

**PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION**

2002-D48

PROVIDER –
Milton Hospital Transitional Care Unit
Milton, Massachusetts

Provider No. 22-5673

vs.

INTERMEDIARY – Blue Cross and
Blue Shield Association/Associated
Hospital Services (formerly C&S
Administrative Services)

DATE OF HEARING-
November 14-15, 2001

Cost Reporting Periods Ended
September 30, 1995, 1996, 1997 and
1998

CASE Nos.
96-2035, 96-2036,
96-2037 and 96-2038

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ISSUE:

Did the Centers for Medicare and Medicaid Services (“CMS”)¹ properly deny Milton Hospital Transitional Care Unit’s request for an exemption from the Medicare skilled nursing facility routine service cost limits (“SNF RCLs”) as a new provider under 42 C.F.R. § 413.30(e)?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Milton Hospital Transitional Care Unit (“Provider or TCU”) is a 20-bed hospital-based skilled nursing facility (“SNF”) located on the campus of Milton Hospital (“Hospital”) in the town of Milton, Massachusetts. Milton is located in health service area HSA IV (Greater Boston HSA) as designated by the Massachusetts Department of Public Health (“DPH”). The Provider admitted its first patient on May 1, 1995 and became certified under the Medicare program on May 12, 1995.

Under the Massachusetts’ statutes and regulations, a provider must possess a determination of need (“DON”) from DPH which grants the legal right to establish a facility with a specific number of skilled nursing care beds. In addition, since 1994 Massachusetts imposed a moratorium on the issuance of DONs for the right to operate new long-term care beds which remained in effect until May 1, 2000. DPH Regulation 105 C.M.R. § 100.302(D).² Accordingly, providers who wanted to obtain the legal right to establish a new SNF in Massachusetts during this time period were required to participate in the DPH regulatory process set forth in 105 C.M.R. § 100.710.³ Under this regulatory process, a provider which does not possess the legal rights to establish SNF beds can obtain those rights from another provider. Upon the approval of DPH, a provider which possesses a DON authorization to establish a specified number of long-term-care beds, but which has not yet operated those beds, may transfer the DON authorization to another provider. The provider receiving the DON authorization may then seek approval from DPH to establish the beds at its own site under the DPH regulatory provisions set forth at 105 C.M.R. § 100.720.⁴

In accordance with Massachusetts’ DON requirements, the Provider in the instant case obtained the legal rights to establish its 20-bed SNF from Neponset Hall, Inc., a separate corporation unrelated to the Provider. Neponset Hall, Inc. had received a DON on July 20, 1994 from DPH authorizing the construction of a new facility in Milton, Massachusetts. The new facility would

¹ CMS was known as the Health Care Financing Administration (“HCFA”) at the time denial actions were taken. This decision will refer to the name of the agency as CMS unless otherwise required by the context.

² See Provider Exhibit P-1.

³ See Provider Exhibit P-2.

⁴ See Provider Exhibit P-3.

replace the 98-bed Level III Neponset Hall Nursing Home and the 77-bed Level III Ashmont Manor Nursing Home, both located in Dorchester, Massachusetts, and add 12 DON exempt beds, for a total of 187 authorized beds.⁵ On September 23, 1994, Milton Hospital (“Buyer”) entered into an agreement (“DON Agreement”) with Neponset Hall, Inc. (“Seller”), wherein the Seller agreed to request approval from DPH for the transfer of 20 beds from the DON to the Buyer to be put into service at the Milton Hospital site. As consideration for the DON transfers, the Buyer agreed to pay the Seller the sum of \$400,000.⁶ On October 28, 1994, DPH approved: (1) the transfer of ownership of 20 BANYL beds (Beds Approved But Not Yet Licensed) from Neponset Hall, Inc. to Milton Hospital; and (2) the establishment of the 20 beds at the Milton Hospital campus.⁷ The DPH approval letter contemplated that Milton Hospital would request that the 20 Level III beds be upgraded to Level II beds at the time of the licensure of the facility. By letter dated December 5, 1994, Milton Hospital requested that the 20 approved beds be upgraded to skilled nursing care beds in connection with the licensure of the hospital-based unit.⁸

Licensure and Medicare certification of health care facilities in Massachusetts are also the responsibility of DPH. The licensure regulations at 105 C.M.R. § 150.000 *et seq.* recognize four levels of licensure, which consist of Level I (Intensive and Rehabilitation Care), Level II (Skilled Nursing Care), Level III (Supportive Nursing Care), and Level IV (Resident Care).⁹ The Provider was granted its first license on May 1, 1995 with all 20 of its authorized beds classified as Level II beds.¹⁰ As a transitional care unit, the Provider furnishes skilled nursing services to patients in transition between a hospital and their home.

On June 2, 1995, Milton Hospital requested an exemption from the Medicare SNF routine service cost limits as a new provider under the regulatory provisions of 42 C.F.R. § 413.30(e). The exemption was requested on behalf of its TCU for the fiscal years ended (“FYE”) September 30, 1995 through September 30, 1998.¹¹ The exemption request was submitted to C&S Administrative Services, the Provider’s Intermediary at that time, which forwarded the request to CMS for a decision. In response to inquiries from the Intermediary, additional information regarding the TCU was submitted by the Hospital on July 13, 1995.¹² By letter dated November

⁵ See Provider Exhibit P-4/Intermediary Exhibit I-18.

⁶ See Provider Exhibit P-5/ Intermediary Exhibit I-20.

⁷ See Provider Exhibit P-6/ Intermediary Exhibit I-21.

⁸ See Provider Exhibit P-7.

⁹ See Provider Exhibit P-24.

¹⁰ See Provider Exhibit P-9/ Intermediary Exhibit I-25.

¹¹ See Provider Exhibit P-10.

¹² See Provider Exhibit P-11/ Intermediary Exhibit I-1.

20, 1995,¹³ CMS notified the Intermediary that the Provider's exemption request had been denied stating the following:

We have reviewed the information submitted with the request of Milton Hospital Transitional Care Unit (Milton), Provider Number 22-5673, for an exemption to the Medicare skilled nursing facility routine service cost limits

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. . . .

Lastly, the key to understanding HCFA's regulations and policy concerning new provider exemptions is recognizing that we look at the operation of the institution or institutional complex under both “past and present ownership” exclusive of specific provider numbers, name, location, etc., since these are subject to change, but in fact no change in the operation of the institution or institutional complex has occurred. . . .

Given this context, Milton became Medicare certified May 12, 1995. However, Milton, previously an integral component of Neponset Hall and Ashmont Manor, had operated as a NF [Nursing Facility] since October 1, 1990 and therefore is considered to be an equivalent provider of skilled nursing or rehabilitative services. Both Neponset Hall a 98 bed NF and Ashmont Manor a 77 bed NF were certified for Medicaid participation in June of 1978, under Provider Numbers 22E712 and 22E764, respectively, prior to their closure and subsequent

¹³ See Provider Exhibit P-12/Intermediary Exhibit I-3.

consolidation and relocation to Neponset Circle Skilled Nursing and Rehabilitation Center, now Provider Number 22-5680.

This consolidation also included the addition of 12 DON-exempt beds; DON-Exempt beds are not purchasable under Massachusetts State Law. Consequently, prior to this relocation, the facility delicensed 20 of its existing long term care beds and sold them to Milton. These 20 previously licensed beds were then relocated to 92 Highland Avenue, Brooks 3, Milton, Massachusetts on February 1, 1995. The relocated beds at Milton are not BANYL beds, as indicated on the facilities DON Project Number 4-1296. BANYL beds are beds approved but not yet licensed. Furthermore, BANYL beds are not purchasable under Massachusetts State law. This is supported by a letter dated January 9, 1995 from the Commonwealth of Massachusetts, Division of Health Care Quality relating to the licensure process for Milton which states that:

“consistent with the information filed with the Department, the licensure of the proposed skilled nursing facility at Milton Hospital is contingent upon the following:

- Prior or simultaneous delicensure of beds at Long Term Care Facility at Neponset: Ashmont Manor and/ or Long Term Care Facility at Neponset: Neponset Hall, adding up to 20 beds; or
- Prior or simultaneous delicensure of 20 beds at the facility resulting from the completed consolidation of the above mentioned two facilities, which is to be licensed as Neponset Circle Skilled Nursing and Rehab Center, Inc.

This relocation was in accordance with the transfer of site approved by the Massachusetts Department of Public Health, Division of Health Care Quality based upon the transfer of ownership of twenty beds from Neponset Hall to Milton Hospital, assuming relocation of the long-term care beds to the campus of Milton Hospital. For Medicare reimbursement purposes, this relocation represents a change in ownership as defined under

Section 1500 of HCFA Pub. 15-1, the Provider Reimbursement Manual.

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 described in sections 1819 (b) (4) and 1919 (b)(4) of the Act in order to be certified for Medicare or Medicaid. 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, would have already incurred the start-up costs associated with the development of the capacity to furnish inpatient SNF 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.

Furthermore, skilled nursing and rehabilitative services were provided at Neponset Hall and Ashmont Manor, regardless of the change in the law, and are now provided at Milton. These services included, but were not exclusive of, use of indwelling and external catheters, bowel and bladder training, care of pressure ulcers, respiratory care (i.e. administration of oxygen), trach care, special rehab services, injections and tube feedings. This information was retrieved from Neponset Hall and Ashmont Manor's self reported resident census reports from their 1991, 1992 and 1993 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.

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. In reviewing a certificate of need, the State of Massachusetts Department of

Public Health, Determination of Need Program (“DNP”) considers if a substantial change in the population has occurred or if there has been a change in the primary service area. Consequently, DNP considers all of Greater Boston to be one service area, referred to as HSA IV (see attachment). If a facility remains in this area upon relocation, the State does not consider that to be a substantial change in the population served or in the primary service area. Neponset Hall, Ashmont Manor, and Milton Hospital are all included in HSA IV. Therefore, there has been no substantial change in the population served or in the primary service area. . . .

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

1. It was a portion of an existing long term care institution that was relocated to the hospital complex, due to a CHOW in accordance with Section 1500 of HCFA Pub. 15-1.
2. The portion of the existing long term care institution, prior to relocation, operated as a NF since October 1, 1990 and is considered an equivalent provider of skilled or rehabilitative services in accordance with the changes in the law resultant from OBRA-1987.
3. Notwithstanding the change in the law, the existing long term care institution, prior to relocation, operated in the manner equivalent to a SNF by performing skilled nursing and rehabilitative services, for three or more years prior to Medicare certification.
4. Upon relocation, the population served did not substantially change, nor was there a change in the primary service area.

While the Provider was not granted approval for an exemption, CMS advised that the Provider may qualify for an exception to the RCLs under the regulatory provisions set forth in 42 C.F.R. § 413.30(f). The Provider requested and received relief from the RCLs through the exception provision of atypical services for the FYEs September 30, 1995, 1996, 1997 and 1998.¹⁴

The Provider appealed CMS’ denial of its new provider exemption request for each of the fiscal years in controversy to the Provider Reimbursement Review Board (“Board”) pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The

¹⁴ See Intermediary Exhibits I-87, I-88, I-89 and I-90.

estimated amount of Medicare reimbursement in dispute as set forth in the Intermediary's position paper for each of the fiscal years in contention is as follows:

<u>Case No.</u>	<u>FYE</u>	<u>Amount</u>
96-2035	9/30/95	\$309,000
96-2036	9/30/96	\$537,000
96-2037	9/30/97	\$740,000
96-2038	9/30/98	\$807,000

The Board consolidated the four appeals and a concurrent hearing was conducted on November 14 and 15, 2001. The Provider was represented by Richard P. Ward, Esquire, and Susan T. Nicholson, Esquire, of the Ropes and Gray law firm. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it is entitled to an exemption from the SNF RCLs for fiscal years 1995 through 1998 under the new provider provisions set forth in 42 C.F.R. § 413.30 (e).¹⁵ This controlling regulation states that:

- (e) 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. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

42 C.F.R. § 413.30(e).

The qualifying criteria for the new provider exemption are further described in § 2604.1 of the Provider Reimbursement Manual ("HCFA Pub.15-1").¹⁶ The Provider points out that this applicable manual provision, which was in effect at the time the exemption was requested, stated the following in its entirety:

A new provider is an institution that has operated in the manner for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than three full years. For example, an institution that has been furnishing only custodial care to patients for two full years prior to its becoming certified as a hospital furnishing covered services to Medicare beneficiaries,

¹⁵ See Provider Exhibit P-16.

¹⁶ See Provider Exhibit P-18.

shall be considered a “new provider” for three full years from the effective date of its certification. However, if an institution had been furnishing hospital healthcare services for two full years prior to its certification, it shall only be considered a “new provider” in its third full year of operation, which is its first full year of participation in the program.

Although a complete change in the operations of the institution, as illustrated above, shall affect whether and how long a provider shall be considered a “new provider,” changes of the institution’s ownership or geographic location do not in itself [themselves] alter the type of health care furnished and shall not be considered in the determination of the length of operation.

However, for 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 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. 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 the relocation. The periods compared must be at least three months in duration.

HCFA Pub. 15-1 § 2604.1

The Provider notes that CMS replaced HCFA Pub. 15-1 § 2604.1, effective October 19, 1997, with § 2533¹⁷ which redefined the meaning of a “substantially different inpatient population” as follows:

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 or institutional complex is located. If an

¹⁷ See Provider Exhibit P-35.

institution or institutional complex relocates within the same HSA for long term facilities, or its equivalent, it will not qualify for a new provider exemption, as the population normally served would continue to be expected to be served at the new location. To demonstrate a substantial change in the population served, an institution or institutional complex must show that 50 percent or more of its admissions (or payers) are from a different HSA

HCFA Pub. 15-1 §2533.

The Provider points out that, under the provisions of 42 C.F.R. § 413.30 and HCFA Pub. 15-1 § 2604.1, a provider may be entitled to a new provider exemption if it has “operated” under present and previous ownership for less than three years. An existing provider that “relocates” from another location may also qualify for the exemption under § 2604.1 if certain conditions exists. However, under the new provisions of HCFA Pub.15-1 § 2533, CMS determines whether the pre-existing facility and the “relocated” facility serve the same population solely upon whether the facilities are located within the same HSA for long-term facilities, or its equivalent. The Provider argues that this single-factor approach of § 2533 is inconsistent with the more flexible multi-factor standard under § 2604.1 which was in effect in 1995 when the exemption request was filed. Given the complete conflict between § 2533 and § 2604.1, CMS’ reliance on § 2533 represents an impermissible retroactive application of a subsequent change in policy.

In denying the Provider’s exemption request, CMS cited the following reasons:

1. The TCU was a portion of an existing long term care institution that was relocated to the hospital complex due to a change in ownership.
2. The portion of the existing long term care institution had, prior to relocation, operated as a nursing facility certified under Medicaid since October 1, 1990 and is therefore considered an equivalent provider of skilled or rehabilitative services.
3. The existing long term care institution, prior to relocation, operated in the manner equivalent to a skilled nursing facility certified under Medicare by performing skilled nursing and rehabilitative services for three or more years prior to Medicare certification.
4. Upon relocation, the population served did not substantially change nor was there a change in the primary service area.

The Provider contends that none of the above reasons support CMS’ denial of the new provider exemption because each is based upon unfounded assertions and unsupportable interpretations of the law and regulations. As grounds for its denial, CMS stated that: (1) The Provider was a portion of an existing long term care institution that had been relocated to the Milton Hospital complex due to a change of ownership (“ CHOW”) in accordance with HCFA Pub. 15-1 § 1500 et seq.; and (2) Prior to relocation, the existing long term care institution had been operated as

the equivalent of a skilled nursing facility. Contrary to CMS' determination, the Provider contends that under the governing regulation at 42 C.F.R. § 413.30(e) the Board should find CMS' denial improper if either of the following conditions is met:

- (1) The establishment of the TCU did not involve a CHOW of all or any portion of an existing long term care institution;
- (2) Assuming arguendo that a CHOW did occur, the existing long term care institution had not, in the three-year period prior to the CHOW, been operated as the "equivalent" of a skilled nursing facility.

The following constitutes a summary of the evidence and arguments presented by the Provider to demonstrate that both of the above conditions have been satisfied, and that CMS' denial was inappropriate and should be reversed.

I. Background and Summary of Evidence:

A. The Massachusetts Regulatory System for Nursing Facilities:

1. Classification of Nursing Facilities in Massachusetts:

The Provider points out that DPH's licensure regulations at 105 C.M.R. § 150.000 et seq.¹⁸ recognize four levels of nursing facilities. For purposes of the cases before the Board, two levels of nursing facilities are relevant:

- (1) Level II, or "Skilled Nursing Care Facilities," defined in §150.001 as "a facility or units thereof that provide continuous skilled nursing care and meaningful availability of restorative services and other therapeutic services in addition to the minimum, basic care and services required in these rules and regulations for patients who show potential for improvement or restoration to a stabilized condition or who have a deteriorating condition requiring skilled care;"
- (2) Level III, or "Supportive Nursing Care Facilities," defined in §150.001 as "a facility or units thereof that provide routine nursing services and periodic availability of skilled nursing, restorative and other therapeutic services, as indicated, in addition to the minimum, basic care and services required in 105 C.M.R. § 150.000 for patients whose condition is stabilized to the point that they need only supportive nursing care, supervision and observation."

105 C.M.R. § 150.000 (emphasis added).

¹⁸ See Provider Exhibit P-24.

Based on the testimony of its witnesses at the hearing before the Board,¹⁹ the Provider points out that the distinction in levels is reflected in the requirements for physical plant, unit size and staffing requirements.²⁰ Whereas a Level III facility is permitted to provide a skilled nursing service to its patients on a periodic or occasional basis, it is not permitted to admit patients who require continuous skilled nursing care under the terms of its license. DPH does not regard Level III facilities as having sufficient staff to meet the patients needs, and as a matter of policy, DPH does not certify a nursing facility to participate in the Medicare program as a SNF unless it is certified as a Level II facility.²¹

2. The Massachusetts DON Program and the Moratorium on Construction of New Nursing Facilities :

Under Section 25C of Chapter 111 of the Massachusetts General Law,²² any person seeking to construct a nursing facility must apply for a determination that there is a need for the proposed facility at a designated location where construction involves more than a certain minimum capital expenditure. In addition, during the 1990's DPH issued regulations at 105 C.M.R. §§ 100.301-302 postponing the filing dates for DON applications.²³ This action imposed a moratorium on new construction of nursing facilities with certain limited exceptions.

B. History of the Establishment of the Milton Hospital TCU:

At the time Milton Hospital sought to establish a TCU, the Moratorium on Construction was in effect. Accordingly, the Hospital conducted a search for an entity that had already obtained a DON. This resulted in the identification of Neponset Hall, Inc., an unrelated corporation that held an approved DON to construct a specified number of new nursing facility beds in the future. In Massachusetts, such beds are referred to as BANYL beds, i.e. bed approved but not yet licensed.

1. DON Project No. 4-1296:

Neponset Hall, Inc. ("Neponset") received DPH approval for the proposed project on July 20, 1994 which was identified as DON Project No. 4-1296.²⁴ The approval provided for the construction of a new facility to replace and relocate the 98-bed Level III Neponset Hall Nursing

¹⁹ The hearing transcripts for the two-day hearing will be identified as 1 Tr. for the November 14, 2001 proceedings and 2 Tr. for the November 15, 2001 proceedings.

²⁰ See Provider Exhibit P-85; 1 Tr. 451-457.

²¹ 1 Tr. 75-92, 407-411; 2 Tr. 17-19.

²² See Intermediary Exhibit I-8.

²³ See Provider Exhibit P-1.

Home and the 77-bed Level III Ashmont Manor Nursing Home which were located side by side in the town of Dorchester, Massachusetts. An additional 12 DON - exempt beds were also approved for a total of 187 beds. DPH approved the proposed project with specific conditions which included: (1) The requirement to request licensure of its new facility as a Level II nursing home and to obtain Medicare certification; and (2) A guarantee that residents of the existing nursing homes would be cared for in the new facility. Due to various difficulties, Neponset requested a transfer of site for the approved but not yet implemented project from the town of Milton to Marina Bay, a development located in the City of Quincy, Massachusetts.²⁵ DPH did not approve the new proposed site until June of 1999.²⁶ It was not until January 8, 2001, more than six years after DON Project No. 4-1296 had been approved by DPH, that the project was finally implemented with the opening of a 167-bed Level II facility at Marina Bay.²⁷ Consequently, the nursing facility described in DON Project No. 4-1296 had not yet been built at the time of the transaction between the Hospital and Neponset.

2. The 1994 Transaction Between Milton Hospital and Neponset:

Having identified Neponset as the holder of a DON for the future construction of a new nursing facility, Milton Hospital proceeded with the necessary steps to obtain a portion of the DON authorization as follows:

- September 2, 1994 – Neponset wrote a letter to DPH requesting transfer of ownership of 20 beds of the approved but not yet implemented determination of need (“DON”) Project No. 4-1296” to Milton Hospital.²⁸
- September 23, 1994 – Parties executed “DON Agreement” whereby Milton agreed to pay Neponset \$400,000 for transfer of ownership and site of the 20-bed portion of the DON authorization.²⁹
- October 28, 1994 – DPH approved requested transfer referring to the beds as “20 BANYL beds (Beds Approved But Not Yet Licensed).”³⁰

²⁴ See Provider Exhibit P-4.

²⁵ See Provider Exhibit P-47.

²⁶ See Provider Exhibit P-48.

²⁷ See Provider Exhibit P-49.

²⁸ See Provider Exhibit I-19.

²⁹ See Provider Exhibit P-5.

³⁰ See Provider Exhibit P-6.

The Provider points out that DPH imposed no requirement that Milton Hospital ensure that patients at the existing Neponset nursing homes be offered care at its facility, and that no patients were ever transferred to the TCU. When DON Project No. 4-1296 was finally implemented with the opening of the Marina Bay facility in January, 2001, the facility had a licensed bed capacity of 167 beds, thus reflecting the previous transfer to Milton Hospital of the authorization to build 20 of the 187 beds originally approved for the project.

C. Description of the Provider:

As a licensed Level II facility, the Provider is certified to participate in the Medicare program as a skilled nursing facility. The Provider's utilization is overwhelmingly Medicare (96 percent in the first three years of operation) with the remaining being private pay patients.³¹ The Provider does not participate in the State Medicaid program. All patients admitted to the Provider have previously been discharged from a hospital, with Milton Hospital accounting for approximately 95 percent of the discharges.³² The Provider's patients average length of stay ("LOS") for its first year of operation (1995) was 16.4 days, and has decreased each succeeding year to a current LOS of about nine days.³³ The stated policy of the TCU is to limit admissions to patients who need skilled nursing or rehabilitative services on a daily basis.³⁴ An internal review of all patients residing in the TCU on a randomly selected day in February, 1996 showed that all patients received either skilled nursing services on each day of their entire stay or rehabilitation services at least five days a week throughout their entire stay.³⁵ Eighty percent of the patients are discharged to home; the remainder are discharged to other health care facilities.³⁶

D. Description of the Neponset Facilities:

At all times prior to the opening of the Milton Hospital TCU, Neponset Hall and Ashmont Manor were licensed by the State of Massachusetts as Level III supportive nursing care facilities. They were certified to participate in the Medicaid program as nursing facilities ("NFs") as defined in 42 U.S.C. § 1396r(a). Neither facility participated in the Medicare program nor had rehabilitation space or an isolation room.³⁷ The Provider notes that the LOS for the two facilities was extremely long with the majority of the residents remaining at both homes until death.³⁸

³¹ 1 Tr. 137-138.

³² 1 Tr. 92-93

³³ See Provider Exhibit P-82; 1Tr. 96-97

³⁴ See Provider Exhibits P-79 through P-82.

³⁵ See Provider Exhibits P-87 through P-100.

³⁶ 1 Tr. 86, 96.

³⁷ 2 Tr. 14.

During fiscal year 1992, the LOS for Neponset Hall was over three years and not a single resident was discharged to home during calendar year 1994.³⁹ As Level III facilities, the facilities were not permitted to admit patients who needed skilled care on a daily basis nor were they staffed to do so.⁴⁰ While skilled services were provided on occasion as needed, the residents served by these facilities were primarily in need of supportive assistance associated with daily living. Whereas the Provider was primarily engaged in providing skilled nursing care and rehabilitation services, Neponset Hall and Ashmont Manor were primarily engaged in providing unskilled, supportive services.

II. Provider's Arguments:

A. CMS' Conclusion That a Portion of an Existing Long Term Care Institution, Neponset Hall or Ashmont Manor, was Relocated to Milton Hospital Has No Rational Basis.

1. CMS' Stated Basis for Concluding that the Provider was Established through a CHOW of a Portion of an Existing Facility is Factually Mistaken as a Matter of Massachusetts Law

The Provider acknowledges that a CHOW would have occurred had it: (1) Purchased a portion of one of the two existing Neponset Facilities located in Dorchester and operated it in that location; or (2) Physically relocated the beds, equipment, staff and patients to the campus of Milton Hospital. The Provider asserts that the transaction in the instant cases does not even remotely resemble the above descriptions. The evidence presented clearly demonstrates that what the Provider purchased was solely an intangible right. Moreover, the intangible right did not even pertain to an existing facility, but to a portion of a facility that had not yet been built.

At the hearing before the Board, the Provider's DPH witness (Director of the Division of Healthcare Quality and Deputy Director of the Bureau of Health Quality Management) flatly rejected CMS' characterization of the transaction between the Hospital and Neponset as one involving the purchase of existing beds. The DPH witness testified that the transaction in question did not involve a CHOW of: (1) existing licensed beds; or (2) the acquisition of the assets of an existing nursing facility which would have required the filing of a "Notice to Intent to Acquire" (See Provider Exhibit P-105).⁴¹ This witness further testified that, in authorizing

³⁸ 2 Tr. 60.

³⁹ See Provider Exhibits P-44 at 46 and P-65.

⁴⁰ 1 Tr. 409, 411; 2 Tr. 23-30, 43-45.

⁴¹ 1 Tr. 383 –384, 404-406.

the establishment of the Provider, DPH was in fact acting under two sections of the Massachusetts DON regulations, 105 C.M.R. § 100.710 and § 100.720,⁴² which pertain to projects that have not yet been implemented rather than existing health care facilities.⁴³ The provisions of 105 C.M.R. § 100.710 allow a holder of a DON that has not yet been implemented to request permission from DPH to transfer ownership of all or some portion of the DON authorization. Under 105 C.M.R. § 100.720, the DON holder for the unimplemented project may also request a transfer of the site for the project. The Provider points out that both of these regulations were explicitly cited in the Hospital's September 2, 1994 request to DPH (Intermediary Exhibit I-19), and DPH's response letter of October 28, 1994 (Provider Exhibit P-6) which approved the transfer of ownership and site of 20 BANYL beds from Neponset to Milton Hospital. As to CMS' statement that BANYL beds are not purchasable under Massachusetts State law, the DPH witness responded unequivocally that the statement was not true, and that the transaction involved the "transfer of an authorization for an unimplemented project" that could be characterized as "the transfer of an authorization for BANYL beds."⁴⁴ Based on the relevant documents and the testimony of the DPH witness, the Provider concludes that there is no room for doubt that CMS relied upon an erroneous understanding of both the actual facts and Massachusetts State law in denying the new provider exemption as the transfer of a portion of an existing long term care facility.

With regard to a Board member's question of whether there is any authority which would indicate that CMS must follow State DON laws when it comes to a transfer of bed DON's from one party to another, the Provider notes that this is a legal question to which the DHS witness, who is not an attorney, could not answer. As to matters over which the State has exclusive jurisdiction (i.e. licensing of health care facilities and DON programs), the Provider argues that federal agencies are obliged to show deference to the State's interpretation of its own laws. A State has exclusive authority as to whether it will have a DON program, the types of facilities that require a DON, the specific criteria and procedures that must be satisfied to obtain a DON, and whether and how a DON may be transferred. Where an applicant has explicitly asked and received permission of a State to establish a health care facility pursuant to that State's DON regulations on unimplemented projects, and where a senior State official subsequently testifies that is how the facility was in fact established, the Provider contends that it is clearly presumptuous for a federal agency to declare otherwise. The Provider insists that on this central factual issue, the official State pronouncements are controlling.

2. The Intermediary's Witness Offered Shifting and Self-Contradictory Testimony as to What Assets the Provider Had Purchased and How That Purchase Resulted in a CHOW.

⁴² See Provider Exhibits P-2 and P-3.

⁴³ 1 Tr. 385-386.

⁴⁴ 1 Tr. 386-387, 460-461.

In direct examination, the Intermediary's sole witness, a health insurance specialist employed by CMS, testified that she was responsible for reviewing new provider exemption requests, and that she was significantly involved in denying the Provider's exemption and the subsequent appeal process.⁴⁵ While the Intermediary's witness acknowledged that a CHOW was necessary to support CMS' exemption denial, she had no consistent position as to the nature of the assets purchased by the Provider that supposedly resulted in a CHOW. Initially, she testified that the Provider had been established through the purchase of part of an existing nursing home as set forth in the denial letter and the Intermediary's position paper.⁴⁶ Later she shifted her position and volunteered that the Provider had actually purchased a portion "of a replacement facility," and that the replacement facility had not yet been built.⁴⁷ The Provider points out that similar vacillation as to exactly what the Provider had purchased was apparent in the following testimony:

- A. We have an asset transfer here, a purchase of an asset called a Determination of Need. That asset was owned by an existing facility, Ashmont Manor and Neponset Hall, one or the other, whoever ultimately had the CON-DON. Based upon Medicare reimbursement principles, then the purchase of an asset to render patient care constitutes a change of ownership.

1 Tr. 217-218.

The Intermediary's witness later conceded that the particular DON in question was an authorization for beds approved but not yet licensed (BANYL).⁴⁸ Subsequently, she reverted to the position that what occurred was a "transfer of license."⁴⁹ The Provider notes that this last position was offered by the Intermediary's witness despite the fact that the Intermediary's counsel had acknowledged in her opening statement that no licenses had been transferred because such transfers are not permitted under Massachusetts law.⁵⁰

Having previously declared that the transaction constituted a CHOW under HCFA Pub. 15-1 § 1500.7, the Intermediary's witness was unable to explain how that section could apply to a transfer of BANYL beds. This manual provision states that a CHOW includes the following:

⁴⁵ 1 Tr. 185, 272.

⁴⁶ 1 Tr. 185 – 190

⁴⁷ 1 Tr. 190-191.

⁴⁸ 1 Tr. 228-230.

⁴⁹ 1 Tr. 233.

⁵⁰ 1 Tr. 54.

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.

HCFA Pub.15-1 § 1500.7 (emphasis added).

While the Intermediary's witness effectively conceded the point that a bed that did not yet exist could not be "used to render patient care," she nonetheless contended that a CHOW had occurred as long as the owner of the assets was an "existing business."⁵¹ The Provider concludes that it is absurd to accept the general proposition that the transfer of any asset by an existing health care provider constitutes a CHOW. In summary, the confused and self-conflicting testimony of the individual primarily responsible for the denial of the exemption suggests that CMS has no reasonable basis for its determination.

3. Transfer of an Authorization for an Unimplemented Project Cannot Conceivably Constitute a CHOW Under Medicare Principles

The Provider contends that the evidence clearly establishes that the asset purchased was an authorization to establish 20 beds that did not yet exist. This authorization was part of a larger one issued by the State of Massachusetts in July of 1994 to construct a new facility consisting of 187 beds. Neither the 187-bed facility nor the 20-bed facility existed at the time the parties agreed to transfer a portion of this authorization to the Provider in September of 1994. This authorization for 20 beds of an unimplemented project was the sole asset the parties agreed to transfer and the only asset whose transfer was approved by the State of Massachusetts.

When the Provider received its license and admitted its first patient in May of 1995, DPH required Neponset to reduce its licensed beds.⁵² As to what happened to the delicensed beds at the existing facility, the Provider points out that no one contends that the beds were physically removed from Neponset and transported to the Provider's location at Milton Hospital. Nor was the license for the beds transferred to the Provider because licenses cannot be transferred under Massachusetts law. The Provider further notes that there was no DON for the beds transferred because the only DON which Neponset possessed was DON No. 4-1296, a DON pertaining to beds not yet in existence. Since the Provider had already purchased a portion of DON No. 4-1296 and needed no further authorization from DPH to proceed with its TCU, there simply was no further transfer of anything to the Provider. As to the delicensed beds, the DPH witness testified that they were merely taken out of service,⁵³ a common place occurrence in the State of Massachusetts.

⁵¹ 1 Tr. 237-238.

⁵² See Provider Exhibit P-46.

⁵³ 1 Tr. 415.

Contrary to CMS' determination and the arguments made by the Intermediary, the transaction between the Provider and Neponset did not constitute a CHOW under HCFA Pub.15-1 § 1500 et seq. . The manual provision at § 1500 states the following:

When a provider undergoes a change of ownership, ceases to participate in the program, or experiences an event otherwise described below, for which a Provider Tie-In Notice (Form HCFA-2007) has been issued, a final cost report must be filed by that provider covering the period under the program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement, change of ownership, or event (42 C.F.R. § 405.453(f)(1)).

HCFA Pub.15-1 § 1500.

The specific manual provision cited by CMS in its exemption denial defines a CHOW as follows:

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.

HCFA Pub.15-1 § 1500.7 (emphasis added).

The Provider re-emphasizes that a CHOW under § 1500.7 necessitates the transfer of an asset "used to render patient care." The authorization for a facility transferred to the Provider in 1994 had never been utilized to provide care to anyone. Neponset made no use of the authorization in caring for patients at its two existing facilities, and no patients were admitted to its new facility until 2001. Consequently, the Provider insists that the transfer of this authorization cannot possibly constitute a CHOW under HCFA Pub. 15-1 § 1500.7.

The Provider further contends that the basic concept of a CHOW makes no sense unless it can be applied to a existing provider. Under HCFA Pub. 15-1 § 1500, the provider whose ownership has changed is required to file a final cost report after a CHOW has occurred. This requirement cannot apply where the only asset changing ownership is the authorization to construct a new health care facility in the future. A provider that has not yet come into existence cannot file a cost report, much less a "final" one.

The Provider argues that a similar conclusion can be drawn from a review of § 4500 of the Medicare Intermediary Manual ("HCFA Pub. 13-4) which contains a fuller explanation of a

CHOW.⁵⁴ In addition to defining a CHOW as a “purchase of all or substantially all of a corporation’s tangible assets,” which would disqualify the intangible authorization transferred in this instant cases, HCFA Pub. 13-4 § 4500 et seq. sets out additional consequences of a CHOW. Under HCFA Pub. 13-4 § 4501.1, if a CHOW occurs for certification purposes, the Medicare participation agreement is automatically assigned to the new owner. If a CHOW occurs for reimbursement purposes, the seller is allowed to claim a loss on its cost report. Again, the Provider points out that the assignment of a participating agreement and the claiming of a loss both presupposes an existing provider.

In summary, the Provider believes it has proven conclusively that the only asset that it received from Neponset was part of an authorization for a health care facility that had not yet been built. Consequently, the transfer of this asset cannot conceivably constitute a CHOW, which is the lynchpin of CMS’ and the Intermediary’s denial of the Provider’s exemption request.

4. A Decision That No CHOW Occurred is Consistent with Prior Board Decisions and Recent Case Law.

In support of its position, the Provider cites a previous Board decision and two recent district court decisions which ruled in favor of the provider on the new provider exemption issue. In the case of 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 (“Maryland”)⁵⁵ a hospital-based TCU was established through the purchase of bed rights from three existing, free-standing nursing facilities. The Board majority found that the bed rights pertained to “waiver beds” that, prior to their purchase, had not been licensed, certified, or operational for the purpose of providing patient care services. Under Maryland law, waiver beds are beds that a provider is permitted to add without going through the State’s Certificate of Need (“CON”) process. The majority of the Board ruled that the transfer of the intangible rights for beds that had never been operational did not constitute a CHOW as defined in HCFA Pub. 15-1 § 1500.7 and, thus, the hospital-based TCU was entitled to a new provider exemption. Like Maryland, the Provider in the instant cases purchased intangible rights to beds that were not yet licensed or operational for patient care purposes. Accordingly, the Provider believes the Board should likewise rule that the purchase in these cases does not constitute a CHOW.

The Provider is aware that the HCFA Administrator reversed the Board’s decision in Maryland,⁵⁶ and that the Maryland District Court upheld the Administrator’s decision.⁵⁷ The HCFA Administrator rejected the Board’s factual conclusions, finding instead that the bed rights

⁵⁴ See Provider Exhibit P-51.

⁵⁵ See Intermediary Exhibit I-70.

⁵⁶ HCFA Administrator’s Decision, November 22, 1999 – See Intermediary Exhibit I-71.

⁵⁷ Maryland General Hospital, Inc. v. Thompson, 155 F. Supp. 2d 459 (D. Md. 2001) – See Intermediary Exhibit I-72.

pertained to existing operational beds, and that the State's characterization to the contrary was a post-hoc rationalization. In upholding the Administrator's decision, the Maryland District Court was heavily influenced by the conflicting versions of the transaction presented by state officials stating the following:

Perhaps the strongest rationale, in this Court's view, for denying new provider status where waiver beds were transferred, is the ease by which the transaction was re-characterized by the Commission [a state agency]. It is undisputed that Plaintiff and the Selling Facilities entered into the transaction anticipating that operational beds would be transferred. That a year later the Commission fortuitously chose to re-cast the transaction as the transfer of waiver beds (whether for administrative convenience or some other reason) should not impact the Secretary's determination of new provider status.

Maryland General Hospital, 155 F. Supp. 2d at 459.

The Provider advises that no similar criticism of State officials applies in the instant cases. All official State correspondence, contemporaneous with the transaction, as well as the subsequent Board testimony by the State official with oversight authority for the Massachusetts DON program, has uniformly characterized the transaction as the transfer of a portion of DON No. 4-1296, an authorization for a healthcare facility that was yet to be built.

Subsequent to the Board's hearing in the instant cases, two district court decisions were issued which focused exclusively on the CHOW issue, and both decisions were decided in the provider's favor.⁵⁸ Both cases involved states with a moratorium on nursing beds and both involved the transfer of intangible DON or CON rights. The first case, South Shore Hospital v. Thompson, Civil Action No. 99-11611 (D. Mass., Jan. 3, 2002) ("South Shore") concerned a Massachusetts provider where the DON pertained to beds that had been closed for over a year at the time the DON was transferred. The second case, Ashtabula County Medical Center v. Thompson, Case No. 1:00 CV 1895 (N. Dist. Ohio, Feb. 8, 2002) ("Ashtabula") involved an Ohio provider where the CON pertained to existing operational beds.

In South Shore, the TCU was established by the purchase of DON rights from the receiver for Prospect Hill, a defunct facility that had been certified for Medicaid only. In reaching its decision, the Court relied upon the following facts:

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.

⁵⁸ The District Court decisions were submitted with the Provider's Post-Hearing Brief.

Consequently, the Court reasoned, “there was simply no transaction from which there could have been a reasonable finding of a change of ownership,” and the Board’s decision to the contrary was “arbitrary and capricious.” The Court also distinguished its decision from the contrary ruling of the United States Court of Appeals for the Seventh Circuit in Paragon Health Network, Inc. v. Thompson, 251 F.3d 1141 (7th Cir. 2001) (“Paragon”) on two bases. First, while the transfer of CON rights in Paragon took place between two facilities owned by the same company, the parties to the transfer in South Shore were entirely unrelated. Second, in Paragon the Seventh Circuit was in part persuaded by the Secretary’s public policy argument that the transfer of CON rights simply moved SNF services from one location to another at considerable cost but no benefit in the overall delivery of health care services. By contrast, the South Shore TCU purchased its bed rights from a facility that had gone out of business. Consequently, the District Court stated that there was an overall gain to society in the form of added health care beds to the area.

The Provider contends that the present cases can be distinguished from Paragon on identical grounds. First, the Provider and Neponset were not owned by the same corporation. Second, while the establishment of the Milton Hospital TCU did not add to the State’s overall inventory of long term beds (beds licensed either as Level II or Level III), the TCU did add 20 new Level II beds . Increasing Level II beds was in fact an important public policy objective of the Massachusetts DPH at the time, in light of a shortage of the more highly skilled Level II facilities and an oversupply of Level III facilities. This public policy objective is articulated in a letter dated February 27, 1996 to HCFA from the Commissioner of the Massachusetts DPH,⁵⁹ and was confirmed at the hearing by the DPH witness.⁶⁰ Consequently, while the transaction at issue in Paragon may have lacked social utility, the establishment of the Milton Hospital TCU was authorized by the State of Massachusetts because it furthered explicit social policy goals.

With respect to Ashtabula, the Court found that the term “provider,” as understood in ordinary English usage and defined in Medicare authority, was unambiguous and referred to an institution or distinct part of an institution, not to a mere characteristic such as an intangible CON right. Consequently, the Court reasoned that an institution that was new in all respects except for a pre-existing CON right was a new provider within the plain terms of the controlling regulation. The Ashtabula Court, moreover, was clearly concerned by the plaintiff’s argument that the Secretary’s interpretation of the new provider exemption in effect discriminated against providers located in states with a CON program or moratorium, without any showing that the start-ups costs were any different for the two classes of providers. After carefully considering and rejecting each of the justifications advanced by the Secretary, the Court concluded that “[t]he Secretary has advanced no reasonable argument to support a distinction between these providers [in moratorium states] and other “new providers” deserving of a subsidy to offset high startup costs in the first three years of operation.” Accordingly, the Court concluded that “even if the language of the regulation were ambiguous, Secretary’s interpretation would be arbitrary, capricious, and clearly erroneous.”

⁵⁹ See Provider Exhibit P-50.

⁶⁰ 1 Tr. 398-399, 410-415.

B. Assuming *Arguendo* that a CHOW Occurred, Neither Neponset Hall Nor Ashmont Manor Was Operated as the Equivalent of a Skilled Nursing Facility During The Prior Three-Year Period.

1. CMS' Standard For Determining When an Institution That is Not Certified by Medicare as a Skilled Nursing Facility is Being Operated as the Equivalent of a Skilled Nursing Facility is Arbitrary and Capricious and an Abuse of Discretion.

The regulation at 42 C.F.R § 413.30(e) defines a new provider as one which “has operated as the type of provider (or its equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years” (emphasis added).⁶¹ The Provider asserts that neither Neponset Hall nor Ashmont Manor was certified by Medicare as a SNF; rather, each participated in the Medicaid program as a nursing facility (“NF”). Under CMS’ standard for determining equivalency, an institution is deemed equivalent to a SNF if it delivers a single skilled service to a single individual.⁶² Applying this standard, CMS denies a new provider exemption if during each year of the prior three-year period (“look-back period”) at least one example of skilled care was rendered to at least one patient. The Provider argues that this standard conflicts with the plain meaning of the statutory definition of a SNF as well as CMS’ own regulations and is, thus, arbitrary and capricious and an abuse of discretion.

(a) CMS’ equivalency standard is in direct conflict with the statutory definition of a SNF.

As specified in relevant part at 42 U.S.C. § 1395i-3(a), the term “skilled nursing facility” means an institution (or a distinct part of an institution) which - -

(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,

and is not primarily for the care and treatment of mental diseases.

42 U.S.C. § 1395i-3(a) (emphasis added).⁶³

⁶¹ See Provider Exhibit P-16.

⁶² In determining whether a particular service is skilled, CMS relies upon the specific examples of skilled services set forth in 42 C.F.R § 409.33 – See Provider Exhibit P-57.

⁶³ See Provider Exhibit P-28.

At the hearing before the Board, the Intermediary's witness affirmed that CMS looks to this statutory definition in determining equivalence of operations.⁶⁴ She also testified that the term "primarily," which is defined in the American Heritage College Dictionary as "an adjective meaning chiefly or mainly," was not applicable to the Medicare statute.⁶⁵ Given CMS' reliance on the statutory definition, the equivalency standard applied by CMS makes no sense. Moreover, the standard applied depends upon the repudiation of the ordinary meaning of a statutory term in favor of an alternative meaning that CMS has declined to specify.

In further support of its position, the Intermediary advances the argument that the statutory language "primarily engaged in providing to residents skilled nursing care and related services" is applicable to an institution whose "primary focus" is the provision of custodial services," because the term "related service" refers to custodial care. The Provider points out that this argument restores the ordinary usage of the word "primarily," while ignoring the plain meaning of the word "related." The Provider insists that the statutory phrase "and related services" clearly refers back to the preceding term "skilled nursing care." Thus, in order for an unskilled service to be "related" the patient receiving that service must also receive a skilled service. The Provider reasons that, if only one patient in the institution receives a skilled service, the unskilled services delivered to everybody else cannot be "related" services, and the institution cannot be "primarily" engaged in providing either "skilled nursing care" or "related services."

(b) CMS' equivalency standard is in direct conflict with applicable Medicare regulations and Manual guidance.

In its final Amended Position Paper, the Intermediary explains the requirements for an exemption as follows:

As stated in the Manual provisions, to be eligible for an exemption an institution must demonstrate a complete change in the operation of the institution, i.e., from solely custodial care to its provision of skilled nursing and related services or rehabilitative services or what is more commonly referred to as a skilled level of care.

Intermediary's Position Paper at 46 (emphasis added).

The Provider argues that a review of Medicare regulations and guidelines unequivocally demonstrates that facilities such as Neponset Hall and Ashmont Manor which provide skilled nursing or rehabilitation services on an intermittent rather than a daily basis are engaged solely in "custodial care." Custodial care is defined in the Intermediary Manual as follows:

Institutional care that is below the level of care covered in a SNF is custodial care.

⁶⁴ 1 Tr. 285.

⁶⁵ 1 Tr. 289-290

HCFA Pub. 13-3 § 3159 (emphasis added).⁶⁶

An analogous provision in the Medicare regulations defines “custodial care” as:

. . . any care that does not meet the requirements for coverage as SNF care as set forth in §§ 409.30 through 409.35 of this chapter.

42 C.F.R. § 411.15 (g) (emphasis added).⁶⁷

The regulations at 42 C.F.R. § 409.31⁶⁸ set forth the level of care requirements for SNF and establish specific conditions for meeting these requirements. The first such specific condition is as follows:

- (1) The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.

42 C.F.R. § 409.31(b)(1).

The term “daily” as defined in 42 C.F.R. § 409.34⁶⁹ requires the following frequency:

- 7 days a week for skilled nursing services or skilled rehabilitation services, except
- if skilled rehabilitation services are not available 7 days a week those services must be needed and provided at least 5 days a week.

42 C.F.R. § 409.34 (a).

Lastly, the Provider cites the provisions of § 214 of the Skilled Nursing Facility Manual (“HCFA Pub. 12”)⁷⁰ which states that even though a patient’s stay “might include the delivery of some skilled services,” the “level of care” requirement is not met “if the patient needs an intermittent rather than daily skilled services.” (emphasis added).

Based on the above-cited definitions, the Provider contends that a facility where all of whose patients receive some skilled nursing services but on a frequency that is less than seven days a week (or on a frequency less than five days a week for skilled rehabilitation services), is engaged

⁶⁶ See Provider Exhibit P-56.

⁶⁷ See Provider Exhibit P-55.

⁶⁸ See Provider Exhibit P-57.

⁶⁹ Id.

⁷⁰ See Provider Exhibit P-58.

solely in custodial care. Pursuant to HCFA Pub.13-3 § 3159, such a custodial institution is eligible for a new provider exemption if it changes its operations to provide skilled services on a daily basis.

(c) HCFA’s equivalency standard does not effectuate the underlying purpose of the new provider exemption.

As the HCFA Administrator explained in the Maryland decision,⁷¹ the purpose of the new provider exemption is to “allow a provider to recoup the higher costs normally resulting from low occupancy rates and start up costs during the time it takes to build its patient population.” Given this policy purpose, the Provider asserts that the equivalency standard utilized by CMS makes no sense. The start-up costs associated with the development of a SNF are the cost of staffing the unit to be in readiness to provide daily skilled nursing care to every single patient. It is irrational to suppose that such costs would have already been incurred by an institution that merely administered a skilled service to one patient once a year. While the education and licensure of a nurse administering a single skilled service are similar to those of a nurse administering that same service on a daily basis, the obvious point is that many more such nurses are necessary in circumstances in which every patient in the facility requires such care every day of the year. Consequently, CMS’ standard of regarding an institution as equivalent to a SNF if it performs a single skilled service has no relationship whatsoever to the underlying purpose of the exemption.

2. CMS’ Claim that as a Result of OBRA 1987 All NFs are Equivalent to SNFs and As Such Neponset Hall and Ashmont Manor Would Already Have Incurred the Start-Up Costs Associated with Becoming a SNF Rests Upon a Clearly Mistaken and Specious Interpretation of the Act.

It is CMS’ position that the Omnibus Budget Reconciliation Act of 1987 (“OBRA-1987”) established uniform certification requirements for Medicare-certified SNFs and Medicaid-certified NFs. Pursuant to this CMS argument, both SNFs and NFs are required to provide the same basic range of services and there is no functional difference between such facilities. The Provider contends that CMS’ argument is specious for several reasons. First, the Provider points out that the statutory definitions of a SNF and a NF introduced by OBRA-1987 differ significantly, as evidenced by the following examination of the two definitions set forth under 42 U.S.C. § 1395i-3(a) and § 1396r(a), respectively:⁷²

<u>SNF</u>	<u>NF</u>
An institution which	An institution which
(1) is primarily engaged in providing	(1) is primarily engaged in providing

⁷¹ See Intermediary Exhibit I-71.

⁷² See Provider Exhibits P-28 and P-29.

- | | |
|--|---|
| <p>to residents --</p> <p>(A) skilled nursing care and related services for residents</p> <p>who require medical or nursing care, or</p> <p>(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons</p> | <p>to residents –</p> <p>(A) skilled nursing care and related services for residents</p> <p>who require medical or nursing care, or</p> <p>(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons</p> <p style="text-align: center;">or</p> <p>(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) that can be made available to them only through institutional facilities</p> |
|--|---|

The Provider believes that an analysis of this difference proves that a facility can qualify as a NF under OBRA-1987 without incurring the start-up costs associated with being a SNF. The two definitions are stated in the disjunctive: (A) or (B) for SNFs; (A) or (B) or (C) for NFs. Thus, an institution could qualify as a NF under (C) without at the same time qualifying as a SNF under (A) or (B). Institutions qualifying as a NF solely under (C) would include institutions such as Neponset Hall and Ashmont Manor whose patients require more than room and board but less than daily skilled services.

Whereas the Intermediary's witness testified that there was no difference between a SNF and a NF, and that all of the language in (C) is unnecessary,⁷³ the Provider notes that it is an accepted canon of statutory construction that every term or phrase in a statute must be given a meaning. Potter v. United States, 155 U.S. 438, 466 (1894). The Provider contends that this canon assumes even greater weight in the instant cases where the two statutory definitions were introduced by the same Act as exact mirror images of each except for the phrase in question. Accordingly, CMS' argument rests upon a statutory interpretation of OBRA-1987 that is indefensible.

⁷³ 1 Tr. 286-287.

Second, the Provider argues that it is a myth that OBRA-1987 required a NF such as Neponset Hall and Ashmont Manor to operate the same as a SNF. Rather, OBRA-1987 merely required a NF to deliver the care that its patients need. As Level III facilities, Neponset Hall and Ashmont Manor were not permitted by their state license to admit patients needing skilled care on a daily basis. The legislative history of OBRA-1987 clearly shows that Congress did not intend to alter the functioning of NFs whose patients did not require a skilled level of care. In the 1980s, such facilities were referred to as intermediate care facilities (“ICFs”). The House Report for OBRA-1987⁷⁴ explicitly stated the following:

In redefining nursing facility, the Committee Amendment would not in any way alter the entitlement of current Medicaid beneficiaries or applicants, or future beneficiaries or applicants, to what is now an ICF level of care. Those beneficiaries who now reside in an ICF would continue to be eligible to reside in a nursing facility if they continue to meet the ICF level of care requirements – that is, because of their mental or physical condition they require institutional care and services above the level of room and board. It is sufficient that the individual require care and services that are health related; a beneficiary need not require skilled nursing care. The same would apply to those individuals who in the future seek Medicaid coverage in a nursing facility, whether before or after admission.

Legislative History – House Report No.100-391 I (emphasis added).

The Provider believes it is clear from the legislative history that Congress recognized that there would continue to be Medicaid –certified NFs, such as Neponset Hall and Ashmont Manor, whose patients did not need a skilled level of care.

Third, the Provider points out that the start-up costs associated with developing the capacity to furnish SNF services are those associated with staffing up to provide skilled services to every patient in the facility every single day. At the hearing, the Executive Director of Nursing at Neponset Hall and Ashmont Manor from 1990 to 1995 testified that the facilities were not staffed to deliver skilled services to residents on a daily basis.⁷⁵ Since the facilities needed additional staff to merely provide occasional skilled services, they clearly had not incurred the costs of staffing up to provide the skilled services associated with a SNF.

3. The Patient Care Evidence Submitted By the Intermediary Demonstrates That Neponset Hall and Ashmont Manor Did Not Operate as the Equivalent of a Skilled Nursing Facility During the Relevant Time Period.

⁷⁴ See Provider Exhibit P-103.

⁷⁵ 2 Tr. 44-45.

While the Intermediary's counsel suggested that the look-back period began three years prior to the date the CHOW occurred,⁷⁶ HCFA's denial letter of November 20, 1995 stated that "the provider does not qualify for a new provider exemption because . . . the existing long term care institution, prior to relocation, operated in the manner equivalent to a SNF by performing skilled nursing and rehabilitation services, for three or more years prior to Medicare certification."⁷⁷ (emphasis added). Since the Provider received Medicare certification on May 12, 1995, the three year look-back period began on May 12, 1992. The Provider notes that extensive testimony was presented by the Executive Director of Nursing at Neponset Hall and Ashmont Manor from 1990 to 1995 concerning the type of care delivered during the relevant look-back period. This witness testified that (1) neither facility was permitted under State law to admit residents needing skilled services on a daily basis,⁷⁸ (2) the facilities were not staffed to do so,⁷⁹ and (3) as Director of Nursing she would not have permitted anyone to be admitted to the facility who needed that level of care.⁸⁰ This witness acknowledge that there were occasions where residents developed illnesses which necessarily required the provision of skilled services. However, if their care required more aggressive monitoring than could be provided by existing staffing levels, the residents would be transferred to a hospital setting.⁸¹ During the relevant time period, no resident of the facilities received daily skilled services through the duration of the resident's stay.⁸²

The Provider points out that the testimony of the Director of Nursing is borne out by documentary evidence submitted by the Intermediary. This documentary evidence consisted of over a thousand Management Minutes Questionnaires ("MMQ") purporting to pertain to 220 residents of Neponset Hall and Ashmont Manor during the relevant time period.⁸³ The MMQ is a document utilized by the Massachusetts Department of Public Welfare ("DPW") to determine the Medicaid reimbursement due to a nursing facility for the care of a particular Medicaid beneficiary. The form is filled out by NFs on a quarterly basis and documents care given to residents, both unskilled and skilled services as defined by DPW, for at least 15 days in the

⁷⁶ 2 Tr. 143-144.

⁷⁷ See Provider Exhibit P-12.

⁷⁸ 2 Tr. 24-25.

⁷⁹ 2 Tr. 44-45.

⁸⁰ 2 Tr. 25.

⁸¹ 2 Tr. 264 –268.

⁸² 2 Tr. 138-139.

⁸³ See Intermediary Exhibit I-106.

preceding month. The Intermediary prepared a summary of the MMQs with respect to the following nine categories of care:⁸⁴

Skilled Observation
Tube Feeding
Continence
Bladder/Bowel Retraining
Decubitus Care
Skilled Procedure
Special Attention
Restorative Nursing
Consultations

Based on an extensive review of all of the MMQs for residents identified in the summary, it was the Director of Nursing's conclusion that no resident of Neponset Hall or Ashmont Manor had received skilled services on a daily basis throughout his or her stay.⁸⁵ The Provider contends that the testimonial and documentary evidence conclusively shows that during the three-year look-back period, the NFs provided some skilled services, but only on an intermittent basis. Accordingly, even if ownership of a portion of those facilities was transferred to Milton Hospital, the TCU still qualifies as a new provider when it opened in May of 1995 because neither Neponset Hall nor Ashmont Manor operated as the equivalent of a skilled nursing facility.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that CMS properly adhered to Medicare law, regulations and program instructions in denying the Provider's request for an exemption from the SNF RCLs under the new provider provisions set forth in 42 C.F.R. § 413.30(e). In support of its position, the Intermediary's position paper included a detailed presentation regarding the statutory and regulatory background of 42 C.F.R. § 413.30(e) which encompassed: (1) The establishment of the RCLs; (2) Implementation of the new provider exemption; (3) Intent of the new provider exemption; and (4) The exemption process.⁸⁶ Based on the application of the governing law, regulations and program instructions, CMS' denial letter of November 20, 1995⁸⁷ concluded that the Provider did not qualify for a new provider exemption for the following reasons:

1. It was a portion of an existing long term care institution that was relocated to the hospital complex, due to a CHOW in accordance with Section 1500 of HCFA Pub.15-1

⁸⁴ See Intermediary Exhibit I-103.

⁸⁵ 2 Tr. 83-136.

⁸⁶ See Intermediary's Position Paper at 17-34.

⁸⁷ See Intermediary Exhibit I-3

2. The portion of the existing long term care institution, prior to relocation, operated as a NF since October 1, 1990 and is considered an equivalent provider of skilled or rehabilitative services in accordance with the changes in the law resultant from OBRA-1987.
3. Notwithstanding the change in the law, the existing long term care institution, prior to relocation, operated in the manner equivalent to a SNF by performing skilled nursing and rehabilitative services, for three or more years prior to Medicare certification.
4. Upon relocation, the population served did not substantially change, nor was there a change in primary service area.

The following is a summary of the arguments presented by the Intermediary:

1. CMS' Review of Milton Hospital TCU's Request for an Exemption:

Upon receipt of the written request and additional documentation relating to the relocation provision, no impediments were found with regard to timeliness or statutory exclusions for any of the cost reporting periods for which relief was sought. CMS determined that the "type of provider" requesting the exemption was a SNF as defined in 42 U.S.C. § 1395i-3(a)(1).⁸⁸ In determining the length of operation, CMS looked at the operation of the institutional complex and how the SNF was established. Milton Hospital began participation in the Medicare program on July 1, 1966, and the facts indicated that the Hospital had acquired a portion of a replacement facility from two existing nursing homes known as Neponset Hall and Ashmont Manor.

The Intermediary notes that during the early 1990s, there were at least two options a potential owner/operator could pursue to establish a nursing home in Massachusetts. The first option was for an acute care hospital to acquire a DON authorization for conversion of excess hospital capacity to SNF beds. Under the second option, potential owners/operators were required to submit to DPH a Notice of Intent to Acquire an Existing Health Care Facility and a Notice of Intent to Acquire Ownership. Upon approval by DPH, the current owner surrenders the existing license, and the ownership of the DON rights are subsequently transferred to the prospective owner in the form of a prospective license. The prospective owner must then file a Notice of Intent to Transfer Site of Freestanding Facility with the Determination of Need Program. The Intermediary advises that the Hospital's TCU was established through the second option.

With respect to the CHOW transaction, the Intermediary recapped the chronology of events which culminated with a transfer of the 20 BANYL beds from Neponset Hall, Inc. to Milton Hospital, as previously set forth in this decision. By letter dated December 27, 1994,⁸⁹ DPH informed Neponset Hall, Inc. of the following issues associated with the proposed licensure changes:

⁸⁸ See Intermediary Exhibit I-56.

⁸⁹ See Intermediary Exhibit I-92.

- a. The 20-bed transfer will occur before the replacement facility is constructed, so it must be associated with an actual decrease in the number of originally licensed beds, rather than a decrease in not yet licensed beds.
- b. The two facilities may not be actually consolidated and licensed as one facility when the 20 SNF beds at Milton Hospital are licensed; it is not apparent whether one facility or both will be affected by a bed decrease (decrease or cumulated-decreases should amount to 20 beds).

In accordance with licensure requirements, DPH advised that the licensure changes would need to occur according to the following phases:

Phase 1: Decrease(s) in the licensed bed quota at Neponset Hall and/ or Ashmont Manor, for a total decrease of 20 beds.

Phase 2: Licensure of a 20-bed skilled nursing facility at Milton Hospital.

Phase 3: 12-bed increase at Neponset Hall or Ashmont Manor.

Phase 4: Consolidation of Neponset Hall or Ashmont Manor into one licensed facility

Phase 5: Completion of the replacement facility for the consolidated Neponset Hall/Ashmont Manor.

In a subsequent letter dated January 9, 1995,⁹⁰ DPH notified Milton Hospital that the licensure of its proposed SNF was contingent upon the following:

- Prior or simultaneous delicensure of beds at Long-Term Care Facility at Neponset: Ashmont Manor and/or Long-Term Care Facility at Neponset: Neponset Hall, adding up to 20 beds; or
- Prior or simultaneous delicensure of 20 beds at the facility resulting from the completed consolidation of the above mentioned two facilities, which is to be licensed as Neponset Circle Skilled Nursing and Rehab Center, Inc.

⁹⁰ See Intermediary Exhibit I-93.

The Provider was officially licensed by DPH and began operating on May 1, 1995,⁹¹ and was certified under the Medicare program on May 12, 1995.⁹²

Based on the above factual data, CMS then determined whether there was a “break in service” or if the institution was in continuous operation under past and present ownership. Since DPH approved the CHOW and relocation of the DON for 20 beds on October 28, 1994, and the date that the portion of the replacement facility re-opened as the Milton Hospital TCU was May 1, 1995, CMS determined that the break in service was a little more than five months. Thus, CMS was required to consider the operation of the prior location because the “break in service” was less than the three full years required under Medicare policy.

In order to review the operations of Neponset Hall and Ashmont Manor, CMS relied upon documents submitted by the Provider to determine if either of the nursing facilities had operated in the manner of a SNF or its equivalent for three or more years prior to October 28, 1994. The Provider’s exemption request indicated that May 1, 1995 was the date the nursing home first performed skilled nursing/rehabilitative services under past or present ownership. However, this was contradicted by a statement provided by Neponset Hall, Inc. wherein it was conceded that some skilled services had been intermittently performed for a few residents (i.e., catheter care, gastrostomy feedings, bowel and bladder training). CMS notes that such services are examples of skilled nursing and rehabilitative services as found in 42 C.F.R. § 409.33. In order to validate disclosures made by Neponset Hall, Inc., CMS utilized data found in the “On-line Survey and Certification Report” (“OSCAR”), a CMS database used for survey and certification activities. CMS found that under prior ownership, the nursing homes had operated in the manner of a SNF (or its equivalent) by providing skilled nursing and related services and rehabilitative services for more than three years since either began operating in 1959.

Based on data reported by Neponset Hall and Ashmont Manor, CMS confirmed that the nursing facilities had been providing skilled nursing/rehabilitative services which included: insertion; sterile irrigation and replacement of catheters; care of pressure ulcers; rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment; respiratory therapy; nasopharyngeal and tracheostomy aspiration; subcutaneous and intramuscular injections; levin tube and gastrostomy feedings; and specialized rehab services. Accordingly, these nursing facilities were not solely providing custodial care to the residents which essentially entails personal care that does not require the attention of trained medical or paramedical personnel. The Intermediary further notes that, as NFs under the Medicaid program, Neponset Hall and Ashmont Manor were required to provide NF services as of October 1, 1990. NF services are defined in the regulations at 42 C.F.R. § 440.40 as those services that are needed on a daily basis and required to be provided on an inpatient basis under §§ 409.31 through 409.35 of Part 42 of the C.F.R. by a facility or distinct part of a facility that is certified to meet

⁹¹ See Intermediary Exhibit I-25.

⁹² See Intermediary Exhibit I-26.

the requirements for participation and ordered by and provided under the direction of a physician.⁹³

In summary, the Intermediary contends that an institution must demonstrate a complete change in the operation of the institution to be eligible for a new provider exemption under the provisions of 42 C.F.R. § 413.30(e) and HCFA Pub.15-1 § 2533.1 (i.e., from solely custodial care to the provision of a skilled level of care). Changes in the institution's ownership or geographic location do not in itself alter the type of health care furnished and are not considered in the determination of the length of operation. In the instant cases, Neponset Hall and Ashmont Manor had operated in the manner of a SNF or its equivalent since as early as 1991, which was prior to the date of the CHOW. This factor would automatically disqualify the Provider from an exemption to the SNF RCLs for the cost reporting periods in contention. However, since Milton Hospital purchased and then relocated a portion of two existing nursing homes to a new location, CMS also reviewed the exemption request under the change in location provisions found in HCFA Pub. 15-1 § 2533.1B.3 (formerly § 2604.1).

2. The Changes in Location Provision:

Under the provisions of HCFA Pub. 15-1 § 2533.1B.3, an institution that undergoes a change in location may be allowed a new provider exemption even if it has operated in the manner of the "type of provider" for which it had been certified or its equivalent. To qualify for this exception to the general rule, the institution must meet the following two criteria: (1) The normal inpatient population can no longer be expected to be served at the new location; and (2) The total number of 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 order to review the Provider's request under the relocation provisions, CMS requested a list of all admissions to and residents of Neponset Hall and Ashmont Manor for one year prior to the relocation, and the same information for the Provider from the date it began operation to the date of the exemption request. Based on the relocation documentation furnished by the Provider,⁹⁴ CMS determined that the change in location did not change the service area known as HSA IV (Greater Boston). Moreover, the documentation showed that 100 percent of the population served at the new location came from HSA IV. Since the Provider failed to meet the first criterion for the change in location exemption, CMS denied the Provider's request for a relocation exemption for all years at issue. The Intermediary notes that CMS' denial is consistent with numerous prior determinations that have been upheld by the Board, the HCFA Administrator, and several district and circuit court decisions.⁹⁵

3. Neponset Hall and Ashmont Manor Meet the Statutory Definition of a SNF:

⁹³ See Intermediary Exhibit I-58.

⁹⁴ See Intermediary Exhibit I-60.

⁹⁵ See Intermediary Exhibit I-63 through I-76.

A SNF is defined in the statutory provisions of 42 U.S.C. § 1395i-3 et seq. as “an institution that is primarily engaged in providing skilled nursing care and related services for residents who require medical and nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases.” (emphasis added). While it is the Provider’s contention that neither Neponset Hall nor Ashmont Manor meets this definition because neither has “primarily engaged in providing skilled nursing services,” the Intermediary argues that the Provider misapplies the statute by glossing over critical words in the definition. Contrary to the Provider’s contention, an institution does not have to provide skilled nursing services to all or even most of its residents to be a SNF. Rather, an institution is a SNF as long as its primary focus is the provision of skilled nursing care and related services.

The Intermediary contends that the term related services refers to services that constitute custodial care. Custodial care consists of assisting an individual in the activities of daily living (i.e., assistance in walking, bathing, dressing, feeding, preparation of special diets, and supervision of medication). In contrast, skilled care must be ordered by a physician and requires the skills of technical or professional personnel to directly perform or supervise such care. Under the Medicare program, the requirement for skilled nursing or rehabilitation services on a daily basis is a specific condition of coverage, and is not part of the definition of what constitutes skilled nursing care. Based on the documentation provided for Neponset Hall and Ashmont Manor, the Intermediary prepared an analysis of specific services performed by each facility which included skilled care for continence skin care and special treatments.⁹⁶ All of the services identified corroborated that the care was ordered by a physician and required the skills of technical or professional personnel.

4. A Nursing Facility (“NF”) that Provides Skilled Nursing and Related Services or Rehabilitative Services is Equivalent to a Skilled Nursing Facility (“SNF”):

The Intermediary points out that OBRA-1987 included the Nursing Home Reform provisions that regulate the certification of long-term care facilities under the Medicare and Medicaid programs. As a result of these provisions, which became effective October 1, 1990, both Medicare SNFs and Medicaid NFs are required to provide the basic range of services described in sections 1819(b)(4) and 1919(b)(4) of the Social Security Act. 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 further notes 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, thereby eliminating the current regulatory distinction between skilled and intermediate nursing facilities.⁹⁷ Moreover, the provisions established a single standard of “skilled” care for all Medicare and Medicaid beneficiaries and forced facilities to provide “skilled” care as required by federal law and was in itself self-effectuating. The Intermediary

⁹⁶ See Intermediary’s Position Paper, pp 53-57.

⁹⁷ See Intermediary Exhibit I-81.

notes that this interpretation has been upheld in Newman v. Kelly, 849 F. Supp. 228 (1994)⁹⁸ where the court held that:

Effective 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 facility” under Medicare and simply “nursing facility” under Medicaid imply that a level of care distinction may be inferred between the two statutes. However, 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 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 level of skilled care required by the resident who is eligible for Medicare or Medicaid reimbursement. Therefore, the court finds that the term “skilled nursing facility” in § 1395i-3 is the substantial equivalent of the term “nursing facility.”

The Intermediary points out that an institution may have restrictions on the type of services it makes available and the types of health conditions it accepts, or may establish other criteria relating to the admission of patients. In addition, a nursing facility might not have furnished skilled nursing or rehabilitative services as frequently as a skilled nursing facility providing those services on a continuous basis. However, the regulation at 42 C.F.R. § 413.30(e) makes no allowance for institutions providing a low volume of skilled nursing services prior to certification as a SNF. An institution having provided skilled nursing or rehabilitative services for three or more years prior to certification under past and present ownership, regardless of the specific volume, is not entitled to the new provider exemption.

5. Why Milton Hospital TCU Exceeded the Skilled Nursing Facility Routine Service Cost Limits:

When CMS informed the Provider of its denial of the exemption request, the Provider was advised to seek relief from the effect of the SNF RCLs through the exception process. Relief from the cost limits for the provision of atypical services is provided for under the exception provision found at 42 C.F.R. § 413.30(f). As stated at 42 C.F.R. § 413.30(f), limits under this

⁹⁸ See Intermediary Exhibit I-83.

section may be adjusted upward for a provider under the circumstances specified only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary. An exception may be granted if an institution can demonstrate that it has a lower than average length of stay, higher than average ancillary cost per day and higher than average Medicare utilization than that of its peers. CMS utilizes a uniform peer group that is based on data from SNFs whose costs are used to compute the cost limits when assessing atypical status.

The Intermediary advises that the Provider requested and received relief from the effects of the SNF RCLs through the exception provisions due to the provision of atypical services, which amounted to a total of approximately \$2,020,000 for the four cost reporting periods in controversy. The Provider obtained the exception because it demonstrated that it provided atypical services due to lower than average length of stay compared to its peers, a higher than average ancillary cost per day and higher than average Medicare utilization. While the Provider attempted to utilize these factors for its exemption request, the Intermediary argues that none of these factors is relevant to the determination as to whether the Provider was eligible for an exemption as a new provider.

In summary, the Intermediary contends that the Provider has failed to demonstrate that it met the requirements for an exemption to the SNF RCLs. The decision by Milton Hospital to purchase and relocate a portion of two existing nursing homes that operated in the manner of a SNF, or its equivalent, for more than three years prior to its participation in the Medicare program does not make the TCU a new provider of skilled nursing or rehabilitative services under the regulation. The fact that the Provider may have furnished a “higher level” of skilled services does not negate the reality or legal significance that the acquired predecessors were in the business of providing skilled care as well as other services. The regulations make no distinction between level and intensity in the provision of skilled services in determining who might qualify for the new provider exemption.

The Provider’s reliance on Massachusetts’ law is irrelevant to the federal administration and interpretation of the Medicare program. The state statutory and regulatory proscription imposed on certain classified levels of nursing home providers is simply inconsistent with the facts of what was occurring in the provision of services by Neponset Hall and Ashmont Manor. The facts of the predecessors behavior - - their provision of and reimbursement for skilled services - - not abstract constructions of statute or regulations, resulted in CMS’ denial of the Provider’s request for a new provider exemption. The Intermediary concludes that a CHOW occurred within the meaning of the Medicare regulations and implementing manual instructions whereby valuable consideration was paid for the beds released under a specified plan of action which complied with the exiting moratorium provisions of the state of Massachusetts. In consideration of the facts in the instant cases, the Intermediary urges the Board to uphold CMS’ denial of the Provider’s request for an new provider exemption under 42 C.F.R. § 413.30(e).

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:1. Laws:42 U.S.C.:

- § 1395i-3 et seq.
(§ 1819 et seq. of Act) - Requirements for, and Assuring Quality of Care in, Skilled Nursing Facilities
- § 1396r et seq.
(§ 1919 et seq. of Act) - Requirements for Nursing Facilities

2. Regulations – 42 C.F.R.:

- §§ 405.1835 -.1841 - Board Jurisdiction
- § 409.30 et seq. - Requirements for Coverage of Post- hospital SNF Care – Basic Requirements
- § 409.31 et seq. - Level of Care Requirement
- § 409.32 et seq. - Criteria for Skilled Services and the Need for Skilled Services
- § 409.33 et seq. - Examples of Skilled Nursing and Rehabilitation Services
- § 409.34 et seq. - Criteria for “Daily Basis”
- § 409.35 et seq. - Criteria for “Practical Matter”
- § 411.15 (g) - Custodial Care
- § 413.30 - Limitations on Reimbursable Costs
- § 413.30 (e) - Exemptions
- § 413.30 (f) - Exceptions
- § 440.40 - Nursing Facility Services

3. Program Instructions – Medicare Skilled Nursing Facility Manual (HCFA Pub. 12):

§ 214 - Covered Level of Care – General

4. Program Instructions – Medicare Intermediary Manual (HCFA Pub. 13)

§ 3159 - Custodial Care

§ 4500 - Change of Ownership-General

§ 4501 - Change of Ownership Review Procedures

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

§ 1500 et seq. - Change of Ownership

§ 2533 et seq. - Request for Exemption from SNF Cost Limits

§ 2533.1 - Requests Regarding New Provider Exemption

§ 2604.1 - Definition – New Provider

6. Case Law:

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 and Medicaid Guide (CCH) ¶ 80,334, rev'd, CMS Administrator, November 22, 1999, Medicare and Medicaid Guide (CCH) ¶ 80,406; aff'd sub nom Maryland General Hospital v. Thompson, 155 F. Supp. 2d 459 (D. Md. 2001).

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., CMS Administrator, June 23, 1999, rev'd and reman'd., South Shore Hospital Transitional Care Center v. Thompson, CA 99-11611-JLT (D. Mass Jan. 3, 2002), (2002 U.S. Dist. Lexis 289) Medicare and Medicaid Guide (CCH) 2002-1 ¶ 300,934.

Ashtabula County Medical Center Skilled Nursing Facility v. Blue Cross and Blue Shield Association/AdminaStar 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, Case No. 1:00 CV 1895 (ND Ohio, Feb. 8, 2002); 2002 U.S. Dist Lexis 5499).

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., CMS Administrator, June 8, 1998, aff'd Paragon Health Network, Inc. v. Shalala, No. 98-C-0553 (E.D. Wis. Aug. 17, 2000), aff'd sub nom Paragon Health Network, Inc. v. Thompson, 251 F. 3d 1141 (7th Cir. 2001).

Potter v. United States, 155 U.S. 438, 466 (1894).

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

7. Other:

Omnibus Budget Reconciliation Act of 1987- (OBRA-1987).

OBRA -1987, Legislative History, Pub L. No. 100-203, House Report No. 100-391 (I).

Massachusetts Statutes:

M.G.L c.111 §25C - Determination of Need

Massachusetts Regulations:

105C.M.R. § 100.301 - Acceptance of Applications for Filing

105 C.M.R. § 100.302 - Filing Days for Applications and Amendments

105 C.M.R. § 100.710 - Transfer of Ownership Procedure for Unimplemented Projects

105 C.M.R. § 100.720 - Transfer of Site Procedures

105 C.M.R. § 150.000 et seq. - Licensing of Long-Term Care Facilities

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 submissions, finds and concludes as follows:

Milton Hospital TCU, the Provider in the instant cases, is a 20-bed hospital-based SNF located on the campus of Milton Hospital in the town of Milton, Massachusetts. The Provider received its initial license for 20 skilled nursing beds and admitted its first patient on May 1, 1995. In order to admit patients in the state of Massachusetts, a nursing facility must obtain a license from the Massachusetts Department of Public Health ("DPH") pursuant to the licensure regulations at 105 C.M.R. § 150.000 *et seq.*⁹⁹ In addition to licensing requirements, Massachusetts also controls the construction of nursing facilities under Section 25C of Chapter 111 of the Massachusetts General Laws which requires the issuance of a Determination of Need ("DON") by DPH for the proposed facility at the designated location.¹⁰⁰ During the 1990's, DPH regulations at 105 C.M.R. §§ 100.301-302 also imposed a moratorium on the issuance of DONs with certain limited exceptions.¹⁰¹

Since a moratorium was in effect at the time Milton Hospital sought to establish its TCU, the Hospital conducted a search for an entity that had already obtained a DON. This search resulted in the identification of Neponset Hall, Inc. ("Neponset"), an unrelated corporation that held an approved DON to construct a specified number of new nursing facility beds in the future. Neponset was the owner and operator of two separately licensed Level III facilities (Neponset Hall Nursing Home-98 beds and Ashmont Manor Nursing Home –77 beds) located side by side in the town of Dorchester, Massachusetts. Neponset's application to construct a new single facility in the town of Milton was approved by DPH on July 20, 1994 as DON Project No. 4-1296.¹⁰² The approved project provided for the replacement of the two existing nursing homes and the addition of 12 DON-exempt beds for a total of 187 beds. Upon implementation of the project, Neponset was required to request licensure of its new facility as a Level II nursing home and to obtain Medicare certification.

On September 2, 1994, Neponset submitted a letter to DPH requesting "a transfer of ownership of 20 beds of the approved but not yet implemented determination of need ("DON") Project No. 4-1296" to Milton Hospital.¹⁰³ On September 23, 1994, the parties executed an agreement (DON Agreement) whereby Milton Hospital agreed to pay Neponset \$400,000 for the transfers of ownership and site of the 20-bed portion of the DON authorization.¹⁰⁴ On October 28, 1994,

⁹⁹ See Provider Exhibit P-24.

¹⁰⁰ See Intermediary Exhibit I-8.

¹⁰¹ See Provider Exhibit P-1.

¹⁰² See Provider Exhibit P-4.

¹⁰³ See Intermediary Exhibit I-19.

DPH approved the requested transfers referring to the beds being transferred as “20 BANYL beds (Beds Approved But Not Yet Licensed).”¹⁰⁵ DPH’s transfer of ownership and transfer of site were made pursuant to 105 C.M.R. § 100.710 and § 100.720, respectively.¹⁰⁶

Due to various difficulties with the site originally selected, on July 14, 1997 Neponset requested a transfer of site for its approved DON Project No. 4-1296 from the town of Milton to Marina Bay, a development located in the City of Quincy, Massachusetts.¹⁰⁷ Final plans and specifications for the project at Marina Bay were not approved by DPH until June 3, 1999.¹⁰⁸ The Project was finally implemented with the opening of a 167-bed Level II facility at Marina Bay on January 8, 2001, more than six years after DON Project No. 4-1296 had been approved by DPH.¹⁰⁹

Since the nursing facility described in DON Project No. 4-1296 had not yet been built at the time of the transaction between Milton Hospital and Neponset, DPH advised Neponset in a letter dated December 27, 1994 that the license correlation between the two projects needed to be clarified.¹¹⁰ In light of the fact that the 20-bed transfer would occur before Neponset’s replacement facility was constructed, it would be necessary for the proposed licensure changes to be associated with an actual decrease in the number of originally licensed beds, rather than a decrease in not yet licensed beds. On June 14, 1995, DPH informed Neponset that 20 Level III beds had been permanently eliminated from Neponset Hall Nursing Home effective May 1, 1995, the date the Milton Hospital TCU was initially licensed for 20 Level II beds.¹¹¹ As a result of this action, combined with DPH’s approval to add 12 Level III DON-exempt beds to the facility, Neponset Hall Nursing Home became licensed for 90 Level III beds as of May 1, 1995.

On June 2, 1995, Milton Hospital requested that CMS grant its TCU an exemption from Medicare’s SNF RCLs as a new provider under the regulatory provisions of 42 C.F.R. § 413.30(e). This controlling regulation states the following:

¹⁰⁴ See Provider Exhibit P-5.

¹⁰⁵ See Provider Exhibit P-6.

¹⁰⁶ See Provider Exhibits P-2 and P-3.

¹⁰⁷ See Provider Exhibit P-47.

¹⁰⁸ See Provider Exhibit P-48.

¹⁰⁹ See Provider Exhibit P-49.

¹¹⁰ See Provider Exhibit P-45.

¹¹¹ See Provider Exhibit P-46.

(e) Exemptions. Exemption 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. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

42 C.F.R. § 413.30(e).

CMS denied Milton Hospital's exemption request stating in part that the Provider did not qualify for a new provider exemption because:

1. It was a portion of an existing long term care institution that was relocated to the hospital complex, due to a CHOW in accordance with Section 1500 of HCFA Pub. 15-1.
2. The portion of the existing long term care institution, prior to relocation, operated as a NF since October 1, 1990 and is considered an equivalent provider of skilled or rehabilitative services in accordance with the changes in the law resultant from OBRA-1987.
3. Notwithstanding the change in the law, the existing long term care institution, prior to relocation, operated in the manner equivalent to a SNF by performing skilled nursing and rehabilitative services, for three or more years prior to Medicare certification.

The Board majority has been confronted several times with the issue of whether the acquisition of bed rights (operating rights, certificate of need, determination of need, etc.), in and of itself, constitutes a CHOW for the purpose of determining whether the "present and previous ownership" provision of 42 C.F.R. § 413.30 (e) is applicable. More specifically, the question at issue is whether or not a CHOW has occurred, thus triggering a review of the relinquishing facility's historical operations, which could result in the denial of a "new provider" exemption request.

In prior decisions regarding this matter, the Board majority has followed CMS' interpretation, in most instances, finding that such action does result in a CHOW. Importantly, the majority also notes that its prior decisions on this issue always contained a measurable degree of disagreement resulting in dissenting opinions being rendered in some instances. See e.g., South Shore, Sleep dissenting and Maryland, Wessman and Hoover dissenting. 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 cases. In part, the court states:

“ . . . South Shore opened after the DON 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 history was unwarranted.

South Shore at CCH 2002-1 ¶ 300,934.

The Board also notes the Ashtabula decision where the court found the Secretary's interpretation of the “new provider” regulation arbitrary, capricious, and erroneous. The court focused on 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 Ashtabula court’s analysis of this matter concentrated 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 Medicare and Medicaid Guide (CCH) ¶ 300,964. 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.

Based upon these facts, the Board majority finds that CMS improperly denied the Provider’s request for an exemption to Medicare’s routine services cost limits. Similar to the courts’ findings in both South Shore and Ashtabula, the Board majority finds that Milton Hospital’s acquisition of the rights to 20 beds as part of the DON approved by DPH does not represent a change of ownership, and that the services that may or may not have been performed by Neponset are irrelevant. The Provider meets the program’s definition of a “new provider” at 42 C.F.R. § 413.30(e); 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.

DECISION AND ORDER:

CMS’ denial of the Provider’s request for an exemption to Medicare’s SNF RCLs as a new provider under 42 C.F.R. § 413.30 (e) was improper and is reversed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esquire (Dissenting)
Stanley J. Sokolove
Gary B. Blodgett, D.D.S.
Suzanne Cochran, Esquire (Concurring)

DATE OF DECISION: September 30, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman

I concur with the majority's conclusion that Milton's acquisition of DON rights from Neponset 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 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)

It is undisputed that Milton's acquisition of the DON from Neponset was the only transaction between those parties. CMS denied Milton's application on the basis that the DON transaction resulted in a provider change of ownership (CHOW). Thus, Neponset was treated as a prior owner of the provider applicant, Milton, and Neponset's history of providing services was used to disqualify Milton as being "new." 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*¹¹² and *Ashtabula*¹¹³ Courts held that denying new provider status based solely on the transfer of DON rights from an unrelated entity as constituting a CHOW is plainly erroneous. 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 involving 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. Thompson*, 155 F. Supp. 2d 459 (D.Md, 2001) and *Larkin Chase Nursing and Restorative Center v. Thompson*, 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* is somewhat similar to Milton in that both involve a question of whether the rights covered by the DON were for beds that were never put into use. These were referred to as "waiver" beds in

¹¹² *South Shore Hospital Transitional Care v. Thompson*, 2002 U.S. Dist. LEXIS 289 (D.Mass. January 3, 2002).

¹¹³ *Ashtabula County Medical Center v. Thompson*, 2002 U.S. Dist. LEXIS 5499 (N.D. Ohio, Feb 8, 2002)

Maryland General and BAYNL (beds approved but not yet licensed) in the instant case. However, *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 CON. 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 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.¹¹⁴ 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

HCFA Pub.13-4 §4502.5 "Purchase of Corporate Assets" states:

¹¹⁴ 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.

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.”¹¹⁵ (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)

The State Operations Manual, HCFA Pub 7 §3210, is particularly instructive in determining what constitutes 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)

¹¹⁵ The original agreement between Milton and Neponset was for a new consolidated project that had been approved for Neponset and Ashmont but was to be built in the future. The future approved beds would have replaced beds already approved and in use. Because the Neponset-Ashmont new project was delayed beyond Milton's opening, the transaction had to be modified to take Milton's bed rights out of Neponset's current rights. Whether the bed rights were for BANYL beds or operational beds is not material to this analysis of the Agency's view that bed rights are the equivalent of a “provider.”

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.”

While, admittedly, none of these manual provisions deal expressly with the SNF new provider exemption issue,¹¹⁶ they do indicate the Agency’s consistent view 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. 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 business enterprise so that licensure and certification may continue.¹¹⁷ There is nothing in these provisions that would support the Agency’s position that Milton’s acquisition of a single asset, DON rights, from the unrelated Neponset makes Milton Neponset’s legal successor. Conversely, there is nothing to support the position that Neponset previously had legal responsibility for operation of Milton’s business enterprise. On the contrary, it is undisputed that Neponset and Milton operated nursing homes totally independent of each other.

Hospital New Provider Interpretation

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. 412.74.¹¹⁸ 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

¹¹⁶ See p. 9. HCFA published a manual provision in 1997, after the cost report years in issue, that sets out the interpretation that the Agency has applied here.

¹¹⁷ I am forced to concede that in DON states a provider must have a DON 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 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 DON as being the equivalent of a provider would also require a wholly different treatment in those states that do not have a DON or CON process.

¹¹⁸ The hospital new provider exemption provision was moved to 42 C.F.R. 413.40(f).

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 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." This statement reflects that 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 Milton's acquisition of a single intangible asset from a totally independent Neponset 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

I dissent. I echo the primary contentions of my recent dissent in Mercy Medical (PRRB Dec. No. 2002-D31, August 7, 2002).

I am particularly intrigued by the liberal stance of the presently constituted PRRB majority whereby the significant “sale price” of \$400,000 for twenty (20) operating LTC beds and DoN rights (Intermediary Position Paper, Exhibit I-20) purchased by Milton Hospital TCU from Neponset Hall, Inc. through the Massachusetts DPH/DHCQ process, does not rise to the level of a CHOW (change of ownership). It is very clear, at least to me, that licensure/certification of both the buyer, Milton, and the seller, Neponset/Ashmont Manor, were affected by this transaction (Provider Position Paper, Exhibit P-45), clearly making this a CHOW under Medicare regulation, (HCFA Pub. 15-1 § 1500.7; HCFA Pub. 13-1 § 4502.5) which triggers the three (3) year look back and location considerations.

I suspect, as noted *infra*, that Milton TCU will be surprised to learn, at least in the logic of the PRRB’s current liberal majority, that they paid \$400,000 for nothing of substance. As discussed *infra*, \$400,000 for nothing certainly does not mesh with the bedrock Medicare determinant of “reasonable cost” as mandated under 42 U.S.C. § 1395x(v)(1)(A).

Precedent Ignored

The PRRB Majority finds the 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 new 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 its own regulations is a critical axiom of Administrative Law. In my opinion, DHHS Secretary Thompson has met the standard of Chevron (Chevron U.S.A v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984)) and certainly the standard of Skidmore (Skidmore v. Swift & Co., 323 U.S. 134 (1944)), and deserves more respect than proffered by two (2) lower courts and the PRRB Majority in the instant case.

Provider Paid \$400,000 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's liberal 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 \$400,000 (Intermediary Exhibit I-20) for actual operating beds (Provider Exhibit P-45), yet 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 liberal 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 \$400,000 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. But in the instant case, the purchase consisted of actual operating LTC beds (Provider Exhibit P-45), beyond even the weak “intangibles” argument of South Shore and Ashtabula. But even that fact apparently did not sway the PRRB’s provider-oriented majority.

All Elements of a “CHOW” Present

In the instant case, it is undisputed that there was a Sale (Intermediary Exhibit I-20) between the purchaser-Provider, Milton Hospital, and the seller, Neponset Hall, Inc., whereby the appealing Provider, Milton Hospital TCU, acquired the right, title and interest in twenty (20) operating long term care beds/bed rights/licensure pursuant to the process identified by the Massachusetts DPH/DHCQ. Milton paid the significant sum of \$400,000 to Neponset Hall, Inc. (Intermediary Exhibit I-20) for the operating beds/ DoN beds/ bed rights/licensure transfers (Provider Exhibit P-45) thus unequivocally affecting the licensure and certification of both Milton and Neponset Hall (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 Milton TCU) and the seller (Neponset Hall, Inc.). 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, Milton TCU. 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 the charade presented in the instant case by Milton Hospital TCU.

Bed Purchase Benefit/Convenience for Provider – not Medicare

If Milton Hospital TCU had attempted to acquire the requisite “licensed beds” or “bed operating rights” through Massachusetts’s 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. 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 Position Paper at 43-47; Intermediary Exhibits I-31, I-32, I-33, I-34) 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 the significant additional cost of \$2,393,000 to U.S. taxpayers via the Medicare Trust Fund. In my humble opinion, the liberal PRRB Majority’s decision is tantamount to paying a \$2,393,000 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 Milton Hospital TCU Neuters Medicare “Reasonable Cost” Mandate

The question than becomes did the instant Provider, Milton Hospital TCU, 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 Exhibit I-20), had inherent value to the seller (but not to the extent of a Medicare windfall as a “new provider”), and that Milton was willing to pay for the licensed/certified, operating LTC 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, Milton Hospital TCU appropriately sought, and appropriately received, an exception resulting in a payment of \$1,590,066 for documented “atypical services” in FYEs September 30, 1995, 1996 & 1997 (Intermediary Position Paper at 61-62). 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.

Milton Hospital TCU appropriately sought, and received a significant exception for FYEs 1995, 1996 & 1997; 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. Milton Hospital TCU received the appropriate exception. CMS’ new provider cost exemption denial in the instant case is appropriate and should be upheld.

Henry C. Wessman, Esq.
Senior Board Member