PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D37

PROVIDER –
Carney Hospital Transitional Care Unit

Provider No.: 22-5681

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services

DATE OF HEARING -
May 4, 2009

Cost Reporting Periods Ended - September 30, 1996; September 30, 1997; September 30, 1998

CASE NO.: 02-0816

INDEX

ISSUE:

Was the Intermediary's denial of the Provider's request for a new provider exemption from Medicare routine service cost limits proper in light of the standards set forth in *St. Elizabeth's Medical Center of Boston, Inc. v. Thompson,* 396 Fed. 3rd 1228 (D.C. Cir. 2005)?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

42 U.S.C. §1395 x(v)(1)(A), authorizes the Secretary to establish prospective limits on provider costs that are reimbursed under Medicare. Through regulation, the Secretary established limits on routine care costs, referred to as routine cost limits (RCLs). The Medicare regulations at 42 C.F.R. §413.30(c) permit providers to obtain relief from the cost limits by requesting a reclassification, exception or exemption.

Program regulations at 42 C.F.R. §413.30 set forth the general rules under which CMS may establish cost limits. The regulations explain that an exemption may be granted to a "new provider," and the manual guidelines further explain that new provider status may be granted where an existing provider relocates its facility to a new location. Specifically, 42 C.F.R. §413.30(e) states in part:

> *Exemptions.* Exemptions from the limits imposed under this section may be granted to a new provider. 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.

For the period at issue, CMS program instructions contained in CMS Pub. 15-1, Medicare's Provider Reimbursement Manual Part I ("PRM-1"), contains guidance under which a provider may obtain an exemption from the limits for relocation. Specifically, PRM-1 §2604.1, states:

> [F]or purposes of this provision, 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 for granting new provider status. A provider seeking such new provider status must apply to the

> intermediary and demonstrate that in the new location a substantially different inpatient population is being served. In addition, the provider must demonstrate that the total inpatient days at the new location were substantially less than at the old location for a comparable period during the year prior to relocation.

In September 1997, CMS amended its program guidelines at PRM-1 §2533.1.E.1, which deal with changes of ownership. The guidelines now explain that where an institution acquires the right to operate long-term beds from an existing institution or institutional complex, which is or has been providing skilled nursing care or rehabilitative services, the transaction will be considered a change of ownership for new provider exemption purposes.

The intent of the new provider exemption is to mitigate the difficulties in meeting the applicable cost limits due to under utilization during the initial years of providing skilled nursing and/or rehabilitative services. PRM-1 §2533.1.A.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Carney Hospital is a general acute care facility located in Boston, Massachusetts. On December 3, 1994, the hospital entered into an asset purchase agreement with Comeau Health Care, Inc. (Comeau) to purchase the rights to operate twenty-seven (27) long-term care beds and certain other assets associated with Franklin Nursing Home (Franklin). On October 5, 1995, the hospital opened a 27-bed transitional care unit (TCU) (herein Carney TCU or Provider) which, on October 26, 1995 was certified to participate in the Medicare program as a skilled nursing facility (SNF).

On January 4, 1996, the Provider submitted a request for a "new provider" exemption from Medicare's routine service cost limits.[1] The Centers for Medicare & Medicaid Services (CMS) reviewed the Provider's request and, by letter dated May 8, 1996, notified C&S Administrative Services for Medicare (the former Intermediary) that the Provider's request was denied.[2] The Provider timely appealed the denial to the Provider Reimbursement Review Board (Board). On July 16, 2004 the Board majority upheld CMS's denial.[3] The Administrator declined review of the Board's decision.[4]

[1] Administrative Record (AR) Volume (Vol.) 8, Tab 212. Citations to the AR, compiled by CMS and submitted to the District Court on May 5, 2005, are indicated by AR, Vol. (number), Tab (number) at page (if applicable).
[2] AR Vol. 8 Tab 214. The current Intermediary in this appeal is National Government Services.
[3] *Carney Hospital Transitional Care Unit, v. BlueCross BlueShield Association* PRRB Dec. No. 2004-D29, (July 16, 2004) contained in AR Vol. 1 Tab 4. (The Board majority upheld the Intermediary's determination that a change of ownership ("CHOW") had occurred between Franklin Nursing Facility ("Franklin") and Carney TCU and that there was substantial evidence to support that the Franklin Nursing Facility had been primarily engaged in providing skilled service to its residents. Board Chairman Cochran dissented from the decision finding that Franklin was not "primarily engaged" in providing skilled nursing services, and was, therefore, not an equivalent to Carney TCU.), *declined review* CMS Administrator (September 16, 2004).
[4] AR Vol. 1 Tab 1.

The Provider appealed the Board's decision to the federal district court of the District of Columbia (D.C.). On June 1, 2006, following a decision from the D.C. Circuit Court, *St. Elizabeth's Medical Center of Boston, Inc. v. Thompson*, 396 F.3d 1228 (D.C. Cir. 2005) ("*St. Elizabeth's*)[5], the district court remanded the case to the Secretary of Health and Human Services, for a determination consistent with the standard in *St. Elizabeth's*, and for full consideration of the administrative record that was before the Board.[6]

On remand, CMS issued a final determination dated November 2, 2006, denying the Provider's request for exemption from the routine cost limitations.[7] The Provider filed an appeal before the Board. The Provider contemporaneously filed an appeal in the district court, District of Columbia, on the basis that CMS violated the court's order by misconstruing and misapplying the standard mandated by the D.C. Circuit in *St. Elizabeth's*.[8] On April 24, 2008, the district court dismissed the lawsuit for lack of subject matter jurisdiction because the Provider failed to exhaust its administrative remedies before the Board.[9]

The Provider meets the jurisdictional requirements of 42 C.F.R. §§405.1835- 405.1841. The Provider was represented by Deborah Gardner, Esq. of Ropes & Gray, LLP. The Intermediary was represented by L. Sue Anderson, Esq., BlueCross BlueShield Association.

BACKGROUND OF THE PROVIDER'S REQUEST

Prior to Carney Hospital's decision to open a TCU, the State of Massachusetts established a moratorium prohibiting the licensure of any new long-term care beds. Under the State's policies there were exceptions: nursing facilities that were unable to participate in Medicare could upgrade to facilities capable of providing SNF care, and hospitals were permitted to establish SNFs through the purchase of existing nursing facility bed rights. With respect to hospitals, this process resulted in a nursing home's surrender of its bed rights, transferring its patients to other suitable facilities and then closing. Upon closure, the State granted the hospital a new license.

On August 19, 1994, the Provider reached an agreement with Comeau to purchase the rights to operate twenty-seven (27) long-term care beds and certain other assets associated with Franklin Nursing Home (Franklin) subject to states approval.[10] Pursuant to the agreement, the Provider would pay Comeau two hundred and seventy five thousand dollars ($275,000). Comeau would retain ownership of Franklin's accounts receivable, plant and machinery, processing and laboratory equipment, leasehold improvements, furniture, fixtures, and certain other assets.

On September 9, 1994, the Provider filed a "Request for Change in Location of Licensed Beds" with the Massachusetts Department of Public Health in order to relocate the subject beds to its

[5] A copy of court's decision in *St. Elizabeth's* is located at Provider's Supplemental Position Paper Exhibit P-77.
[6] *Carney Hospital Transitional Care Unit v. Tommy G. Thompson, Secretary, United States Department of Health and Human Services* Civil Action No. 04-1598 (RCL)(June 1, 2006) (contained in Provider's Supplemental Position Paper Exhibit P-79).
[7] Position Paper Exhibit P-80.
[8] Letter from BlueCross BlueShield Association to Chairman Cochran PRRB, dated May 17, 2007.
[9] Letter from BlueCross BlueShield Association to Chairman Cochran PRRB, dated August 26, 2008.
[10] AR Vol. 8 Tab 233; See also Provider's Supplemental Position Paper at 28.

campus.[11] Thereafter, having received the State's approval, the Provider and Comeau entered into the asset purchase agreement on December 2, 1994.[12] On the same day, the Provider leased from Comeau all of the real and personal property that had been excluded from the purchase agreement. The lease agreement was necessary since Comeau no longer owned the right to operate nursing home beds yet some patients remained in its facility awaiting relocation. All patients were ultimately relocated by December 16, 1994,[13] and the Provider filed a Medicaid cost report for the period December 3 through December 16, 1994, as the owner of the facility.[14] Thereafter, Franklin was closed. Approximately ten (10) months later, the Provider's TCU was licensed by the State and was opened to accept patients. The Provider's TCU became certified to participate in the Medicare program on October 26, 1995.

PARTIES' CONTENTIONS

The Provider contends that it is entitled to the new provider exemption for three reasons. First, the Provider asserts that it is a new provider of SNF services that has never provided skilled nursing and/or rehabilitation services under its present ownership or under any "skewed" construction of prior ownership.[15] The Provider acknowledged it had purchased Franklin's operating rights (which it then relinquished to a Massachusetts State agency in exchange for a brand new license to operate a completely different type of facility), but this was done in order to comply with the Massachusetts regulatory scheme at the time.[16] The Provider argues that the Board and several Circuit courts have concluded that the purchase of intangible operating rights does not amount to a change of ownership within the meaning of 42 C.F.R. §413.30(e).[17] The Provider further asserts it is not the successor to Franklin, as it never operated pursuant to Franklin's license nor received any of Franklin's assets, patients or staff.[18] Instead, the Provider contends it opened a wholly new and different type of facility (i.e. hospital based skilled nursing facility) in a new location, with new equipment, patients and personnel.

Second, even if the Board were to consider the Provider as the successor to Franklin, the Provider asserts it is still entitled to the exemption because Franklin never operated as a SNF or its equivalent.[19] The Provider maintains that in *St. Elizabeth's*, the D.C. Circuit ruled that a facility cannot be equivalent of a SNF unless it is "primarily engaged in providing skilled nursing or rehabilitative services."[20] The Provider submits that to be "primarily engaged" in

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[11] AR Vol. 8 Tab 235; See also Provider's Supplemental Position Paper at 28.
[12] AR Vol. 9 Tabs 241 and 242.
[13] AR Vol. 2 Tab 36.
[14] AR Vol. 1 Tab 19.
[15] Provider's Supplemental Position Paper at 25.
[16] Provider's Supplemental Position Paper at 28; Transcript (Tr.) at 22 -25.
[17] Provider's Supplemental Position Paper at 31-33. *See*, *Milton Hospital Transitional Care Unit v. BlueCross BlueShield Association*, PRRB Dec. 2002-D48 (September 30, 2002); *Jordan Hospital Plymouth Massachusetts v. BlueCross BlueShield Association*, PRRB Dec. 2007-D23 (February 28, 2007); *Harborside Healthcare-Reservoir* v. *BlueCross BlueShield Association*, PRRB Dec. 2006-D14 (January 25, 2006); *Maryland General Hospital v. Tommy G. Thompson, United States Department of Health and Human Services*, 308 F.3d 340 (4th Cir. 2002); *Ashtabula County Medical Center v. Tommy G. Thompson Secretary of Health and Human Services*, 352 F.3d 1090 (6th Cir. 2003).
[18] Provider's Supplemental Position Paper at 29; Tr. at 25.
[19] Provider's Supplemental Position Paper at 35; Tr. at 28.
[20] *St. Elizabeth's*, 396 F.3d 1234.

furnishing Medicare covered skilled services, a facility must provide skilled services on a daily basis to each of its patients and each patient must require those services.[21] The Provider contends that during the look-back period,[22] the medical record demonstrates that at most only 30% of the Franklin residents in any month received even one skilled service during that month.[23] In most months only 12% of the residents received even one skilled nursing service. Considering the number of patient days per month in which Franklin purportedly provided skilled nursing services, the Provider asserts that at most, only for 11% of Franklin's patient days during all of the months at issue in the look-back period were any skilled services furnished. The Provider further asserts that the average number of patient days per month in which Franklin purportedly provided skilled nursing services during the look-back period was 2.6%.

The Provider contests CMS's computation that 73% to 84% of Franklin's residents received at least one skilled service at some time during their stay at Franklin. The Provider asserts CMS's computation is flawed because CMS merely totaled all the residents for which it claims had received one skilled service during a year long period (i.e., one instance of a skilled service in 365 days) and dividing the total by the census during the same period.[24] The Provider contends that CMS computation does not provide a measure of SNF equivalency because it fails to capture the daily skilled service volume of a SNF, where every patient requires and receives skilled services every day.

The Provider also contends that the CMS' conclusion is flawed because the data used was unreliable and often irrelevant.[25] Specifically, the list of purportedly skilled services compiled by CMS and presented to the Provider in 2008 does not directly cite any medical records; instead it cites only documents prepared by CMS, which do not provide any exhibit or page citations.[26] CMS used medical reports that pre-dated the look back period (i.e., dates prior to October 26, 1992).[27] The Provider contends that the majority of services that CMS characterized as skilled, (e.g. medication administration, inhalation treatment, catheters, decubitus care, consultation visits) as documented on the MMQ[28] and medical summaries, do not rise to the level of skilled care as established by the applicable regulations and decisional law.[29]

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[21] Provider's Supplemental Position Paper at 37 (citing to 42 C.F.R. §§409.31(b)(1) and 409.34 and Skilled Nursing Facility Manual CMS Pub. 12, §214.5); Tr. at 29-30.

[22] Provider's Supplemental Position Paper at 49; Tr. at 39-40. The regulatory "look-back period" for new providers runs three years prior to the date of its Medicare certification. 42 C.F.R. §413.30(e). In this case, the look-back period runs from October 25, 1992 to October 25, 1995.

[23] Provider's Supplemental Position Paper at 70. In reviewing the medical record, the Provider prepared a chart "Review of Franklin Nursing Home MMQs and CMS Exhibit Regarding "Medical Records." S*ee,* Provider's Exhibit P-67; Tr. 43. In preparing the chart, the Provider considered all the comments made by the Intermediary in its various summaries of the medical records and Management Minutes Questionnaires ("MMQs"). (The MMQ records information about both unskilled and skilled services as defined by the Massachusetts Department of Public Welfare. ("DPW"). MMQs are completed by nursing facilities on a quarterly basis and document care given to residents for at least 50% of the preceding month. *See,* Provider's Supplemental Position Paper at 48, Fn 148). *See also,* Provider's Exhibit P-68 "Affidavit of Janna J. Hansen," for a detailed description on how the Provider reviewed the medical record and prepared the chart at Provider's Exhibit P-67.

[24] Provider's Supplemental Position Paper at 39; Tr. at 35-37.

[25] Provider's Supplemental Position Paper at48-51; Tr. 39-41.

[26] Provider's Exhibit P-81.

[27] Provider's Supplemental Position Paper at 49; Tr. at 39-40.

[28] Provider's Supplemental Position Paper at 70. In reviewing the medical record, the Provider prepared a chart "Review of Franklin Nursing Home MMQs and CMS Exhibit Regarding "Medical Records." S*ee,* Provider's

The Provider contests CMS's claim that the D.C. District court in *Milton* held that if more than 50% of residents received at least one skilled service at any point in their stay, the facility was primarily engaged in providing skilled services.[30] The Provider argues that *Milton* did not establish a 50% threshold without regard to the volume of skilled services provided to each resident. Instead, the court noted that only 31% to 45% of the residents at the nursing home received skilled services at all, thus the facility was not primarily engaged in providing skilled services.

Finally, the Provider asserts it is entitled to the exemption as a relocated provider because CMS' own policy guidance, which was in effect during the first two years of the Provider's operation, authorized an exemption for providers whose normal inpatient population at the old location could no longer be expected to be served at the new location and whose total patient days in the new location were substantially fewer than at the old location for a comparable period.[31] The Provider submits that it is undisputed that no resident of Franklin was or could have been admitted to the Provider. Franklin's normal patient population, therefore, could not be expected to be served at the Provider. In addition, the Provider's total patient days were half those of Franklin for a comparable period.

The Intermediary contends that the Board was correct in its first decision that a change of ownership (CHOW) had occurred through the execution of the Notice of Intent to Acquire an Existing Health Care Facility dated August 19, 1994 and statements made by the Provider on its application for licensure.[32] The Intermediary maintains that the Provider's actions in purchasing the bed rights from Franklin and then leasing all of Franklin's facilities before closing it, constitute a CHOW.[33]

The Intermediary contends that the Provider does not qualify as a new provider because Franklin primarily engaged in rendering skilled services to its residents during the three year look back period preceding the purchase by the Provider.[34] Contrary to the Provider's assertions that to be considered "skilled" the care needs to be delivered on a daily basis, the Intermediary contends that the requirement for "daily" is used only for purposes of Medicare reimbursement, and is not a factor in evaluating whether the care provided was skilled in nature.[35] The Intermediary asserts that the regulation at 42 C.F.R. §409.33(a) provides the definition and examples of skilled care, which include "overall management and evaluation of a care plan" and the "observation and

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Exhibit P-67; Tr. 43. In preparing the chart, the Provider considered all the comments made by the Intermediary in its various summaries of the medical records and Management Minutes Questionnaires ("MMQs"). (The MMQ records information about both unskilled and skilled services as defined by the Massachusetts Department of Public Welfare. ("DPW"). MMQs are completed by nursing facilities on a quarterly basis and document care given to residents for at least 50% of the preceding month. *See*, Provider's Supplemental Position Paper at 48, Fn 148). *See also*, Provider's Exhibit P-68 "Affidavit of Janna J. Hansen," for a detailed description on how the Provider reviewed the medical record and prepared the chart at Provider's Exhibit P-67.

[29] Provider's Supplemental Position Paper at 53-67; Tr. at 41 – 42.

[30] Provider's Supplemental Position Paper at 40, citing to *Milton*, 377 F. Supp. 2d at 27.

[31] Provider's Supplemental Position Paper at 75 – 76.

[32] Intermediary's Supplemental Brief at 12.

[33] Tr. at 85-86.

[34] Intermediary's Supplemental Brief at 14.

[35] Tr. at 91-93.

assessment of a patient's changing medical condition."[36] The Intermediary asserts that the patient medical records, the MMQs and the medical summaries demonstrate that Franklin was providing skilled services as defined by the regulation.[37]

The Intermediary asserts that combining the information from the patient records, the MMQs and the patient days report data provides a calculation of the percentage of residents, by patient days, who received skilled services.[38] The Intermediary submits that this data reveals the portion of the patient population receiving skilled nursing and related services or rehabilitative service at Franklin was 84% in calendar year (CY) 1992, 78% in CY 1993, and 83% in CY 1994.[39] Based on this data and by applying the standard in *Milton*, the Intermediary argues that Franklin was primarily engaged in skilled services because more than 50% of the patients received skilled services.

The Intermediary contends the Provider does not qualify as a new provider under Medicare's relocation rules because both the Provider and Franklin are located within the same health service area designated by the state and, therefore, the same patient population can expect to be served at the Provider's location as was served at Franklin's location.[40] The Intermediary noted that according to the Provider's "Request for Change in Location of Licensed Beds" dated September 9, 1994 and filed with the State of Massachusetts, the Provider stated it intended to serve the same population as at Franklin and that there was not going to be any substantial change in the nature of its services or the population.[41] In addition, the Intermediary contends that the Provider has not demonstrated that it suffered from a lack of utilization following its purchase of Franklin. On the contrary, the evidence shows that the Provider increased its bed utilization and patient load in 1995. Moreover, testimony from the first hearing obtained from the Provider's witness reveals that the Provider was at full occupancy and that the only limitations to full occupancy was staffing.[42]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION

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

Based on a review of the transaction that occurred in this case coupled with the assets actually purchased from Comeau, the Board finds that there was a CHOW and, consistent with its earlier decision, that the Provider did, in fact, purchase and relocate Franklin. Specifically, on August 19, 1994, the Provider filed with the state a "Notice of Intent to Acquire an Existing Health Care

[36] Tr. at 93-97.
[37] Intermediary's Supplemental Brief at 19 – 22; Tr. at 115 -17. At the hearing, the Intermediary explained that the medical evidence consist of patient medical records contained at Intermediary's Exhibit I-99 and a consolidated medical summary contained at Intermediary's Exhibit I-110B. The Intermediary explained that Exhibit I-110B was prepared by nurse reviewers from the Intermediary and consists of a consolidation of the medical records contained in Intermediary's Exhibit I-99 and the MMQs contained in AR Vol. 9 Tab 257.
[38] Intermediary's Supplemental Brief at 22 and 23.
[39] Intermediary's Supplemental Brief at 24.
[40] Intermediary's Supplemental Brief at 25.
[41] Tr. at 150-151; AR Vol. 8 Tab 235.
[42] Tr. at 154; AR Vol. 5 Tab 133 at 1994, 2089 and 2093.

Facility," not simply operating rights or bed rights.[43] Thereafter, on September 9, 1994, the Provider filed with the state a request to transfer Franklin to its campus, and on September 16, 1994, the Provider filed with the state a "Notice of Intent to Acquire Ownership of Franklin Nursing Home."[44] Then, on November 17, 1994, the Provider advised the State that "[a]s you are aware, Carney Hospital . . . is in the process of purchasing the Franklin Nursing Home . . ."[45] and on December 2, 1994, the Provider filed a "License Application in Connection with Transfer of Ownership of Franklin Nursing Home, Braintree."[46] From December 3, 1994 to December 16, 1994, the Provider operated Franklin, apparently under its existing Medicaid Agreement, and filed a Medicaid cost report for this period as Franklin's owner.[47] Based on these facts, the Board finds that Provider was purchasing more than just Franklin's operating rights or bed rights. These documents reveal the assets acquired included: Franklin's name and goodwill associated with that name; all transferable licenses, permits and other rights and interests including any transferable licenses, permits, registrations or authorizations from Federal and state authorities relating to the ownership, management or operation of the facility; certain contracts and agreements and commitments related to the ownership of the facility; books and records, customer and supplier lists, provider agreements, patient lists, approvals, permits, contracts, plans, surveys, policy manuals, accounts and other records used in connection with the ownership of the facility; trademarks, service marks, etc.; and, advances or pre-payments made by patients of the facility for services not rendered prior to the closing.[48]

The Board acknowledges that CMS Pub. 15-1 §2533.1.E.1.b was modified after the transaction central to this case to explain that the acquisition of operating rights to long-term care beds reflects a change of ownership for the purpose of determining new provider status pursuant to 42 C.F.R. §413.30(e). The Board, however, did not rely upon this instruction when reaching its decision that the Provider had, in fact, purchased Franklin. Rather, as discussed immediately above, the Board relied upon general rules of ownership.

The Board finds that the Provider does not qualify for new provider status based upon Medicare's relocation rules. While the Provider argues that it serves a different inpatient population than that served at Franklin's location, the Provider did not demonstrate that its total inpatient days were substantially less than Franklin's. In fact, the record shows that the Provider's utilization was not low. According to testimony elicited at the previous hearing, held on February 7, 2002, the Provider experienced a utilization rate of about 74 percent during its first year of operation.[49]

While the Provider does not qualify for new provider status under the CHOW or relocation criteria, the Board finds the Provider does qualify as a new provider because Franklin did not operate as a SNF or its equivalent for three years prior to the October 26, 1995 certification date.

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[43] AR Vol. 8 Tab 233.
[44] AR Vol. 8 Tabs 235 and 236.
[45] AR Vol. 8 Tab 238.
[46] AR Vol. 9 Tab 240.
[47] AR Vol. 1 Tab 19.
[48] AR Vol. 8 Tab 234 at 3049-3050.
[49] AR Vol. 5 Tab 133 at 1873.

In examining whether Franklin operated as a SNF or its equivalent, the Board applies the standard under *St. Elizabeth's.* In *St. Elizabeth's* the Circuit Court reviewed the Medicare statutory definition of a SNF in 42 U.S.C. §1395i-3(a), and compared it to the Medicaid statutory definition of a nursing facility (NF) in 42 U.S.C. §1396r(a). The Medicare statute defines a "skilled nursing facility" as one that 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. (emphasis added)

42 U.S.C. §1395i-3(a)(1).

On the other hand, the Medicaid statute, while incorporating the definition in the Medicare statute, adds a third alternative definition and defines a NF as one which provides:

> (C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

42 U.S.C. §1396r(a)(1)(C).

As a result, the court in *St. Elizabeth'*s concluded that a NF does not have to provide any skilled services. To qualify as a NF it could primarily provide only the custodial services set forth in the alternative section in 42 U.S.C. §1396r(a)(1)(C).[50] The court held to be qualified as an SNF or its equivalent, the institution must be "primarily engaged in providing to its residents" skilled nursing care and related services or rehabilitative services.[51]

In this case, the parties have presented two competing charts to demonstrate whether Franklin was primarily engaged in providing skilled nursing and related services or rehabilitative services. The Provider prepared its chart by synthesizing all the comments made by the Intermediary in its various summaries of the MMQs and patient records and organized these comments by residents.[52] Following completion of the chart, the Provider calculated the percentage of residents receiving even one skilled service in any month during the MMQ quarters of the look-back period.[53] The Provider argues that, at most, the number of residents receiving at least one skilled service per MMQ time period was 30% with the average number being 12.4%.[54]

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[50] St. Elizabeth's 396 F.3d. at 1234.
[51] *Id*.
[52] Provider's Exhibit P-67; *supra* note 17; Tr. 43.
[53] Provider's Supplemental Position Paper at 70. The Provider excluded from its calculation all those services for which Medicare authority is clear that the service claimed by the Intermediary is either not skilled or where there is insufficient evidence to support a finding that the service is skilled. *See*, Provider's Supplemental Position Paper at 68-69; Tr. at 58.
[54] *Id*.

The Intermediary prepared its chart based on the MMQs and abbreviated medical summaries prepared by its nurse reviewers.[55] The Intermediary combined the data with the patient report data and calculated the percentage of residents, by patient days, who received skilled services. The Intermediary contends that during the relevant period 71% to 83% of Franklin patients received skilled services.

The Board questions the accuracy of the Intermediary's statistical findings in support of its conclusion that Franklin primarily engaged in providing skilled nursing and rehabilitation services to its patients. The Intermediary relied heavily on the MMQs and abbreviated medical summaries to support its conclusion. While some of the services listed on the MMQs appear to be skilled services, for many other services it is impossible to determine whether those services qualify as skilled nursing.[56] For example, as documented on the MMQ, the Intermediary identified "dispense meds and chart" as a skilled service. However, the instructions on the MMQ require that every completed form contain the code for dispensing and charting medications.[57] Indeed, the MMQs are preprinted with the appropriate boxes already completed. Consequently, the nurse completing the form has no discretion to assess whether the patient is receiving the service or to determine whether it constitutes a skilled nursing service. Moreover, the MMQ defines "dispense meds and chart" as "pouring, delivering and charting medications; routine injections, prn (when necessary) medication, eye drops, eye ointment, and suppositories…" Some of these services are clearly, by regulation, not skilled services.[58]

A second example that the Intermediary identified as a skilled service on the MMQ is "special attention for behavioral problems." The MMQ defines a patient as having behavioral problems if "the resident displays, at least three times a week, selected types of behavior that are generally considered dependent or disruptive, and require staff intervention, such as: disrobing or exposing oneself; screaming; being physically abusive to oneself or others; stealing; getting lost or wandering into inappropriate places; or inability to avoid simple danger."[59] The Intermediary has not cited to any physician orders or nursing notes to verify that the patient's psychological behavioral symptoms required the skilled observation by a professional to ensure the safety of the patient and the safety of others.[60] Therefore, there is no support to confirm that the services were indeed skilled in nature.

A final example the Intermediary identified on the MMQ as a skilled service is "skilled observation daily." Instructions on the MMQ require that a "skilled observation daily" must be specifically ordered in writing by a physician, performed by a licensed nurse daily and recorded at least once a day.[61] The Board notes that the audits of Franklin's MMQs by the Massachusetts Department of Public Welfare for the period of April 1993 indicate the state downgraded the MMQs for seven residents for which Franklin reported skilled observation because of lack of

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[55] Tr. 123.
[56] *Milton* 377 F. Supp. 2d at 30.
[57] AR Vol. 9 Tab 257 at 3555.
[58] Milton 377 F. Supp. 2d at 30 citing to 42 C.F.R. §409.33(d)(1) stating that the administration of routine oral medications, eye drops, and ointments are not skilled services.
[59] AR Vol. 9 Tab 257 at 3563.
[60] 42 C.F.R. §409.33(a)(2)(ii).
[61] AR Vol. 9 Tab 257 at 3556.

supporting medical documentation.[62] For these reasons, the Board does not find statements in the MMQs credible in identifying skilled services and , therefore, not supportive of the Intermediary's conclusion that Franklin was primarily engaged in skilled services more than 50% of the time.

The Board finds the Provider's calculations more accurate because it considered the number of residents that received even one skilled service in each month for which Franklin submitted a MMQ during the look-back period. Also, while the MMQs record services provided for at least 50% of the preceding month, the Provider conservatively considered that any service reflected on the MMQ was performed for the entire month.[63] Therefore, the Provider's calculations of patient days are conservative and may have overstated the services provided at Franklin. Even with the conservative approach, though, the Provider's data shows less than 50% of Franklin residents had received skilled services, and under *Milton*, fails to demonstrate that Franklin was primarily engaged in providing skilled nursing or rehabilitative services.

The Board finds other evidence further demonstrates that Franklin was not primarily engaged in providing skilled services, and instead furnished services of the type of care described in subsection (C) of the Medicaid statute. First, unlike the Carney TCU, Franklin was never certified by Medicare to operate as a SNF. Instead, Franklin was licensed by the state as a Medicaid intermediate care facility, a Level III nursing home , which allowed it to provide long term custodial care to its residents as described in subsection (C) of the Medicaid statute.[64] The record shows that Franklin operated consistent with its state license in providing only "periodic . . . skilled nursing, restorative or other therapeutic services;" that Franklin's patients were long term residents who were "aging in place," needing primarily "maintenance" or "supportive care;" and that they were transferred to facilities which could offer intensive skilled nursing or rehabilitative care when acute episodes occurred.[65]

As acknowledged by the Provider, the record shows that some skilled services were occasionally rendered at Franklin, there is no evidence that these services were being provided on a regular basis.[66] Indeed, the record shows that Franklin was not staffed to operate as a SNF. Franklin's staff consisted of a cook, a nurse, some nurses' aides, an administrator and custodial/gardening staff.[67] Franklin's medical director, Dr. Baer, conferred with the staff on a monthly basis, but there was no physical or occupational therapist on site, no psychiatrist, no social workers and none of the medical services that would be available in a SNF. The Board finds that the limited availability of skilled personnel does not support a determination that Franklin was "primarily engaged" in rendering skilled nursing care and related services or rehabilitation services on an ongoing or regular basis.

In summary, using of the standards set forth in *St. Elizabeth's*, the Board finds Franklin was not "primarily engaged" in providing skilled nursing care and related services or rehabilitation

[62] AR Vol. 2 Tab 76 at 822-23.
[63] Provider's Supplemental Position Paper at 70, note 228.
[64] AR Vol. 5 Tab 132 at 1370-73, 1390-97.
[65] AR Vol. 5 Tab 133 at 1895, 1901-02, 2023-24.
[66] Tr. at 170-71.
[67] AR Vol. 5 Tab 133 at 2019-21.

services, and was, therefore, not a SNF or its equivalent. Consequently, the Provider meets the definition of a "new" provider as set forth at 42 C.F.R. §413.30(e) in that it is a licensed and Medicare-certified SNF that has operated as this type of provider for less than three years.

DECISION AND ORDER

The Provider was improperly denied a new provider exemption from the routine service cost limits for its hospital-based skilled nursing facility. The Intermediary's denial is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A
John G. Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: JUNE 29, 2010