having had a skilled nursing admission. On the other hand, no contradiction would arise if the character of the facility were determined by reference to the larger reality, which is the type of care in which the provider was "primarily engaged" in accordance with the Medicare statute.

The Provider further asserts that even if the TCU were considered a "relocated" provider, it would still be entitled to new provider status pursuant to HCFA Pub. 15-1 § 2604.1 since it serves a substantially different inpatient population than that formerly served by Friel.[26] Specifically, HCFA Pub. 15-1 § 2604.1 allows for the issuance of a new provider exemption so long as a relocated provider can demonstrate that (1) "in the new location a substantially different inpatient population is being served," and (2) "the total inpatient days at the new location were substantially less than at the old location for a comparable period [of at least three months] during the year prior to the relocation."

Respectively, the Provider argues that its TCU satisfies these conditions. First, the treatment needs of Friel's patients were dramatically different from those of the patients the TCU serves. Friel's normal population consisted exclusively of patients who did not require the continuous skilled care that the TCU offers. Friel's patients were truly long-term; they stayed for years and Friel's primary care for them was purely supportive in nature. The patients that Friel served would not have required the advanced skilled nursing services that the TCU furnishes its patients, nor would it have made economic sense for the patients or for third party payors to treat Friel's patients at a facility like the TCU. At the TCU, patients typically suffer from the immediate after-effects of acute conditions that require care considerably more sophisticated than the care Friel offered. Furthermore, the TCU's patients stay in the facility for only a few days after which they return to their homes.

The Provider notes that the patient bases of Friel and the TCU show wide geographical differences. As HCFA Pub. 15-1 § 2604.1 notes, a provider's "relatively short distance" move within a metropolitan area may substantially affect the patient base it serves in cases where the provider is a general care facility, such as a general hospital. Nursing facilities, like general hospitals, are general care facilities that typically attract patients only from nearby neighborhoods and towns. Thus, Friel, based in Quincy, primarily served Quincy and other South Shore towns southeast of Boston. The TCU, on the other hand, is in the northwest corner of Boston and primarily serves northwestern Boston and towns north and west of Boston. There is little commonality between the facilities' respective geographical patient bases: while more than three-quarters of Friel's patients appear to have been from Quincy or from six towns surrounding Quincy including

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[26] Provider Position Paper at 25.

Weymouth, Randolph, Braintree, Milton, and Scituate, only three percent of the TCU's patients were from Quincy or those towns.[27]

The Provider notes that CMS offered no reasoned explanation for its conclusion that the TCU could expect to serve the same patients as had been served by Friel. CMS' decision cites no evidence of market overlap, patient transfers, common referral sources, or the like. Instead, CMS begins and ends its inquiry with the simple observation that the TCU and Friel were co-located in Health Service Area ("HAS") IV. If held to no greater burden of analysis or reason than this, CMS could as freely hold that no material relocation exists where a provider and its former situs lie within the same state.

With respect to the second condition of HCFA Pub. 15-1 § 2604.1, the Provider asserts that the TCU's total inpatient days were substantially less than Friel's. The TCU suffered from exactly the sort of low occupancy that CMS intended the new provider exemption to address; whereas Friel, even as it was about to close, operated at nearly full occupancy. In contrast, the TCU, during its first full three months of operation had an average occupancy of 42.9 percent. Friel's occupancy rate in its last three months of full operation was 93 percent. In other words, the TCU's occupancy rate was less than half the rate that Friel enjoyed. The TCU's patient days clearly were substantially less than Friel's.

Finally, the Provider contends that CMS' denial of its exemption request is inconsistent with the way CMS administered the new provider exemption rules in the past.[28] Previously, CMS approved a new provider exemption request submitted by a provider that obtained its operating rights from another nursing facility, just as, according to CMS, the Provider obtained its operating rights. In January 1994, Meridian Healthcare Center at Spa Creek ("Spa Creek") opened a Medicare-certified SNF after obtaining operating rights in part from an existing nursing facility. See letter from William McNeal to Betty Betler, February 4, 1994; and, letter from Joseph Dvorak to Dennis Phipps, March 15, 1994 (enclosing Certificate of Need showing that Spa Creek would consist of "40 beds relocated from other Meridian comprehensive care facilities").[29] Thus, to the extent that CMS claims that the TCU is a "relocated" nursing facility, Spa Creek also must have been a "relocated" facility. In spite of this circumstance, one which CMS found sufficient to disqualify the Provider from obtaining new provider status, CMS granted Spa Creek's request for a new provider exemption.[30] See also, San Diego Physicians &

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[27] Provider Position Paper at 26. Provider Post Hearing Brief at 39. Tr. at 237, 317, 418, 422 and 563.

[28] Provider Position Paper at 27. Provider Post Hearing Brief at 44.

[29] Exhibits P-42 and P-43.

[30] Exhibit P-44.

Surgeons Hospital v. Aetna Life Insurance Company, HCFA Admin. Dec., January 12, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,007 at 25,062.[31]

Furthermore, CMS repeatedly has approved new provider exemption requests for facilities operating as NFs after the implementation of the OBRA certification standards, that later converted to SNFs. See e.g., Exhibits P- 45 and P- 46 (showing CMS files of two providers that received new provider exemptions after converting from NF to SNF status). If CMS had considered these providers' new provider exemption requests using the same mode of analysis that CMS employed in considering the Provider's exemption request, CMS inevitably would have determined that each of these providers had operated as an "equivalent" type of provider during the three years prior to opening as a SNF. Obviously, CMS approved these requests without employing the standards that it used to justify its denial of the Provider's request.

As these decisions show, CMS has not applied the new provider regulation consistently. CMS' past determinations granting new provider exemptions to SNFs that acquired their operating rights from existing providers or that previously operated as NFs cannot be reconciled rationally with CMS' decision here to deny the Provider its new provider exemption request. In practice, then, CMS has applied the new provider exemption regulation arbitrarily. Such blatant violation of the Administrative Procedure Act mandates reversal by the Board. See 5 U.S.C. § 706 (agency decision must be set aside if it is "arbitrary");[32] see also Saint Mary of Nazareth Hospital Center v. Schweiker, 718 F.2d 459, 465 (D.C. Cir. 1983) (where CMS "in effect condoned reimbursement practices diametrically opposed to the agency's interpretation . . . [no] particular deference is due the present interpretation of controlling regulations merely because it is the interpretation of the administering agency").[33]

In all, the Provider contends that policy reasons dictate that its TCU should be granted new provider status.[34] The Provider explains that the purposes of the new provider exemption are to recognize and accommodate the special circumstances that confront a new entrant into the long-term care market. In particular, Medicare has repeatedly articulated the underlying objective of recognizing the higher unit costs that new providers incur as the result of start-up costs and or low occupancy. CMS' application of the new provider exemption rules to this case, as well as other recent cases involving Massachusetts providers that opened hospital-based SNFs through similar transfers of operating rights, has wandered far afield of the policy objectives that should canalize interpretations of 42 C.F.R. § 413.30(e). Allowing substance to prevail over form, there is no question that the TCU is a bonafide new provider of skilled nursing services and

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[31] Exhibits P-3 and P-4.

[32] Exhibit P-49.

[33] Exhibit P-50.

[34] Provider Position Paper at 29.

that the Provider incurred start-up costs to accomplish its creation. It is pure fiction to suggest that the TCU is a re-start of Friel and that the federal government is somehow at risk of paying twice for the costs of establishing the same facility. As demonstrated earlier, there is no substantive continuity between the two facilities, and the transaction with Friel, without the transfer of any patients, hard assets, or even, technically, operating rights, cannot be said to have relieved the TCU of either the business risks of becoming a Level II provider or the costs of establishing a new facility. Clearly, the Provider had no guaranteed patients when it opened its doors, and it operated at low occupancy in its initial months.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider's request for a new provider exemption to the SNF routine service cost limits was properly denied. The Intermediary asserts that the subject hospital-based SNF had provided skilled nursing and rehabilitative services for more than three years under past and present ownership prior to becoming certified in the Medicare program.[35] This fact automatically disqualifies the Provider's SNF for a new provider exemption pursuant to 42 C.F.R. § 413.30(e), which states in part:

> [a] new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

42 C.F.R. § 413.30(e).

The Intermediary explains that this determination is based upon the following analysis of the facts in this case.[36]

First, CMS determined that the "type of provider" requesting the exemption was a SNF. A SNF is defined at 42 U.S.C. § 1395i-3 as an institution that is engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured and disabled, or sick persons and does not primarily care and treat residents with mental diseases.

Next, to determine the length of the operation, CMS looked at the operation of the institution under both past and present ownership. Here it was determined that Friel was the original owner of the institution, and had operated as a nursing home since at least 1974, the year it was certified to participate in the Medicaid program. Significantly, the State transferred ownership of Friel to the Provider in 1996, pursuant to the Asset-Purchase Agreement dated February 28, 1996, between Friel and the Provider wherein

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[35] Intermediary Position Paper at 28.

[36] Intermediary's Position Paper at 22.

the Provider acquired all rights of Friel to operate a 29 licensed bed nursing home.[37] As stated by the Commonwealth's DPH, in its letter dated May 1, 1996:

> [t]he Department understands that St. Elizabeth's and Friel have executed an agreement whereby St. Elizabeth's will acquire certain assets of Friel . . . . In order to facilitate the transaction, the Department is granting permission to temporarily discontinue operation of Friel . . . . This approval is granted to allow for the sale of Friel to St. Elizabeth's and is contingent upon continued progress in effectuating the sale.

Commonwealth of Massachusetts, DPH, letter dated May 1, 1996.[38]

The Intermediary adds that, in fact, the Provider was required to undergo a transfer or change of ownership pursuant to 105 C.M.R § 153.022 of the Massachusetts code. Such a transaction also constitutes a change of ownership for purposes of Medicare reimbursement.

The Intermediary believes it is important to understand that any applicant who intends to acquire a long-term care facility in the State of Massachusetts must submit a Notice of Intent form to the Massachusetts Department of Public Health, Division of Health Care Quality ("DHCQ"). 105 C.M.R. § 153.022. This form is a prerequisite to a suitability review that is also preformed by DHCQ to determine if the new owner should be granted the transfer of ownership. Once approved by DHCQ, a new owner that seeks to effect a transfer of site of any approved project or a change in location of an existing long-term care facility must submit a written request to the Determination of Need Program and publish the proposed change in the local newspaper.

With the enactment of the DON Act, any hospital licensed pursuant to the General Laws of Massachusetts must enter into a contract to purchase the DON granted to the existing nursing facility thus causing it to surrender its license and then close. The hospital must then license and begin operation of its hospital-based SNF and submit evidence that it has agreed to be responsible for all overpayments owed the Division of Medical Assistance by the nursing facility it has purchased. All of these requirements must be met prior to receiving a "new" DON. In reality, the process has not changed at all, even though the Provider would like one to believe differently; it has just been inserted into the Massachusetts General laws. If anything, the requirement to agree to be responsible for the overpayments of the acquired nursing facility owed to the Division of Medical Assistance makes the CHOW even more compelling.

The Intermediary believes it is also important to understand that 40 States have a CON program, a moratorium, or both. Consequently, health care facilities are being forced to live within the constraints of their State CON programs which are specifically designed

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[37] Exhibit I-21.

[38] Exhibit I-23

to limit the growth of new health care facilities. However, these policies have not impacted the ability of institutions from being granted a new provider exemption.[39]

And finally, CMS found that Friel had, in fact, provided skilled nursing and related services and rehabilitative services for more than three years prior to the transfer of ownership and the transfer of site to the Provider. These services included, but were not limited to: treatment of pressure ulcers and widespread skin disorders, subcutaneous and intramuscular injections, and specialized rehabilitative services. Specialized rehabilitative services include occupational, physical and speech therapies which were provided by a physical therapist who was employed under contract to provide therapy services to residents on-site.[40] Notably, these services represent only what was actually being provided to residents in-house on the dates of CMS' survey and do not represent all of the skilled nursing and related services or rehabilitative services provided by Friel since it began operating. The date of the first provision of a skilled nursing or rehabilitative service is unknown; therefore, CMS used December 1, 1992, to calculate whether or not the Provider was entitled to an exemption. This is the date of the earliest known provision of a skilled nursing or rehabilitative service based on the data found in the Resident Census and Characteristics Report as contained in the On Line Survey and Certification and Reporting System ("OSCAR").

Essentially, CMS reviewed the documentation submitted by the Provider to determine the types of services the distinct part SNF had provided under past and present ownership. HCFA used the examples of skilled nursing and rehabilitative services set forth at 42 C.F.R. § 409.33 et seq. to determine if any of these services had been provided by the institution since it began operating in 1974. CMS validated this documentation using Friel's Resident Census and Characteristics Reports filed at the time of their 1992, 1994, 1995 and 1996 survey and certification for participation in the Medicaid program.

The Intermediary rejects the Provider's claim that Friel provided only custodial services or supportive services. The Intermediary asserts that Friel did, in fact, provide skilled nursing and related services and rehabilitative services. According to the Intermediary, custodial services include assisting an individual in the activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. As a Medicaid certified NF, Friel was required to provide NF services. These are defined at 42 C.F.R § 440.40 as those services needed on a daily basis, and required to be provided on an inpatient basis under 42 C.F.R. §§ 409.31 through 409.35. Moreover, these services must be ordered by and provided under the direction of a physician, and furnished by a facility or distinct part of a facility that is certified to meet the requirements for participation. The regulations found at 42 C.F.R. §§ 409.31 through 409.35 govern Medicare coverage in a SNF and include the examples of skilled nursing

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[39] See Exhibits I-43 and I-44.

[40] Exhibits I-26 and I-27.

and rehabilitative services that CMS uses when determining whether or not an institution has operated in the manner of a SNF prior to certification in the Medicare program, as discussed above.

In addition, the Intermediary refers to the Nursing Home Reform provisions of OBRA that regulate the certification of long-term care facilities under the Medicare and Medicaid programs.[41] According to the Intermediary, these provisions became effective for services rendered on or after October 1, 1990. The result is that both Medicare SNFs and Medicaid NFs are required to provide, directly or under arrangements, the same basic range of services described in 42 U.S.C. § 1395i-3(b)(4). This range of services includes those nursing services and specialized rehabilitative services needed to attain or maintain each resident's highest practicable level of physical, mental, and psychosocial well-being.

The Intermediary asserts that CMS uses language to this effect in the letter it sends to fiscal intermediaries informing them of its decisions on exemption requests. The use of this language conveys to an institution that has operated as a NF prior to participating in the Medicare program that CMS has verified, through the OSCAR system, that it has provided skilled nursing or rehabilitative services as a NF prior to entering the Medicare program. Such verification did not occur until sometime in 1995. Prior to that time, CMS relied solely upon the institution to honestly report the correct dates of service.

The Intermediary explains that Congress' intent in adopting the Nursing Home Reform provisions was to: "apply a single, uniform set of requirements to all nursing facilities participating in Medicaid, eliminating the current regulatory distinctions between skilled and intermediate nursing facilities." OBRA (P.L. 100-203) at 453.[42] Therefore, the Intermediary argues that the law established a single standard of "skilled" care for all Medicare and Medicaid nursing facilities.[43]

The Intermediary also asserts that the establishment of a "single standard of skilled care" has been upheld in Newman v. Kelly 849. F. Supp. 228 (D.D.C. 1994), where the Court held:

> [e]ffective October 1, 1990, pursuant to the Nursing Home Reform Law, every nursing home resident covered by Medicare and/or Medicaid is entitled to skilled nursing care, defined by the statute as the level of care necessary to attain the highest-practicable physical, mental and psycho-social well-being of each resident . . . . Viewed in isolation, the difference in the terms "skilled nursing

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41 Provider Position Paper at 30

42 Exhibit I-63.

43 Exhibit I-64

> facility" under Medicare and "nursing facility" under Medicaid imply that a level of care distinction may be inferred between the two statutes. While a technical difference does exist in the terms used to describe the facilities eligible for reimbursement under the two schemes, the substantive definition of the facilities covered is the same in both statutes . . . . The statutory definitions clearly state that "skilled" care must be provided to all residents who require nursing care under either the Medicare or Medicaid reimbursement schemes . . . . In addition, there is no indication in these definitions or statutory schemes that any distinction should be made on the basis of the level of skilled care required by the resident who is eligible for Medicaid or Medicare benefits.

Id.

Therefore, the court finds that the term "skilled nursing facility" in 42 U.S.C. § 1395i-3 is the substantial equivalent of the term "nursing facility." The Provider does not agree with this interpretation of the law nor CMS' application of it in the exemption process. However, such disagreement is contrary to that of the nursing home industry, which has argued this interpretation in order to obtain relief under the Boren Amendment for its perceived inadequacy in Medicaid payments to NFs. Kansas Health Care Association, Inc. v. Kansas Department of Social and Rehabilitation Services, 754 F. Supp. 1502 (D. Kansas 1990).[44]

The Intermediary acknowledges the Provider's argument that a SNF is not equivalent to a NF. That is, because the Provider believes that Friel was not engaged in providing skilled nursing and related services or rehabilitative services, but merely provided supportive care or assistance with activities of daily living. The Intermediary points out, however, that institutions participating in the Medicare and/or Medicaid programs are granted the authority not only to determine the scope of services they will provide but also to determine the total number of inpatient days available to beneficiaries.[45] However, once a beneficiary is admitted for inpatient services, any and all services they require including skilled nursing and related services or rehabilitative services must be provided. Accordingly, the Intermediary asserts that it is not uncommon to find that a NF may not be furnishing skilled nursing or rehabilitative services as frequently as a SNF that chooses to provide those services on a more frequent basis. There is no "look behind" to determine the quantity of the skilled nursing and related services or rehabilitative services either in the certification process or in the determination of an exemption request. As long as an institution meets the

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[44] Exhibit I-66.

[45] Exhibit I-67.

"Requirements for Long-term Care Facilities" it can participate in Medicaid as a NF or in Medicare as a SNF. In fact, regulations at 42 C.F.R § 413.30(e), which govern the new provider exemption, do not distinguish between those institutions that provide a low volume of skilled nursing and related services or rehabilitative services and those who provide a high volume, exactly for these reasons.

The Intermediary contends that the Provider also does not qualify for a new provider exemption based upon CMS' "relocation" rule.[46] That is, program instructions at HCFA Pub. 15-1 § 2533.1.B.3, which state in part:

> [a]n institution or an institutional complex that has undergone a change in location may be granted new provider status when the normal inpatient population can no longer be expected to be served at the new location.

Id.

Respectively, CMS did not find that the change in location from Carney, Massachusetts, the previous location of Friel, to Boston, Massachusetts, the present location of the Provider's distinct part SNF, changed Friel's health service area, known as HSA IV, more commonly referred to as greater Boston.[47] An analysis of the data showed that 89 percent of the population served in the new location came from HSA IV and that 86 percent of the population served in the old location could continue to expect to be served in the new location.[48]

The Intermediary notes that in order for a provider to receive a new provider exemption under the relocation provision of HCFA Pub. 15-1 § 2533.1.B.3, it must also demonstrate that it experienced a substantial decrease in patient days at the new location. The Intermediary also notes, however, that CMS did not address this second requirement since it had already been determined that the Provider's distinct part SNF was ineligible for a new provider exemption under the change in location provision discussed immediately above. This denial is consistent with other determinations by CMS that have been upheld by the Board. (See Indian River Memorial Hospital (Florida) v. Blue Cross and Blue Shield Association/Blue Cross of Florida, PRRB Dec. No. 87-D 104, September 24, 1987, Medicare & Medicaid Guide (CCH) ¶ 36,670, aff'd., HCFA Admin., November 17, 1987; Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, Medicare & Medicaid Guide (CCH) ¶ 46,224, decl'd rev., HCFA Admin., June 8, 1998; Larkin Chase Nursing and Restorative Center v. Mutual of Omaha Insurance Company, PRRB Dec. No. 99-D8, November 24, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,145, decl'd rev., HCFA Admin., January 15, 1999; and South Shore Hospital Transitional Care Center v. Blue

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[46] Provider Position Paper at 28.

[47] Exhibit I-51.

[48] Exhibit I-52.

Cross and Blue Shield Association/C&S Administrative Services, PRRB Dec. No. 99-D38, April 21, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,182, decl'd rev., HCFA Admin., June 23, 1999; and, most recently, Maryland General Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Maryland, PRRB Dec. No. 99-D69, September 20, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,334, rev'd, HCFA Admin., November 22, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,406.

The Intermediary rejects the Provider's argument that it established its distinct part SNF to reduce the relatively high cost of a hospital stay and have the benefit of proximity to hospital facilities.[49] The Intermediary asserts that the Provider did not consider establishing relationships with other SNFs in the surrounding area.

The Intermediary explains that there are 173 SNFs located in the health service area in which the Provider is located. Five of these facilities are located less than 8 minutes away from the Provider, with three others less than 2 minutes away. Moreover, several of these facilities provide a full range of skilled nursing and related services as provided by the Provider's distinct part SNF, including radiation therapy, intravenous therapy, chemotherapy and dialysis, and all have a rehabilitation program. According to the Intermediary, it is clear that the Provider's hospital patients recovering from major medical ailments could choose to be discharged to these other SNFs for appropriate care with the knowledge that their attending physician would follow them.

The Intermediary contends that in reality the Provider established its distinct part SNF to avert the consequences of Medicare's prospective payment system ("PPS") in favor of cost-based reimbursement available to the SNF, and not to benefit all of its hospital patients.

The Intermediary explains that over 77 percent and 67 percent of the patients in the Provider's SNF were Medicare beneficiaries in the cost reporting periods ended September 30, 1997 and September 30, 1998, respectively. In contrast, only 51 percent and 56 percent of the Provider's hospital patients, respectively, were Medicare beneficiaries in these same cost reporting periods.[50]

The Intermediary adds that the Provider is taking full advantage of operating a distinct part SNF by achieving a 75 percent occupancy rate in the first eleven months of operation and 82 percent in its second year.[51] These are far higher occupancy levels than would be expected of a new provider. Moreover, the Provider stated that it sought to establish the

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49 Intermediary Position Paper at 34.

50 Exhibits I-69 and I-70.

51 Id.

distinct part SNF in order to "reduce the relatively high cost of a hospital stay." The Intermediary asserts, however, that the facts demonstrate otherwise.

In the cost reporting period ended September 30, 1994, the Provider's average routine service cost for a hospital stay was $456.92.[52] In the cost reporting period ended September 30, 1998, its average routine service cost of a hospital stay had risen to $500.56.[53] The Intermediary points out that this increase incurred even though the Provider's length of stay declined from a high of 8.82 days for Medicare beneficiaries in the cost reporting period ended September 30, 1994, to a low of 6.21 days in the cost reporting period September 30, 1997, the year in which the distinct part SNF began operations.[54]

The Intermediary believes it is clear that the Provider's distinct part SNF was established to maximize reimbursement from the Medicare program. The Provider not only receives reimbursement from Medicare for beneficiaries who require an acute care stay, but it also receives payment based upon reasonable cost for beneficiaries who require a stay in the distinct part SNF, which would have been part of the hospital payment in years past. The Intermediary also believes these reimbursements are improperly shifting costs to the Medicare program.

Specifically, pursuant to 42 U.S.C. § 1395x(v)(l)(A), the Medicare program is not to bear the cost of services furnished to individuals it does not cover. Respectively, a majority of the patients in the Provider's SNF are Medicare beneficiaries not hospital patients; therefore, the Intermediary finds that the costs with respect to individuals not so covered by the Medicare program are in fact inappropriately being borne by the Medicare program de facto.

The Intermediary also contends that the upward adjustment to the routine service cost limits that has already been approved for the Provider fulfills Medicare's responsibility to reimburse the reasonable cost of services furnished Medicare beneficiaries. The Intermediary explains that an exception allows a provider to receive an upward adjustment to its routine service cost limit under the circumstances specified at 42 C.F.R. § 413.30(f) only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary. Respectively, the Provider was granted an exception because it was found to be providing atypical services. The amount granted for the cost reporting period ended September 30, 1997, was an additional $115.45 per day, which resulted in a payment of $584,292.45 over the routine service cost limit for that cost reporting period.[55]

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[52] Exhibit I-71.

[53] Exhibit I-72.

[54] Exhibits I-73 and I-74.

[55] Exhibit I-78.

The Intermediary explains that none of the factors essential for granting an exception to the cost limits, i.e., lower than average length of stay, higher than average ancillary costs, and higher than average Medicare utilization, are relevant in the determination for a new provider exemption. Importantly, however, the Intermediary points out that as a result of the exception request, it reviewed the Provider's costs for reasonableness and found that a total of $585,000.99 for the cost reporting period ended September 30, 1997, is unreasonable and unnecessary in the efficient delivery of needed health services. In all, the Provider exceeded the cost limit by $ 1,169,293.44.[56]

The Intermediary refers to the Chronology of Events it developed and appended to its Post Hearing Brief. The Intermediary explains that this document outlines in considerable detail the relevant facts surrounding the case.[57] In general, the Intermediary asserts that the Chronology of Events and associated documentation show that the Provider had planned to establish a subacute care unit as early as 1995.[58] However, the only way the Provider could achieve this objective, due to Massachusetts' law, was to purchase a licensed long-term care facility operating under an approved CON and transferring the beds to its campus.[59] Friel, on the other hand, was an existing Level III facility that was interested in selling its DON rights and closing. Pursuant to 105 C.M.R. § 151.020, Level III facilities:

> provide routine services and periodic availability of skilled nursing, restorative and other therapeutic services, as indicated, in addition to the minimum, basic care and services required for patients whose condition is stabilized to the point that they need only supportive nursing care, supervision and observation.

Id.[60]

Respectively, on February 28, 1996, the parties entered an asset purchase agreement in which Friel, for $350,000, agreed to "sell, convey, transfer, assign, and deliver" all of its

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[56] Exhibit I-81.

[57] Intermediary Post Hearing Brief at 3.

[58] Exhibits I-95 through I-99.

[59] Tr. at 67, 81, 114, and 127.

[60] Tr. at 494. Exhibit P-6.

"right, title and interest in and to the rights to operate twenty-nine (29) beds." Asset Purchase Agreement.[61]

Two of the recitals preceding the terms of the Asset Purchase Agreement help clarify any issue surrounding what was in fact being sold:

> WHEREAS, Operator owns and operates Friel Nursing Home Located at 58 Beach Street, Quincy, Massachusetts, ("Nursing Home"), and has been granted certain rights to operate twenty-nine (29) Level III beds under the Licensure and Determination of Need ("DON") Program of the Massachusetts Department of Health ("Department")
>
> WHEREAS, Operator wishes to sell and Hospital wishes to buy the rights granted by Department to operate the twenty-nine (29) Level III beds owned by the Operator and used currently in the operation of the Nursing Home . . .

Id.

In summary, the Intermediary contends:[62]

- The documentary and testimonial record is unequivocal -- Friel Nursing Home provided skilled nursing and related services and rehabilitative services for more than three years before the Provider bought Friel's rights to operate long-term care beds under its DON and transferred them to the Provider's campus.

- The Provider badly misconstrues the statutory provisions defining SNFs under the Medicare and Medicaid programs, respectively. No difference of legal significance or consequence exists between the definitions. OBRA effectively equated Medicare and Medicaid SNFs in terms of what was eligible for federal support. Thus, the fact that Friel was Medicaid, not Medicare, certified is a distinction without a difference.

- The Asset Purchase Agreement between the Provider and Friel constituted a change of ownership under both Commonwealth regulations and Medicare program policy. The only asset at stake by the very terms of the agreement was the Friel authority to operate 29 long-term care beds. The fact that no other assets changed hands is immaterial per se and certainly not a condition to determining whether a CHOW took place. The Provider was interested in the only asset it purchased; it did not also have to purchase any other assets to result in a bona fide CHOW.

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[61] Exhibit I-21.

[62] Intermediary Post Hearing Brief at 8.

- Except for completing the licensure Medicaid-Medicare certification processes, at least by July 3, 1996, the Provider was in full legal possession of the rights and the DON for which it paid Friel $350,000, and had already been determined or deemed to be suitable under the Commonwealth's transfer of ownership regulations.

- The statute in question was enacted after the TCU's legal status with regard to the 29 beds was well established. Allowing the temporary bed operation suspension deadline to lapse because of an intervening statute does not rewrite the fact that the Provider already owned Friel's former rights to operate 29 long-term care beds. It made its last payment under the Asset Purchase Agreement on July 9, 1996.

  Arguably, the Provider's dilatory tactics after July 24 were part of a scheme to maximize Medicare reimbursement and shift costs away from the State's Medicaid program, which was operating under a 50 percent state matching requirement, especially when OBRA effectively equated SNFs under Medicare with NFs under Medicaid. It is no accident that the TCU chose to adopt admissions policies that favored acceptance of Medicare patients on grounds that Medicaid patients required less skilled care. Such a premise flies in the face of the statutory symmetry between the two SNF Programs.

  A close reading of the state statute leads to a conclusion that at bottom it is really no more than a statutory codification of an administrative process that was well settled in determining the distribution of scarce bed rights under the administratively imposed moratorium on construction of new long-term care beds. The interpretation that the statute introduced an exception to the moratorium is not well grounded. The same kind of process and conditions that the Provider pursued and accepted in its dealings with Friel seem to be required by the state statute. Some holder of the rights to beds has to give them up and close its facility so that another party may acquire and transfer the beds.

  For example, Exhibit I-25 includes a letter from Joyce James, Director of the state Determination of Need Program to Michael Collins, MD, President of St. Elizabeth's Medical Center. She recounts the reasons for awarding St. Elizabeth's a DON. Steps 1 and 2 had been accomplished before enactment of the state statute. Step 3 was incorrect insofar as the TCU had not yet been Medicare-certified. The statement at Step 4 is in direct contravention of the terms of § 2.03 of the Asset Purchase Agreement.

- Even if one accepts the view that the state statute cut new ground, Medicare is by no means bound to acknowledge the state law in applying the applicable federal statutory, regulatory and policy requirements with regard to reimbursement of services with federal funds.

- The TCU does not qualify as a new Provider under the CMS' relocation provisions. The Provider's Request for Change in Location of Right to Operate Licensed Nursing Home Beds stated that: [t]he Rights are currently located (and will continue to be located if this request for change is approved) in Long-Term Care Planning Area HSA IV . . .".[63] The cities and towns that will be served at the proposed location will be those in the Medical Center's Area IV, which is the same as Friel and includes the cities and towns currently served by Friel. Though cleverly drafted, it is not unreasonable to infer that no geographic change in service delivery/coverage would take place; that is, the population in the areas served by Friel could expect continuity of service even if different services were going to be offered.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1395x(v)(1)(A)	Reasonable Cost
§ 1395i-3 et seq	Requirements for, and Assuring Quality of Care in, Skilled Nursing Facilities

2. Law - 5 U.S.C.:

§ 553	Notice and Comment Procedures
§ 706	Scope of Review

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

§§ 405.1835-.1841	Board Jurisdiction
§ 409.30 et seq.	Requirements for Coverage of Posthospital SNF Care
§ 413.30(e)	Limits on Cost Reimbursement-Exemptions
§ 413.30(f)	Exceptions
§ 440.40	Skilled Nursing Facility Services for Individuals Age

[63] Exhibit I-20.

	21 Or Older (Other Than Services in an Institution for Mental Diseases). EPSDT, and Family Planning Services and Supplies.
§ 483.30 et seq.	Level A Requirement: Nursing Services
§ 483.40(f)	Performance of Physician Tasks in NFs
§ 489.18(c)	Change of Ownership or Leasing: Effect on Provider Agreement. Assignment of Agreement

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

§ 1500 et seq.	Change of Ownership
§ 2533.1 et seq. (formerly § 2604.1)	Requests Regarding New Provider Exemptions

5. Program Instructions - Part A Intermediary Manual, Part 4 (HCFA Pub. 13-4):

§ 4500 et seq.	Change of Ownership

6. Program Instructions - Hospital Manual (HCFA Pub. 10):

§ 261.1(B)(2)	Custodial Care. Primary Purpose of Care Furnished

7. Program Instructions - State Operations Manual (HCFA Pub. 7):

§ 3210.1	CHOW of Providers and Suppliers

8. Case Law:

South Shore Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/C&S Administrative Services, PRRB Dec. No. 99-D38, April 21, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,182, decl'd rev., HCFA Admin., June 23, 1999, rev'd and reman'd, South Shore Transitional Care Center v.

Thompson, Civil Action No. 99-11611-JLT (D.C. MA January 3, 2002), Medicare & Medicaid Guide (CCH) 2002-1 ¶ 300,934.

Thomas Jefferson University v. Shalala, 512 U.S. 504 (1994).

Chevron U.S.A. Inc. V. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).

In re Oregon System of Higher Education, Dkt. No. 92-25-SP, Final Decision at 22, 1993 WL 452646 (Educ. Appeals Bd., April 5, 1993).

Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, Medicare and Medicaid Guide (CCH) ¶ 46,224, decl'd rev., HCFA Admin., June 8, 1998.

Mercy St. Teresa Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 98-D64, June 16, 1998, Medicare and Medicaid Guide ¶ 80,006, decl'd rev., HCFA Admin., August 7, 1998, aff'd, Case No. C-1-98-547 (S.D. Ohio June 16, 1999).

Larkin Chase Nursing and Restorative Center v. Mutual of Omaha Insurance Co., PRRB Dec. No. 99-D8, November 24, 1998, Medicare and Medicaid Guide (CCH) ¶ 80,145, decl'd rev., HCFA Admin., January 15, 1999.

San Diego Physicians & Surgeons Hospital v. Aetna Life Insurance Company, HCFA Admin. Dec., January 12, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,007.

Saint Mary of Nazareth Hospital Center v. Schweiker, 718 F.2d 459 (D.C. Cir. 1983).

Gray Panthers Advocacy Committee et el. v. Louis W. Sullivan, M.D., Secretary, Department of Health and Human Services, 936 F.2d 1285 (D.C. Cir. 1991).

Newman v. Kelly, 849. F. Supp. 228 (D.D.C. 1994).

Kansas Health Care Association Inc. v. Kansas Department of Social and Rehabilitation Services, 754 F. Supp. 1502 (D. Kansas 1990).

Indian River Memorial Hospital (Florida) v. Blue Cross and Blue Shield Association/ Blue Cross of Florida, PRRB Dec. No. 87-D =104, September 24, 1987, Medicare & Medicaid Guide (CCH) ¶ 36,670, aff'd, HCFA Admin., November 17, 1987 (unreported).

Maryland General Hospital Transitional Care Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Maryland, PRRB Dec. No. 99-

D69, September 20, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,334, rev'd, HCFA Admin., November 22, 1999, Medicare & Medicaid Guide (CCH) ¶ 80,406.

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., HCFA 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).

9. Other:

HCFA Letter, June 18, 1997.

Omnibus Budget Reconciliation Act of 1987.

1996 Mass. Acts, 203 § 31.

150 C.M.R. §100 et seq.

63 Fed. Reg. 26252 (May 12, 1998).

Commonwealth of Massachusetts, DPH, Letter, May 1, 1996.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post-hearing briefs, finds and concludes as follows:

St. Elizabeth's Medical Center, the Provider in this case, is a general, acute care hospital located in Boston, Massachusetts. In July 1995, the Provider decided to open a TCU that would be certified under Medicare as a SNF. Prior to this decision, however, the State of Massachusetts had established a moratorium prohibiting the licensure of any new long-term care beds. Although, under the State's policies Level III nursing facilities unable to participate in Medicare could upgrade to new facilities capable of providing Level II SNF care, and hospitals were permitted to establish Level II SNFs through the purchase of existing Level III nursing facility bed rights. With respect to hospitals, this process results in a Level III nursing home's surrender of its bed rights, transferring its patients to other suitable facilities and then closing. Upon closure, the State grants the hospital a new license.

With respect to the instant case, on February 28, 1996, the Provider entered into an agreement with Friel Nursing Home to purchase its "rights" to operate twenty-nine (29) long-term care beds. Pursuant to this agreement the Provider paid Friel three hundred

and fifty thousand dollars ($350,000) for the bed rights while Friel retained ownership of all of its other assets including all interests in real estate, furnishings, fixtures and equipment, accounts receivable, medical records, leases, contracts and agreements.

Subsequently, on April 5, 1996, the Provider filed a "Request for Change in Location of Right to Operate Licensed Nursing Home Beds" with the Massachusetts Department of Public Health in order to relocate the subject bed rights to its campus. On June 25, 1996, Friel discharged its last patient. On October 31, 1996, the Provider's TCU was certified to participate in the Medicare program and was assigned Provider Number 22-5713. And, on January 15, 1997, the Provider requested that CMS grant the TCU an exemption from Medicare's routine service cost limits on the basis of Medicare's "new provider" rules at 42 C.F.R. § 413.30(e). In part, these rules state:

> (e) Exemptions. Exemptions from the limits imposed under this section may be granted in the following circumstances:
>
> (2) New Provider. The Provider of inpatient services has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. . . .

42 C.F.R. § 413.30(e)(emphasis added).

Upon review, CMS determined that the TCU did not qualify for the exemption and denied the Provider's request. In part, CMS stated that the Provider had purchased the subject bed rights from Friel, which reflects a change of ownership. CMS further explains that the change of ownership triggered a review of the services performed by Friel pursuant to the present and previous ownership provision of 42 C.F.R. § 413.30(e), quoted above, and that Friel had, in fact, performed skilled nursing services for more than three years.

The Board majority finds that it has been confronted several times with the issue of whether or not the acquisition of bed rights (operating rights, certificate of need, determination of need, etc.), in and of itself, constitutes a change of ownership for the purpose of determining whether or not the present and previous ownership provision of 42 C.F.R. § 413.30(e) is applicable; specifically, that is, whether or not a change of ownership occurs triggering a review of a relinquishing facility's historical operations that could result in denial of a new provider exemption.[64]

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[64] The Board majority acknowledges that HCFA Pub. 15-1 § 2533.1.E.1.b was modified to explain, in general, that the acquisition of operating rights to long term care beds, albeit from an open or closed facility, reflects a change of ownership for the purpose of determining "new provider" status pursuant to 42 C.F.R. § 413.30(e). However, the Board majority also notes that this modification was not published until September 1997, and may not be applicable to the instant case. Moreover, the Board majority

With respect to this matter, the Board majority finds that it has followed CMS' interpretation, in most instances, finding that such action does result in a change of ownership. Importantly, however, the Board majority also finds that its deliberations regarding this matter have always contained a measurable degree of disagreement and have resulted in dissenting opinions being rendered in some instances. See e.g., South Shore, Sleep dissenting; Maryland General, Wessman dissenting, Hoover dissenting; and, Stouder Memorial Hospital Subacute Unit v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D46, April 18, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,437, Wessman dissenting, rev'd, CMS Administrator, June 15, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,517. In addition, a number of district court decisions as well as one circuit court decision have now been rendered on this issue, and they also contain varying conclusions.

In light of these circumstances, the Board majority finds the courts' analyses in these cases especially helpful. In particular, the Board majority finds the court's decision in South Shore instructive with respect to the instant case. In part, the court states:

> South Shore opened after the DON [Determination of Need] rights to 40 beds were purchased from the receiver of the defunct Prospect Hill [Nursing Facility]. The sole connection between Prospect Hill and South Shore was the intangible DON rights. South Shore did not acquire any building, land, patients, staff or equipment from Prospect Hill. As the dissenting member of the Board said,
>
> > [t]he DON rights. . . .[were] at best an intangible asset because it only evidenced the right to create and operate nursing beds. The DON rights had some residual value only because the State had instituted a cap on the number of beds that could be licensed within the State . . . . [Prospect Hill] was like a totaled vehicle with some parts being sold from the carcass. Thus, the receiver was merely selling available assets to generate funds to pay creditors. Hence, the sale of the intangible DON rights in 1994 did not affect the licensure and certification of Prospect Hill within the meaning of section 1500.7 since licensure and certification was lost due to other reasons.
>
> The Secretary's finding that South Shore's purchase of intangible DON rights once owned by Prospect Hill constituted a change of ownership, thus triggering an inquiry into the operational history of Prospect Hill and leading to the denial of the new provider exemption, was clearly not in accordance with the law. Since there was no change of ownership, the inquiry into Prospect Hill's operational

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wishes to point out that while it is bound by applicable program statutes and regulations, it is not so bound by program instructions and guidelines.

history was unwarranted.

South Shore, at ¶ 803,220 and 803,223.

The Board also notes 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"), where the court found the Secretary's interpretation of the new provider regulation arbitrary, capricious, and erroneous. That is, 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. In the first situation the 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), and the basis of 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. Respectively, 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.

Id. at ¶ 803,407

Based upon these facts, the Board majority finds that CMS improperly denied the Provider's request for an exemption to Medicare's routine service cost limits. Similar to the courts' findings in both South Shore and Ashtabula, the Board majority finds that St. Elizabeth's acquisition of bed rights in the instant case does not represent a change of ownership, and the services that may or may not have been performed by Friel are irrelevant. The Provider meets the program's definition of a "new provider" at 42 C.F.R.

§ 413.30(e)(2); it is licensed, certified, and accredited as a hospital based SNF, and it had operated as this type of provider for less than three full years as required.

Notwithstanding, the Board majority believes it is important to address the parties' arguments in this case regarding Medicare's "relocation" rules. The Provider asserts that even if it were not to qualify as a "new provider" according to 42 C.F.R. § 413.30(e), it should still be granted a "new provider" exemption pursuant to HCFA Pub. 15-1 § 2604.1. In pertinent part, these instructions state:

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

HCFA Pub. 15-1 § 2604.1.

Based upon these rules, the Provider argues that its TCU serves a distinguishably different inpatient population than that served by Friel. The Provider argues, in part, that the vast majority of the TCU's patients' residences are not in the same geographical location as Friel's patients. Moreover, the patients served by Friel generally required only supportive care and frequently resided there for years. In contrast, patients served by the TCU are in need of continuous skilled nursing care, generally on a short-term basis, and are usually discharged within ten or fifteen days immediately following an inpatient stay in the hospital.

The Intermediary rejects this argument because the Provider is located in the same health service area as Friel. The Intermediary relies upon program instructions at HCFA Pub. 15-1 § 2533.1.B.3 In pertinent part, these instructions state:

> [a]n institution . . . that has undergone a change in location may be granted new provider status when the normal inpatient population can no longer be expected to be served at the new location. In this case, the institution . . . must demonstrate that in the new location a substantially different inpatient population is being served . . . . <u>The normal inpatient population is defined as the health service area (HSA) for long-term care facilities, or its equivalent, as designated by the State planning agency or local planning authority in which the institution . . . is located</u>.

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

The Board majority's analysis of this matter concludes that the Intermediary's position is unsubstantiated for several reasons. First, HCFA Pub. 15-1 § 2533.1.B.3., the basis of

the Intermediary's argument, was not published until September 1997, and is not applicable to the subject cost reporting period. More importantly, however, the actual meaning or intent or goal of HCFA Pub. 15-1 § 2533.1.B.3 appears to contradict or be at complete odds with that of HCFA Pub. 15-1 § 2604.1. On one hand, HCFA Pub. 15-1 § 2604.1 establishes the fact that a provider relocating even a short distance may result in an entirely new inpatient population being served. On the other hand, HCFA Pub. 15-1 § 2533.1.B.3 appears to disregard this reasoning by maintaining that only one long-term care inpatient population resides within an entire HSA. In view of this apparent discrepancy and vast interpretation that only one inpatient population may reside within an entire HSA, the Board finds that the Intermediary would have to produce substantive data in order to properly refute the Provider's argument, which it did not do. The Intermediary's analysis of the Provider's relocation argument is incomplete.

Finally, the Board acknowledges but rejects the Intermediary's argument that the Provider opened the subject TCU only to enhance its Medicare revenues. The Intermediary explains that with the TCU the Provider receives Medicare reimbursement for beneficiaries requiring an acute care stay in its hospital, and then again as inpatients requiring SNF care. The Intermediary adds that the Provider could have considered using anyone of several SNFs operating within a close proximity of its campus had it wished solely to reduce hospital costs. The Board, however, finds this argument inconclusive noting that at least two government authorities approved the TCU's operation. That is, the Provider obtained a Determination of Need from the Massachusetts Department of Health and was certified by CMS to participate in the Medicare program.

DECISION AND ORDER:

CMS' denial of the Provider's request for an exemption to Medicare's routine service cost limits on the basis of being a "new provider" pursuant to 42 C.F.R. § 413.30(e) is improper and is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq. (Dissenting)
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esq. (Concurring)

DATE OF DECISION: September 30, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman

Concurring Opinion of Board Member Suzanne Cochran

I concur with the majority's conclusion that St. Elizabeth's acquisition of DON rights from Friel was not a provider change of ownership (CHOW) as contemplated by 42 C.F.R. 413.30(e). I write this concurrence because I find the majority decision to be incomplete in two respects. It does not address court decisions that appear, at least facially, to be contrary to our decision. It also does not address positions CMS has taken in various other Manual provisions and in similar cases, positions which I believe are highly relevant to and irreconcilable with the Agency's position taken in this case.

42 C.F. R. 413.30(e)(2) provides, in relevant part:

> New provider. The *provider* of inpatient services *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)

CMS denied St. Elizabeth's application on the basis that the DON transfer resulted in a provider change of ownership (CHOW). Thus, Friel was treated as a prior owner of the provider applicant, St. Elizabeth, and Friel's history of providing services was used to disqualify St. Elizabeth as being "new."

It is undisputed that the only transaction between Friel and St. Elizabeth was the latter's acquisition of a DON; no other assets were acquired. St. Elizabeth agreed to pay Friel in installments timed according to the state's various approvals. At or perhaps after the last installment, state law changed requiring the parties to modify their agreement. The substance remained the same: a provider that wanted to acquire a DON for skilled nursing beds had to arrange to get the DON from an existing provider. However, the new state law specified that the transferring facility had to close and the acquiring facility had to assume responsibility for the transferor's Medicaid overpayment, if any. The new procedure fostered the State's policy of shifting approved nursing home beds from lower level care to higher level. Moreover, the state law set up a new route by which the acquiring facility obtained its DON. Instead of the old facility directly transferring the DON, the DON went back into the state's pool of approved nursing beds and the state issued the DON to the new owner.

Both sides claim an edge as a result of the new procedure. The Intermediary says the provider's having to assume any Medicaid debt Friel might have creates an additional connection between the two parties that bolsters CMS'claim of a CHOW. St. Elizabeth says having to acquire its DON from the State instead of Friel creates an even more distinct break in the connection between the two facilities. The Intermediary counters that St. Elizabeth should not get the benefit of this distinction because the original transaction was substantially complete before the law changed. Whether the transfer was consummated under the old or new procedure is not determinative when analyzed under

Agency guidelines applicable at the time of the transaction. Under either procedure, St. Elizabeth only acquired one asset. The state required assumption of any Medicaid debt as consideration for the single asset acquired but that did not change the character of the transaction as a sale of a single asset.

The inescapable logic of CMS' rationale that a transfer of a DON alone is a change of ownership of a *provider* is that a DON is what substantially constitutes or defines a provider. As the majority aptly points out, both the *South Shore*[65] and *Ashtabula*[66] Courts held that denying new provider status based solely on the transfer of DON rights from an unrelated entity as constituting a CHOW misinterprets the term "provider." The *Ashtabula* Court found the term "provider" refers to "an institution or distinct part of an institution, not to a mere characteristic or attribute of such an institution." *Id.* at 12.

Three other courts that dealt with SNF applications for new provider status that involved a transfer of DON rights upheld a denial, however. *Paragon Health Network, Inc. v. Thompson,* 251 F.3d 1141 (7th Cir. 2001); *Maryland General Hospital, Inc. v. Thompso*n, 155 F. Supp. 2d 459 (D.Md, 2001) and *Larkin Chase Nursing and Restorative Center v. Thompso*n, 2002 U.S. Dist. LEXIS 23655 (Feb 6, 2001). Although each of these cases involved an acquisition of DON rights from another provider, it is important to an analysis that the facts in *Paragon, Maryland and Larkin* are substantially distinct from the facts in the instant case and from those in *South Shore* and *Ashtabula.*

Larkin Chase involved a series of convoluted transactions that included multiple transactions between the DON purchaser and seller, including a transfer of patients. *Maryland General* did not challenge the basis of the Agency's denial that the DON transfer would cause a change of ownership. Instead it focused solely on the character of the bed rights acquired as having been "waiver" beds, never used or licensed by the original owner of the DON. Whether the beds were correctly characterized as "waiver" was in issue and was decided unfavorably to the provider. *Paragon* owned multiple facilities and simply shifted DON rights between two of its nursing facilities that operated in close proximity. Both providers were, therefore, under Paragon's ownership and management and the Paragon organization had a lengthy history of providing skilled nursing services.

The *Paragon* Court looked to the term "provider" in the regulation itself at 42 C.F.R. 413.30(e) and in a reference to the provider as an institution in the manual dealing with relocated providers. (PRM 2604.1) It concluded that the regulation was ambiguous on what constitutes a "provider" and that the Agency's interpretation was, therefore, entitled to deference. It reasoned that

> "Of course, if all the various things that make up a SNF were new in the sense that they had not been part of another facility, then one would have

[65] *South Shore Hospital Transitional Care v. Thompso*n, 2002 U.S. Dist. LEXIS 289 (D.Mass. January 3, 2002).

[66] *Ashtabula County Medical Center v. Thompson*, 2002 U.S. Dist. LEXIS 5499 (N.D. Ohio, Feb 8, 2002)

> to call that SNF a "new provider." Conversely, if a nursing facility did not change any of its aspects, it would unquestionably continue to be the same provider rather than a new one. The difficulty in drawing a line between these two extremes is what makes the word "provider" ambiguous as used in the regulation."

251 F.3d at 1148.

There is no indication the *Paragon* Court was presented with or that it analyzed the Secretary's long standing interpretive guidelines that deal with the term "provider" in the explicit context of a change of ownership. Also absent was the Secretary's interpretation of identical language in regulations that apply to new provider status for a hospital. [67] These authorities provide a highly relevant context for analyzing whether a DON transfer between unrelated providers constitutes a CHOW.

Provider changes of ownership are hardly novel concepts under Medicare. Numerous Agency guidelines address the issue.

Manual Provisions

The State Operations Manual, HCFA Pub 7 §3210, is particularly enlightening in determining what defines a provider in the context of determining whether a CHOW has occurred. The manual instructs state agencies that they have the initial fact development responsibilities in determining whether a CHOW has occurred. Section 3210.1 entitled "Determining Ownership" provides, in relevant part,

> A. General.—For certification and provider agreement purposes, *the provider is the party directly or ultimately responsible for operating the business enterprise. This party is legally responsible for decisions and liabilities in a business management sense. The same party also bears the final responsibility for operational decisions made in the capacity of a "governing body" and for the consequences of those decisions.* (Emphasis added)
>
> * * * * *
>
> To determine ownership of any provider enterprise or organization, the SA determines which party (whether an individual or legal entity such as a partnership or corporation) *has immediate authority for making final decisions regarding the operation of the enterprise and bears the legal responsibility for the consequences of the enterprise's operations.* (Emphasis added)

[67] I do not suggest that the *Paragon* court would have reached a different result if it had considered these authorities because the peculiar facts of that case support the Court's decision. However, the Court commented extensively on its not finding a clear definition of provider and commented that it would have been confronted with a different situation had the Secretary "reversed course" from a prior interpretation. *Id.* at 1147-1148.

Numerous other manual provisions likewise indicate that the "provider" ownership is a determination of who has legal authority and responsibility for the *enterprise* as opposed to ownership of a particular asset. See, e.g. HCFA Pub. 13-4 §A4 4501 "Change of Ownership Review Procedures;" §4502.8 "Purchase of Stock;" §4502.12 Donations; §4502.13 Leases; HCFA Pub. 23-6 §RO2 6320 "Development of Doubtful Change of Ownership."

Other manual provisions deal directly with a transfer of assets. HCFA Pub.13-4 §4502.5 "Purchase of Corporate Assets" states:

> A purchase of *all or substantially all* of a corporation's tangible assets constitutes a CHOW for Medicare certification purposes. Where there is an asset purchase and the transaction affects licensure or certification, it is also considered a CHOW for Medicare reimbursement purposes." [68] (Emphasis added)

Provider Reimbursement Manual, HCFA Pub 15-1 §1500, entitled "Change of Ownership – General" sets out several circumstances that constitute changes of ownership such as changes in the composition of a partnership, sale of sole proprietorship, etc. Two sections deal directly with a disposition of assets.

> 1500.6 Donation – Donation of all or part of a provider's facility used to render patient care *if the donation affects licensure or certification of the provider entity.* (emphasis added)
>
> 1500.7 Other Disposition of Assets –Disposition of all or some portion of a provider's facility or assets (used to render patient care) through sale, scrapping, involuntary conversion, demolition or abandonment *if the disposition affects licensure or certification of the provider entity*. (emphasis added)

While, admittedly, none of these manual provisions deal expressly with the SNF new provider exemption issue,[69] they do indicate the Agency's consistent view during the relevant time period that a "provider" is a legal entity that operates a business enterprise and that a change of ownership of a provider envisions a continuity of the business enterprise. Provisions dealing with asset transfer as a CHOW must be read in the context of and reconciled with other provisions that describe a CHOW. I believe it is a fair reading of these provisions that an asset transfer constitutes a CHOW only if it is of such proportions that the assets transferred substantially make up what is identifiable as the

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[69] See p. 32 ; fn 64 of the majority opinion. HCFA published a manual provision in 1997, a year after the cost report years in issue, that sets out the interpretation that the Agency has applied here.

business enterprise to which licensure and certification apply.[70] Nothing in these provisions support the Agency's position that St. Elizabeth's acquisition of a single asset, DON rights, from the unrelated Friel Nursing Home makes St. Elizabeth Friel's legal successor.[71] Conversely, there is nothing to support the position that Friel previously had legal responsibility for operation of St. Elizabeth's business enterprise.

Hospital New Provider Cases

The Secretary's determinations regarding new provider status for hospitals has been consistent with the CHOW guidelines discussed above. The regulation applicable to hospitals, like the regulation we are dealing with here applicable to SNFs, requires looking to "previous and present ownership" to determine whether a hospital is a "new provider."

Community Hospital of Chandler v. Sullivan, 9th Cir 92 1992 U.S. App. LEXIS 15504, involved new provider status for a hospital under 42 C.F.R. 412.74.[72] Chandler Community Hospital (CCH) was a small, outdated facility with limited services. CCH administration planned and constructed Chandler Regional, a large, state of the art facility. The business operations of CCH were transferred to Regional. The significance of this case is that when Chandler Regional was denied new provider status, it challenged the Secretary's interpretation of "provider" for purposes of the new provider exemption as a *legal or business organization*. The court found reasonable the Secretary's interpretation that the provider was the same legal entity and therefore did not qualify as a "new hospital" despite the major changes in the facility's physical assets and services.

Three years later, the 9th Circuit heard a similar challenge in *Memorial Rehabilitation Hospital of Santa Barbara v. Secretary of HHS*, 65 F2d 134 (9th Cir. 1995) . In this case, the legal entity with authority over the business operations changed but the physical location and business operations otherwise remained the same. A county government that operated an acute care hospital transferred a portion of the business, its entire 45 bed rehab operations, to a foundation. The foundation continued the same business operation

[70] I am forced to concede that in CON states a provider must have a CON to be certified or licensed. However, there are numerous assets that are functionally required to meet standards for certification or licensure depending on the nature of the provider. For example, Providers will be required to have certain furniture and fixtures and medical equipment. It would be ridiculous to suggest that a sale from one provider to another of a single piece of medical equipment, no matter how essential to the provider's business of providing services, would constitute a change of ownership of the provider itself. Common sense requires the manual to be read as constituting a CHOW only upon transfer to another entity of so much of the provider's facility or assets that it could not reasonably expect to continue the business under which it is certified or licensed and that would allow the acquiring provider to substantially begin business. Interpreting a CON as being the equivalent of a provider would also require a wholly different definition of "provider" in those states that do not have a CON or DON process.

[71] On the contrary, only an act of the state legislature made St. Elizabeth responsible for even the potential Medicaid debt to the state. The statute did not provide for general liability for the transferor's prior operations.

[72] The hospital new provider exemption provision was moved to 42 C.F.R. 413.40(f).

in the same facility with substantially the same staff but it was required to add or upgrade costly physical plant changes and support services to meet the state's licensing requirements. It then applied for a "new hospital" exemption. The Secretary denied the exemption under the rationale that the only material change was the transfer of ownership of the *operation* from the county to the foundation. The foundation argued that the rehab unit itself had not been separately licensed as a hospital; therefore, it could not have been a "provider" under previous ownership. In rejecting the Provider's arguments, the court's reliance on a point made by the Secretary is particularly relevant here. "As the Secretary points out, her decision was tailored only to circumstances in which the purported "new hospital" assumes all existing and operating inpatient services of the old hospital." Thus, under the Agency's prior interpretations, only those instances in which an unrelated legal entity acquires all the business operations of another entity will it be considered the same provider. *Memorial* stands in sharp contrast to St. Elizabeth's acquisition of a single intangible asset from a totally independent Friel to be used in a different location, with different facilities, different services and different staff.

Authoritative Agency statements made in Manuals and in the hospital new provider litigation compels a rejection of the interpretation applied to the circumstances of this case. Longstanding interpretations of "provider" in the CHOW context as an entity with legal responsibility for decisions and operations cannot conceivably be reconciled with the Agency's treatment of a new provider in the SNF context as being nothing more than the owner of a CON.

Suzanne Cochran

Dissent - Henry C. Wessman

I dissent.

I echo the primary contentions of my recent dissent in Mercy Medical (PRRB Dec. No. 2002-D31, August 7, 2002). St. Elizabeth's purchased the "bed rights/certification" for twenty-nine (29) long-term care DON beds from Friel Nursing Home through the Massachusetts DPH/DHCQ process (Intermediary Position Paper Exhibits I-18, I-19, I-20, I-21, I-22). St. Elizabeth's paid $350,000 for the 29 beds; there were actual beds closed at Friel and transferred and added to St. Elizabeth's, thus clearly affecting the licensure/certification of both parties. There is no question that this constitutes a CHOW (change of ownership) under Medicare regulations (HCFA Pub. 15-1 § 1500.7; HCFA Pub. 13-1 § 4502.5) which triggers the three (3) year look-back and location considerations.

The PRRB's pro-Provider majority refuses to recognize the critical element of licensure/certification change of the parties, and somehow sees a CHOW of nothing, even for the significant payment of $350,000 for the 29 LTC bed rights DON (Intermediary Position Paper, Exhibit I-23).

Precedent Ignored

The PRRB Majority finds the rather shallow logic of two (2) recent lower court decisions (South Shore, Ashtabula) to be "instructive" in reversing the Intermediary's adjustment and granting a costly "new" provider exemption to the Provider in the instant case. This in apparent disregard for the significant progeny of at least six (6) PRRB Decisions (Indian River Memorial Hospital (Florida), PRRB Dec. No. 87-104, September 24, 1987; Milwaukee Subacute and Rehabilitation Center, PRRB Dec. No. 98-D40, April 14, 1998; Larkin Chase Nursing and Restorative Center, PRRB Dec. No. 99-D8, November 24, 1998; South Shore Hospital Transitional Care Center, PRRB Dec. No. 99-D38, April 21, 1999; Ashtabula County Medical Center Skilled Nursing Facility, PRRB Dec. No. 2000-D70, June 29, 2000; Providence Yakima Medical Center, PRRB Dec. No. 2001-D32, May 16, 2001), eight (8) CMS Administrator Decisions (affirming the above six (6), plus reversing the PRRB Majority in Maryland General Hospital Transitional Care Center, HCFA Adm. Decision November 22, 1999, Medicare and Medicaid Guide (CCH) ¶80,406, and Stouder Memorial Hospital Subacute Unit, CMS Adm. Decision June 15, 2000, Medicare and Medicaid Guide (CCH) ¶80,517), five (5) lower court decisions (Staff Builders Home Health Care, Inc., April 13, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,133; Mercy St. Teresa Center, U.S. Dist. Ct., S. Dist. Ohio, W. Division, Case No. C-1-98-547, June 16, 1999; Paragon Health Network, Inc., [Milwaukee

Subacute and Rehabilitation Center], Case No. 98-C-553, U.S. Dist. Ct. E. Dist. Wisconsin, August 16, 2000; Larkin Chase Nursing and Restorative Center, Civil Action 99-00214(HHK), U.S. Dist. Ct. D.C., February 16, 2001; Maryland General Hospital, Inc. d/b/a Transitional Care Center, Civil Action WNM-00-221, U.S. Dist. Ct. Maryland, June 27, 2001) and one (1) U.S. Court of Appeals decision (Paragon Health Network, Inc., d/b/a Milwaukee Subacute and Rehabilitation Center, No. 00-3707, U.S. Ct. of Appeals, 7th Circuit, June 5, 2001) that all support the Secretary of Health and Human Services in his interpretation of 42 C.F.R. § 413.30(e) and promulgations relevant to Medicare's "new provider" exemption rules.

Lack of Respect/Deference for Bush Administration DHHS Secretary Thompson's Analysis/Reasonable Interpretation of Medicare Regulation

I am not prepared to side with the lower court of either South Shore or Ashtabula, or my liberal colleagues in the Majority opinion who contend that the Bush Administration's DHHS Secretary Tommy Thompson's actions were ". . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law" (South Shore n 23); or that Secretary Thompson's justification in this issue amounts to ". . . little more than a generous amount of conjecture and guesswork." (Ashtabula at 16) Deference toward Agency interpretation of it's own regulations is a critical axiom of Administrative Law. In my opinion, DHHS Secretary Thompson has met both the standard of Chevron (Chevron U.S.A v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984)) and certainly that of Skidmore (Skidmore v. Swift & Co., 323 U.S. 134 (1944)), and deserves more respect then proffered by two (2) lower courts and the PRRB Majority in the instant case.

Provider Paid $350,000 for Nothing According to PRRB Majority

I find South Shore and Ashtabula to be an attempt on the part of the lower court, as adopted blindly in the instant case by the PRRB Majority, to parse the meaning of "change of ownership" (CHOW) in such a manner as to exclude what they refer to as "intangibles." In the South Shore and Ashtabula courts, as in the Majority interpretation in the instant case, the sale or transfer of "bed rights", "licensed beds" or "bed operating rights" are apparently not considered germane to the operation of a SNF, and thus not worthy of CHOW designation. In the instant case, the Provider paid $350,000 (Intermediary Exhibit I-23) and received nothing, if the logic of the PRRB Majority is to prevail.

In the real world, I know of nothing of greater SNF germinal import than the "bed license." If you do not agree, try building the most tangible facility, with the most tangible beds and equipment, with the most tangible personnel – but ignore acquisition of the parsed, intangible "bed operating right." Bill Medicare, Medicaid, or any other third party payor for services rendered, and observe the result. All of a sudden, those "intangible" bed operating rights are *sine qua non.* So, where the PRRB majority in the instant case, and the South Shore and Ashtabula lower courts suggest that the sale, transfer or redemption of "bed rights" does not rise to the level of a CHOW, one can not

identify, in the real world, a more essential or highly-prized element of change in ownership, absolutely critical to the successful operation of a SNF. The provider must assume all legal responsibility for the purchase of the "bed right", and no matter what spin you attempt to put on the term "provider", that term must encompass both the entity and the all-important "bed rights", without the acquisition/CHOW of which the provider would be left impotent as a health care facility. To pay $350,000 for "intangibles" without getting ownership of something is neither a prudent purchase nor a reasonable cost (42 U.S.C. §1395x(v)(1)(A)) whether under Medicare or otherwise.

All Elements of a "CHOW" Present

In the instant case, it is undisputed that there was a Sale (Intermediary Exhibit I-21) between the purchaser-Provider, St. Elizabeth Medical Center, and the seller, Friel Nursing Home, whereby the appealing Provider, St. Elizabeth's , acquired the right, title, and interest in and license and authority for, twenty-nine (29) Nursing Home Beds from Friel via the Massachusetts DPH/DHCQ. St. Elizabeth's paid the sum of $350,000 to Friel for the rights, title, license and operating rights for twenty-nine (29) Nursing Home Beds (Intermediary Exhibit I-21), thus unequivocally affecting the licensure and certification of both St. Elizabeth's and Friel (Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) § 1500.7). All of the elements of a CHOW, as defined by Medicare regulation, are present. (Id.; Provider Reimbursement Manual (HCFA Pub. 13-1) § 4502.5) There is a contract, payment, and impact on licensure/certification of both the buyer (Appealing St. Elizabeth's) and the seller (Friel Nursing Home). The beds, as certified to the seller, and purchased for the same usage intent by the buyer, were to be used in a manner equivalent to their prior certified/licensed capability by the "new" Provider, St. Elizabeth's. Had these beds not had the history and status of prior certification/licensure as skilled beds, they would be of no use to the "new" Provider. Thus neither the spirit nor the intent of 42 C.F.R. § 413.30(e) and promulgations pertaining to Medicare's "new provider" exemption rules, nor the letter of it's law, were met by St. Elizabeth's Medical Center.

Bed Purchase Benefit/Convenience for Provider – not Medicare

If St. Elizabeth's Medical Center had attempted to acquire the requisite "licensed beds" or "bed operating rights" through Massachusetts Determination of Need (DoN) program, they would have been rebuffed because of the state's desire to limit, or reduce, the number of long-term care beds available in the state. The focus of the State of Massachusetts at the time, as with virtually all states in the Union, was to reduce the number of LTC beds in response to a state legislatively-perceived over-bedded situation. Clearly, the bed redemption/transfer was the only avenue open to a Provider who wished to add SNF services. These services were added, by and large, for the convenience and benefit of continuum-of-care services of the Provider, not because of a "new bed" need of the public. This fact is further emphasized by the fact that the purchaser, St. Elizabeth's, quickly escalated the occupancy of it's TCU to 75% within the short period of 11 months (Intermediary Exhibits I-69, I-70), thus negating the need for Federal Medicare subsidy for high "start up costs" as envisioned by Congress. Acquisition of

previously licensed beds, thus at least stabilizing the state's SNF bed inventory, melded with the state's desire to hold the line on the total SNF bed count. In the instant case, as with all of the other "exemption" cases, by state constraint, there was always the element of a transfer/sale/acquisition/redemption of something that had significant value to the provider. That "something" was the operational bed right – the right to operate a bed previously licensed, in the state's LTC bed inventory, and used or available to it's former owner – capitalized/amortized/depreciated long ago at a cost to someone: private payors, third party payors, the state/federal Medicaid program, or the federal Medicare program itself. And the services provided with these beds or bed rights were invariably services, in part, previously offered (Intermediary Exhibit I-26) and now sought to be offered by the "new" provider to Medicare recipients, with the additional "exemption" price tag attached, as "new" services; in the instant case at an additional cost of $585,000 to U.S. taxpayers via the Medicare Trust Fund. In my humble opinion, the PRRB Majority's decision is tantamount to paying a $585,000 Federal bonus to the Provider for having cleverly circumvented a State moratorium.

Critical Issue: Was Licensure/Certification Affected

The criticality of the "affects licensure" language is noted, and has been historically noted, by Medicare since it's inception. Did the sale/transfer/acquisition/redemption of the "asset" affect licensure or certification? If so, it is a CHOW under Medicare guidelines. As a CHOW, the look back questions of "prior use" and "location" come into play. The Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §1500.7 is clear on its face, a CHOW occurs ". . . if the disposition [of assets] affects licensure or certification of the provider entity." (HCFA Pub. 15-1 § 1500.7) Provider Reimbursement Manual (HCFA Pub. 13-1) § 4502.5 reinforces the fact that "Where there is an asset purchase and the transaction affects licensure or certification, it is also considered a CHOW for Medicare reimbursement purposes." (HCFA Pub.13-1 § 4502.5). Coupling these cites with the pragmatics of the need to secure "licensed beds" in order to qualify for Medicare (or any third party) payment for services, reinforces the fact that any transfer/acquisition/sale/purchase/redemption of the essential and critical "bed operating right" must be considered a CHOW, and that such a CHOW, by its very nature, inures to the provider's benefit, and certainly impacts the provider's licensure and certification.

Granting "New Provider" Status to St. Elizabeth's Neuters Medicare "Reasonable Cost" Mandate

The question than becomes did the instant Provider, St. Elizabeth's Medical Center, claiming "newness" as a provider, come to CMS with truly "new beds", worthy of significant "start-up costs" – or were these acquired beds "used" to the extent that their "start-up cost" had previously been capitalized, amortized, depreciated – already paid for in part by Medicare and other payors in a prior life, and thus not deserving of Medicare Trust Fund payment for a cost that was long ago amortized/depreciated by a prior owner and thus not now a reasonable cost under 42 U.S.C. § 1395x(v)(1)(A), and unworthy of yet a second federal tax dollar subsidy. It is clear to me that the "bed rights" existed in a prior life (Intermediary Exhibits I-20, I-21), had inherent value to the seller (but not to

the extent of a Medicare windfall as a "new provider"), and that St. Elizabeth's was willing to pay for the licensed/certified beds, thus effecting the licensure of both buyer and seller. In my opinion, this takes this Provider and this transaction outside of 42 C.F.R. § 413.30(e) eligibility for a "new provider" exemption.
Appropriate Remedy: Exception – Already Granted

The wording of 42 C.F.R. § 413.30(c) is clear: "A provider may request a reclassification, exception or exemption from the cost limits imposed under this section". (emphasis added) In my humble common sense view, this means one of the three (3) remedies per provider, but not two (2) or three (3). A reclassification is a request to change service-orientation, that is not at issue here. The exemption is a broader remedy, less refined, less specific. The exception is surgical – it responds directly to the source of the cost over run, be it due to atypical services/patients, extraordinary circumstances, fluctuating population, education costs, or unusual labor costs. (42 C.F.R. § 413,30(f) et seq) Appropriately, the exception must be verified each year, and employed to dissect out, and pay by Medicare, the specific justifiable cost spike. In the instant case, St. Elizabeth's Medical Center appropriately sought, and appropriately received, an exception resulting in a payment of $584,292 for documented "atypical services". (Intermediary Position Paper at 38; Intermediary Exhibits I-78, I-79, I-80). This is a significant additional payment targeted at a documented cost spike for "atypical services", and demonstrates how the system is intended to work. This is the appropriate remedy in cases such as the one before the Board. The remedy (exception) is surgical, exact, responsive, accurately acute, cost-effective and cost-efficient to the Medicare Trust Fund. It is the type of specific remedy one would expect from a fiscally-responsible tax-funded program such as Medicare.

St. Elizabeth's Medical Center appropriately sought, and received an exception; 42 C.F.R. § 413,30(c) says either an exception or an exemption. One bite of the U.S. Taxpayer financed Medicare exception/exemption remedy is enough. St. Elizabeth's Medical Center received the appropriate exception. CMS' new provider cost exemption denial in the instant case is appropriate and should be upheld.

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Senior Board Member