PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D69

PROVIDER -
Maryland General Hospital Transitional Care Center, Baltimore, MD

Provider No. 21-5282

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Maryland

DATE OF HEARING-
November 5, 1998

Cost Reporting Periods Ended -
June 30, 1996, 1997, 1998 and 1999

CASE NO. 97-0503

INDEX

ISSUE:

Was the Health Care Financing Administration's ("HCFA") denial of the Provider's request for an exemption to the routine cost limits as a new provider under 42 C.F.R. §413.30(e) proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Maryland General Hospital Transitional Care Center ("Provider") is a 24-bed hospital-based skilled nursing facility ("HBSNF") located at the Maryland General Hospital facility ("Hospital" or "MGH"), a community teaching hospital located in Baltimore, Maryland. The Provider obtained Certificate of Need ("CON") approval on July 11, 1995 from the Maryland Health Resources Planning Commission ("MHRPC" or "Commission").[1] The unit opened in March of 1996, and its beds were certified as a Medicare skilled nursing facility ("SNF") effective March 18, 1996.

Under the Maryland law and regulations in effect during 1994 and 1995, the Hospital had three approaches to establish a HBSNF and be licensed as a comprehensive care facility("CCF"). First, a CON application could be submitted to secure approval for new CCF beds that had been identified as needed pursuant to the methodology and need projections identified in the State Health Plan Section on Long Term Care Services. A second alternative was a CON application to obtain new CCF beds from a newly identified pool of 175 beds determined to be needed pursuant to regulations, and specifically available for the establishment of HBSNFs. A third option was to acquire from existing nursing facilities, their right to add beds to their licensed CCF bed complement pursuant to a waiver from CON requirements ("Waiver Beds"), and relocate those beds in the hospital facility in which the HBSNF would be located. In June of 1994, the Hospital chose the last option by entering into letter agreements with three separate nursing facilities located in Baltimore City.[2] Under the contractual agreements, the Hospital agreed to acquire the right to operate CCF beds from the nursing facilities as follows:

	Number of Beds	Purchase Price
Villa St. Michael	10	$30,000
Granada Nursing Home	6	$15,000
Wesley Home	8	$22,000

In addition to the various terms for the timely and efficient closing of the transaction, paragraph 2 of the agreement sets forth the following obligations for the buyer and seller:

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[1] Provider Exhibit P-8.

[2] Provider Exhibit P-5/Intermediary Exhibit I-12.

2. Contingencies to Obligation of Buyer. The obligations of Buyer to proceed with the consummation of the transaction shall be expressly conditioned upon the occurrence of the following:

A. Buyer shall have received all applicable approvals from the Maryland Health Resources Planning Commission (the "MHRPC"), including a Certificate Of Need ("CON') permitting Buyer to acquire and operate the Beds in form and substance satisfactory to Buyer; and

B. As of the date of Closing, (i) there shall be no pending or threatened litigation affecting the Beds, (ii) Seller shall have good title to the Beds, free of all liens and encumbrances, and none of the Beds shall ever have been Medicare-certified, (iii) the transaction contemplated hereby shall have been duly authorized by all necessary corporate action on behalf of Seller, (iv) Seller shall be current in all its state and federal tax obligations so as to avoid any related lien, encumbrances or other restriction on the acquisition and operation of the Beds by Buyer, and (v) the transaction contemplated hereby shall not conflict with or constitute a default under any other agreement to which Seller is a party.

2A. Contingency to Obligation of Seller. The obligations of Seller to proceed with the consummation of the transaction shall be expressly conditioned upon occurrence of the following: Seller shall have received all applicable approvals from the MHRPC permitting Seller to add [ten (10), six (6), eight (8)] comprehensive care beds.

Id.

In July of 1994, each of the nursing facilities which entered into an agreement with the Hospital informed the MHRPC of their desire to replace the beds sold to the Hospital pursuant to the waiver regulations that permit such increases without a CON.[3] In their respective letters, each nursing facility requested that the Letter of Determination confirm that there would be no net change in the licensed CCF complement for the facility, and that it was their understanding the two transactions would occur simultaneously and a new CCF license would not need to be issued. In its response to the nursing facilities, MHRPC advised that, based on the current provisions of the State Health Plan, each would be able to add the number of beds transferred without CON review.[4]

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[3] Intermediary Exhibit I-13.

[4] Intermediary Exhibit I-14.

In its CON application submitted August 2, 1994,[5] the Hospital presented various analysis and explanations as to how its proposed opening of a HBSNF would impact on its facility and other health care providers in the area. In discussing the needs of the population served or to be served by the HBSNF, the CON application included the following:

> The twenty-four (24) comprehensive care facility beds to be utilized in the HBSNF already exist at the three (3) nursing homes referenced earlier from which the beds will be acquired. All twenty-four (24) beds are included in the current inventory of comprehensive care beds identified in the State Health Plan Section on Long-Tern Care Service. As such, these beds--which are in service and meeting the needs of central Maryland residents--are recognized as being needed in Baltimore City. This project entails only a relocation of those twenty-four (24) beds, and continued use as licensed comprehensive care facility beds. Hence, the need for these beds has already been proven and continues to be recognized. Nonetheless, Maryland General Hospital has undertaken its own analysis to determine the extent to which the beds may expect to be utilized for sub-acute purposes from the hospital's own acute care population.

Id.

When the final CON was approved by the MHRPC on July 11, 1995,[6] the project description stated the following:

> Maryland General Hospital will add 24 comprehensive care beds to the Hospital. The beds will be licensed as Comprehensive Care-Special Care Units-General under 10.07.02.14-1, Code of Maryland Regulations and used as a subacute care unit. The 24 comprehensive care beds herein approved will be housed in existing space within the Hospital. The beds will be transferred from existing nursing homes within Baltimore City (Villa St. Michael - 10 beds. Granada Nursing Home - 6 beds, and The Wesley Home, Inc. - 8 beds).

On December 11, 1995, the Hospital advised the Intermediary that it was in the process of completing all necessary inspections and certification requirements for opening its HBSNF and, therefore, was requesting an exemption to the routine cost limits under 42 C.F.R. §413.30(e).[7] In response to a

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[5] Provider Exhibit P-4/Intermediary Exhibit I-11.

[6] Provider Exhibit P-8.

[7] Provider Exhibit P-13.

request for additional information regarding how the beds for the HBSNF were acquired, the Hospital responded as follows:

> All of these beds were "waiver beds" approved by the Maryland Health Resources Planning Commission for the respective facilities for the express purpose of being transferred to Maryland General Hospital for establishment of the Transitional Care Center. Please see the attached excerpts from the "MHRPC Certificate of Need (CON)-Monthly Status Report." These "waiver beds" were never licensed operational or certified for Medicaid or Medicare purposes at Granada Nursing Home, Villa St. Michael, or the Wesley Home. As these beds were never in service, no patients were transferred as part of the transaction.

Id.

As to the Intermediary's request for historical patient occupancy data regarding the 24 beds acquired, the Hospital reiterated in its letters of July 29, 1996 and October 14, 1996 that all of the beds were "Waiver Beds" which were never licensed, operational or certified for Medicare or Medicaid and, hence, there was no census history associated with those beds that could be furnished.[8] The Intermediary subsequently forwarded the new provider exemption request to the Health Care Financing Administration ("HCFA") stating the following:[9]

> Maryland General Hospital Transitional Care Unit was Medicare-certified on March 18, 1996. We have verified that, prior to this date, this provider has never operated as a skilled nursing facility, under present or previous ownership. Based on the information submitted with the request, which we are enclosing for your review, we have determined that the provider meets all of the criteria for the granting of this exemption.
>
> As fiscal intermediary, we recommend that this exemption request be granted.

By letter dated November 20, 1996, HCFA denied the Provider's request for an exemption to the Medicare SNF routine service cost limits.[10] In its denial letter HCFA advised that :

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[8] Id.

[9] Provider Exhibit P-14.

[10] Provider Exhibit P-15/Intermediary Exhibit I-42.

> 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, names, location, etc., since these are subject to change, but in fact no change in the operation of the institution or institutional complex has occurred -- to determine if and when skilled nursing and/or rehabilitative services were performed.

In addition to the regulatory provisions of 42 C.F.R. §413.30(e), HCFA also cited the Omnibus Budget Reconciliation Act of 1987 and the relocation provisions of §2604.1 in the Provider Reimbursement Manual (HCFA Pub. 15-1). Based on its review of the information submitted with the exemption request, HCFA determined that the Provider did not qualify for a new provider exemption because:

1. [Provider] was established due to the purchase and relocation of 10 beds from Villa St. Michael, 6 beds from Granada Nursing Home and 8 beds from Wesley Home, Inc. These beds were relocated from the three nursing homes to the 4 West and 4 South wings of the Hospital on March 18, 1996. According to the CON application, the twenty-four beds already existed at the three nursing homes from which they were acquired. All twenty-four beds were already included in the current inventory of beds identified in the State Health Plan Section on Long-Term Care Services. As such, these beds were in service and meeting the needs of central Maryland residents. The three nursing homes are all located in Baltimore City. This purchase and relocation of 24 beds was approved by the State of Maryland, Maryland Health Planning Commission on June 30, 1995, Docket #94-24-1748.

2. Villa St. Michael, Granada Nursing Home and Wesley Home have all operated as dually certified facilities (Medicare/Medicaid) providing both skilled nursing and rehabilitative services since June 1, 1989, July 1, 1989 and May 7, 1996, respectively. Therefore they are all equivalent providers of skilled nursing or rehabilitative services.

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

While the Provider did not qualify for an exemption under 42 C.F.R §413.30(e), HCFA advised that the Provider may qualify for an exception to the SNF routine cost limits as outlined in Chapter 25 of

HCFA Pub. 15-1.[11] The Provider appealed HCFA's denial of its exemption request to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§405.1835-.1841, and has met the jurisdictional requirements of those regulation. The Provider estimates that the Medicare reimbursement effect is approximately $1,500,000 for fiscal year 1996, and additional amounts for subsequent years.[12] The Provider was represented by Carel T. Hedlund, Esquire, and John J. Eller, Esquire, of Ober, Kaler,Grimes & Shriver. The Intermediary's representative was James R. Grimes, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the plain language of the governing regulation at 42 C.F.R. §413.30(e) allows new provider status for a HBSNF that has "operated" for less than three years. This regulation states the following:

> (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 reporting period beginning at least two years after the provider accepts its first patient.

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

The Provider insists that the key word in this definition of a new provider is the term "operated." If HBSNF beds had never been "operated" by prior owners, then the prior ownership of those beds is not relevant for purposes of the exemption. The Provider argues that it is a new provider of HBSNF services for two reasons: (1) It had never previously owned or operated a HBSNF; and (2) The HBSNF was established using "Waiver Beds" that had never previously existed as licensed beds for any provider, and had never been "operated" by any provider.

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[11] Intermediary Exhibit I-44 shows that a partial exception was granted for FYEs' June 30, 1996 and 1997.

[12] Subsequent to the filing of this appeal, Congress passed the Balanced Budget Act of 1997, which created a prospective payment system ("PPS") for SNFs. This PPS will take effect with cost reporting periods beginning on or after July 1, 1998. Therefore, denial of the new provider exemption from the routine cost limits will have a detrimental effect on the Provider only for FYs 1996 and 1997.

Under Maryland law "Waiver Beds" are not licensed operation beds. Their authorization constitutes the granting of rights to establish beds in the future and, thus, they are inchoate beds until they become licensed. When "Waiver Beds" become licensed, they become ordinary licensed CCF bed which then are "operated" by a provider. "Waiver Beds" may only become licensed, operational beds upon licensure by the Maryland Licensing and Certification Administration, even though they are exempt from CON review. The Provider argues that it acted in concert with the nursing facilities with the singular purpose of adding new CCF beds to the health care system for the express purpose of instituting a HBSNF at its facility. Authorization for "Waiver Beds" was sought by the nursing facilities to allow a like number of beds to be located at the Provider.[13] Accordingly, the Provider's CON application indicated an intent to purchase and locate an identical number of beds at its facility, the rights to which were to be acquired from the nursing facilities for the same purpose.[14] The Provider notes that each of the nursing facilities indicated that its own net licensed and operational bed capacity would not be increased as a result of the transaction, and there would be no licensure change as a result of the transfer of the CCF beds. In approving the "Waiver Beds" for the nursing facilites, MHRPC reiterated these same essential facts.

The Provider points out that there is some confusion in the early documentation in the record of this case because of an error on the part of the Provider and the nursing facilities. Specifically, both the Provider and the nursing facilities erroneously believed that the MHRPC would implement the transaction by transferring operational beds at the nursing facilites to the Provider, and that the "Waiver Beds" would be utilized to replenish those beds at the nursing facilities without any net increase in the licensed CCF capacity at the nursing facilities. However, MHRPC did not handle the transaction as incorrectly requested by the parties. Instead, MHRPC simply authorized the transfer of "Waiver Beds" directly to the Provider, thus avoiding licensure changes and new certifications of additional beds at the nursing facilities which would otherwise be mandatory under the law if operational beds were transferred. Because of the mistaken impression of the parties, the record contains documentation of the parties' erroneous intent to transfer operational beds. However, the Provider points out that other contemporaneous documents clearly reflect that what MHRPC actually did was to approve the transfer of "Waiver Beds" to the Provider for the pupose of establishing a proposed HBSNF.

The Provider points out that the Hospital exchanged a series of letters with MHRPC to clarify the CON approval. In its letter to MHRPC, dated November 19, 1997, [15] the Provider' outlined its understanding of MHRPC's CON approval which included the following:

> The Final Decision made reference to MGH's purchase of "existing beds" (page 4) and further stated that "no new beds will be added to

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[13] Provider Exhibit P-16.

[14] Provider Exhibit P-4.

[15] Provider Exhibit P-17. Note: The attachments referenced on the correspondence appear as Provider Exhibits P-6, P-7 and P-8.

> the system as a result of this project" (page 1; see also page 4). This is consistent with the Commission's position discussed above, when interpreted in light of the overall transaction as a whole, and the respective roles of the Commission and LCA.[16] That is, the waiver beds to be transferred were "existing" from the point of view of having previously been authorized and recognized by the Commission, but they clearly were not yet "existing " for LCA's purposes of licensure and certification of operational beds. Similarly, while the waiver beds to be transferred were not "new" within the [State Health Plan] context of additional beds projected to be needed pursuant to the [State Health Plan] need methodology, and they already existed as approved waiver beds, the beds were"new" from LCA's licensing and certification perspective, as those beds had never previously been in service prior to the institution of the HBSNF at MGH. (See also, Final Decision, page 4: "Thus, the State Health Plan need projections are not applicable to review.") Hence, the Commission approved the transfer of "existing" waiver beds from the Facilities, i.e., beds that existed in terms of the inchoate right of the transferring facility to those beds under the CON laws, but beds which were not previously licensed, certified, or operational, and which for that reason would represent "new" beds to the system upon licensure and certification. In short, the total aggregate number of waiver beds and licensed beds in the system did not change; the unlicensed waiver beds were simply approved for redistribution or reallocation as licensed beds for MGH, thus adding " new" operational capacity without increasing the number of approved beds.

In a letter dated November 20, 1997,[17] MHRPC's Executive Director confirmed the Hospital's understanding of the CON approval stating in pertinent part:

> I concur with your understanding of the action taken by the Commission in this case: in its approval of Maryland General's CON application, the Commission approved the transfer of waiver beds [created pursuant to COMAR 10.24.01.02(A)(2)] to create the new subacute care unit. These beds had not previously been licensed or in service, and so have not been previously included in the State Health Plan inventory. They represent new, additional comprehensive care facility bed capacity in the health care system. As I have stated, those

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[16] Licensing and Certification Administration.

[17] Provider Exhibit P-17.

> waiver beds were approved for transfer to Maryland General Hospital in the Certificate of Need action. (emphasis added).

At the hearing, the Provider's expert witness (former Director of CON at MHRPC) testified that he reviewed the documents in the record and summarized MHRPC's view of the tranaction as follows:

> from a global perspective, the intention was to state on the record the desire of the nursing homes to have their waiver bed rights recognized and to have those beds become available for Maryland General to develop its Transitional Care Center.

Tr. at 27-28.

This witness further testified upon cross-examination that, while there is some confusion in the records, the Board needs to look at all the documents and assess from the beginning until the end what took place under the entire transaction. Based on all of the documentation in the record, it was his conclusion that the hospital purchased "Waiver Beds," and that those beds became licensed, operational and certified, for the first time at the Hospital's HBSNF.[18]

The Provider contends that Maryland's Licensing and Certification Administration ("LCA") licensed and certified the Provider's HBSNF as a new provider, and made no changes in the licensing and certification of the existing bed complements of the nursing facilities from which the "Waiver Beds" were received. This was confirmed by the Assistant Director of the Long Term Care Section of LCA in a letter dated March 19, 1998.[19] With regard to the establishment of a HBSNF utilizing "Waiver Beds," the Assistant Director stated the following:

> The LCA is aware that hospitals have obtained CCF beds in a number of different ways; however, LCA's licensing and certification actions do not vary according to the manner in which hospitals obtain beds for their HBSNFs. <u>All such units are considered new health care facilities</u>. Moreover, where the MHRPC [Commission] has, in the past, granted approval for an HBSNF to be estabilised through the transfer of what are known as "waiver beds" pursuant to COMAR 10.24.01.02, <u>LCA has not amended the license or Medicare or Medicaid certification of the transferring facilities. Rather, the transferring facilities' licensed and certified capacity remains unchanged and the new waiver beds are used to establish the new HBSNF</u>. (emphasis added.)

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[18] Tr. at 76-77.

[19] Provider Exhibit P-53.

The Provider points out that its expert witness also confirmed LCA's position through his testimony, and also addressed the documentaion provided by LCA concerning bed licenses in effect for the nursing facilities in 1993, prior to the time that the "Waiver Beds" requests were made to MHRPC.[20] Based on his review of the documentation, it was his conclusion that there were no changes made to the total number of licensed comprehensive care beds in the three nursing facilities. Accordingly, not only for CON purposes, but also for purposes of licensing and certiifcation, the record is clear that the Hospital established its HBSNF as a new facility, with beds that had never previously been licensed, certified or operational until such time as the HBSNF was established.

The Provider contends that HCFA treated the HBSNF as a new provider for purposes of the SNF prospective payment system ("PPS") under the same test of present or prior ownership. Beginning July 1, 1998, Medicare SNFs are reimbursed under PPS rather than on the basis of reasonable cost. The SNF PPS system provides for a three year transition period, during which time a portion of a SNF's payment will be based on its historic reasonable costs in a "base period." However, "new" SNFs are not entitled to this transition period and are immediatley paid 100 percent of the established PPS rate in accordance with the regulation at 42 C.F.R. §412.340(e) which states:

> SNFs that received their first payment from Medicare, under present or previous ownership, on or after October 1,1995, are excluded from the transition period, and payment is made according to the Federal rates only. (emphasis added.)

The Provider notes that the words of this test "under present or previous ownership" are the same words used in the new provider exemption regulation at issue in this case. However, HCFA has taken two totally contrary positions under this same language. For purposes of the new provider exemption under the routine cost limits, HCFA denied new provider status based on its determination that the Provider operated under prior ownership. For purpose of SNF PPS, however, HCFA treated the Provider as a "new SNF," so that it immediately was paid under the Federal rate. The Provider contends that no evidence or testimony was produced to explain this inconsistency, and that its treatment as a new SNF for PPS purposes was proper, and should have been consistently applied under the cost limit regulation. For HCFA to take such inconsistent positions on the basis of the same language is the hallmark of arbitrary and capricious action.

The Provider argues that HCFA's denial of its new provider exemption request is arbitrary and caprious because it is inconsistent with past agency decisions upon which the Provider detrimentally relied. Specifically, the Provider refers to a circuit court decision in Sunshine Health Systems Inc. v. Bowen, 809 F.2d 1390, 1393 (9th Cir. 1987).[21] In granting "new provider" exemption in that case,

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[20] Tr. at 44-48.

[21] Provider Exhibit P-22. HCFA granted the hospital "new provider" exemption from routine cost limits and treated it as "new hospital" for PPS purposes. The court

HCFA recognized that the hospital had to incur start-up costs because the hospital that was purchased had been closed under prior ownership for 14 months. Since the Hospital in the instant case purchased only "Waiver Beds" that had never been previously operational, licensed or certified, the Provider believes its case for "new provider"status is much more compelling. The Provider refers to a number of examples where HCFA granted new provider status to newly certified Medicare facilites, even though those facilities had previously been certified for Medicaid. One example cited is the requst of Ann Lee Home for a "new provider" exemption.[22] This facility had been in operation for over 50 years and was a Medicaid - certified provider since 1978. Following the OBRA 1987 amendments,[23] this nursing facility became eligible to provide Medicare services and became Medicare - certified as of January 1, 1991. The Intermediary recommended to HCFA that Ann Lee Home's request be denied on the following grounds:

> Ann Lee is one of the facilities that was given Medicare certification due to the provisions of the Nursing Home Reform Law enacted as part of OBRA 87. That law required that the the distinction between skilled nursing facilities and intermediate care facilities be eliminated and that all facilities must meet SNF level of care standards. In actual practice, the conversion to SNF status has had little impact on these providers. According to its application, Ann Lee Home has been in operation for over 50 years. Therefore, there is no quesions of its incurring any extraordinary start up cost. We have no reason to suspect that SNF certification entailed any appreciable change in the patient population that could result in varying utilization levels. It is a virtual certainty that substantially the same patients were receiving substantially the same services after the certification as before it. Therefore, we do not see how this facility, and others like it, would be disadvantaged in terms of its ability to provide routine services within the Medicare cost limits, compared to other, previously certified, skilled nursing facilities in its locality.

Despite the intermediary's explicit discussion of the impact of the OBRA 1987 amendments, the intermediary's assertion that the facility provided the same services both before and after its Medicare certification, and the fact that the facility likely had only minimal start-up costs as a Medicare-certified SNF, HCFA granted Ann Lee Home's request for a "new provider" exemption in October of 1992.

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reversed the PPS determination only, leaving the routine cost limt exemption intact.

[22] Provider Exhibit P-23.

[23] The OBRA 1987 amendments required Medicare-certified SNFs and Medicaid-certified nursing facilities to meet the same conditions of participation.

The Provider cites numerous other instances in which HCFA granted new provider exemptions to nursing facilities that were certified by Medicaid prior to 1990.[24]

The Providers asserts that there were no equivalent services prior to the opening of the HBSNF. Even if HCFA is correct that operational beds were transferred to the Hospital, those beds were not equivalent to Medicare-certified beds. The parties to the letter agreements in this case clearly understood and intended that no Medicare-certified beds would be transferred from the nursing facilities to the Hospital. If only Medicaid-certified beds were transferred, they were not equivalent to Medicare beds. The Provider contends that the major thrust of the OBRA 1987 provisions was to create uniform requirements for survey and certification, not to change the method of reimbursing Medicare-certified SNFs in such a way that new SNFs would be deprived of the ability to obtain a new provider exemption to the cost limits.

The Provider contends that HCFA's new interpretation of a "new provider" violates the notice and comment rulemaking requirements of the Administrative Procedure ACT("APA"). It was not until September of 1997 that HCFA officially revised the definition of "new provider " in HCFA Pub. 15-1 §2533.1, wherein the term "equivalent" was defined for the first time. Prior to this time, HCFA had never publicy and formally suggested that a facility certified under Medicaid was relevant to whether a facility would qualify for "new provider" status. This change occured some ten months after HCFA denied the Provider's "new provider" request. By defining the term "equivalent" in this manner and applying the change retroactively, HCFA changed existing law in a substantive way. It is the Provider's conclusion that such a substantive rule is invalid unless promulgated using the notice and comment rulemaking requirements of the APA.

In response to the Intermediary's extensive reliance on documents generated by the Hospital, the nursing facilities and MHRPC to demonstrate that the Hospital bought operating rights to existing licensed and operating beds from pre-existing institutions, the Provider reiterates the parties' misunderstanding of the manner in which MHRPC and LCA licensed and certified new HBSNFs. At the hearing, the Provider's expert witness testified that the Intermediary's position was wrong for the following two reasons:

> First is that operating rights are only conferred by the Department of Health in its licensing and certification actions, and it's very clear that if you look at the standards for licensure in the State of Maryland, they are site-specific. In order to be licensed, the building, the staffing, all requirements have to be met in a particular location, so you can't relocate an operating right. And the second is existing licensed and operating beds ---- I believe the record shows that since there was no change in the number of licensed beds at these three nursing homes, nor

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[24] See Provider Exhibit 50.

> their operating beds, that in fact there was no relocation of licensed beds from those three nursing homes to Maryland General Hospital.

Tr. at 52-53.

Rather than analyzing the carefully considered and clearly stated documentation provided by both the MHRPC and LCA, which represents the official positions on the part of those agencies regarding CON matters and licensing actions, the HCFA representative who testified on behalf of the Intermediary dismissed the validity of this documentation, and concluded that all of the representations of these authorities should be ignored and dismissed summarily. While the Intermediary's witness believed that HCFA's judgement should prevail, the Provider notes that this conclusion was based on her judgements which reflect no expertise, responsibility or background in licensure or CON matters. The Provider argues that HCFA does not have the option or prerogative to agree or disagree with official state agency pronouncements and actions, and to simply dismiss them because they result in a conclusion at odds with the conclusion HCFA wishes. Agency official actions are not matters of opinion, they are matters of fact and must be recognized as a matter of law.

The Provider rejects the Intermediary's position that a private contract between two parties is the single determinative factor that resolves the key outstanding issue, and supersedes official representations and actions by state agencies that are inconsistent with the private contracts. The Provider contends that it is not legally possible for private parties to engage in contracts that compel state government to handle matters in certain ways, negate state governmment actions, or have the effect of superseding state government actions. MHRPC and LCA handled the Hospital's establishment of the HBSNF according to their established rules, which is binding on the parties (and HCFA), notwithstanding that the various parties expected the matter to be handled differently. It was of no consequence to the parties that their contract legally could not be performed or enforced as written, and that matters were handled outside of the contracts and were not governed by them, as the end result was consistent with what the parties desired.

The Provider also rejects the Intermediary's determination that a change of ownership ("CHOW") occured under the provisions of HCFA Pub. 15-1 §§1500.7 and 2533.1.E.1.b when the beds were transferred from the three nursing facilities to the Hospital. HCFA Pub. 15-1 §1500.7 defines a CHOW as the "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). First, no portion of the three nursing facilities or their assets was disposed of under the letter agreements with the Hospital. Second, the "Waiver Beds" were not assets used to render patient care since they had never been operational, licensed or certified. The nursing facilities did not possess the "right to operate" the "Waiver Beds," but rather only the right to "establish" additional beds at some future time. Third, the Hospital's purchase of the "Waiver Beds" did not affect the licensure or certification of the nursing facilities from which they were acquired.

The provisions of HCFA Pub. 15-1 §2533.1.E.1.b similarly define a CHOW with the following

additional example: "For example, an institution or institutional complex purchases the right to operate (i.e., a certificate of need) long term care beds from an existing institution or institutional complex (be it opened or closed) that has or is rendering skilled nursing or rehabilitation services (in whole or in part) a long term care facility or enlarge an existing facility." The Provider first argues that HCFA Pub. 15-1 §2533 does not apply to the tranasction in this case since it was not published until September of 1997, a year after the "new provider" request was denied by HCFA. Second, the purchase of the right to operate beds is not relevant because the Hospital did not purchase such rights. The purchased beds were not previously licensed, and there can only be a "right to operate" beds once beds have been duly licensed. The Provider believes it is important not to be confused by the Intermediary's use of the terms "the purchase of operating rights" or "the purchase of a certificate of need." When used in the context of a CHOW, these terms must mean the purchase of the right to operate previously licensed or certified beds because the disposition must "affect licensure or certification" in order to be a CHOW. In the instant case, the purchase of "Waiver Beds" by the Hospital had no effect on the licensure or certification of the three nursing facilities.

Since the transfer of the "Waiver Beds" did not consititute a CHOW, any prior ownership of those bed rights is legally irrelevant for purposes of determining whether the Provider qualifies as a new provider. Accordingly, the background on the operation of the three nursing facilities, and the makeup of the population and geographic areas served, are equally irrelevant to the new provider exemption determination. The Provider concludes that the evidence in the record clearly supports its position that "Waiver Beds" were transferred from the nursing facilities to the Hospital, and that this transfer of intangible future rights to establish beds does not constitute a CHOW as defined in the Medicare manual. Under the controlling regulatory provisions of 42 C.F.R. §413.30 (e), the Provider is entitled to an exemption from the routine cost limits as a "new provider."

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider does not qualify for a new provider exemption from the routine cost limits pursuant to the requirements set forth under 42 C.F.R. §413.30(e). This regulation makes the new provider exemption available to 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 or previous ownership, for less than three full years." The Intermediary argues that the phrase "has operated as the type of provider" refers to whether or not, prior to certification, the institution engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured and disabled, or sick persons as identified in 42 C.F.R. §409.33(b) and (c), and did not primarily care and treat residents with mental diseases. This definition of a skilled nursing facility is statutory and can be found in 42 U.S.C. §1395i-3. 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. These provisions became effective for services rendered on or after October 1, 1990. The result is that both Medicare skilled nursing facilities (SNFs) and Medicaid nursing facilities (NFs) are required to provide, directly or under arrangements, the same basic range of services described in 42 U.S.C. §1395i-3 (b)(4). The 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 psychological well-being. The regulation at 42 C.F.R. §409.33 describes services which are considered skilled nursing or rehabilitation, including: intravenous, intramuscular, or subcutaneous injections; feeding tubes; tracheostomy aspiration; catheters; applications of dressing involving prescription medications; treatment of skin disorder; heat treatment; oxygen; respiratory therapy and other rehabilitative nursing procedures; and physical, occupational, and speech therapy.

The regulation at 42 C.F.R. §413.30(e) looks to whether the provider, under past or present ownership, provided skilled nursing services. While the Provider in the instant case was initially certified in March of 1996, the Intermediary contends that it was operated under prior ownership for some years, going back at least three years from the date of certification. The Intermediary relies on HCFA Pub. 15-1 §1500 et seq. for the definition of a CHOW. Section 1500.7 describes an event that is a common form of 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." The purchase of the right to operate existing licensed beds from the three nursing facilities constitutes a CHOW under this definition. The Intermediary contends that the Hospital entered into contracts with the three nursing facilities to buy existing, licensed and operating beds.[25] All three contracts were contingent on the sellers' right to acquire replacement "Waiver Beds." Further, in approving the Hospital's CON application,[26] MHRPC found that "MGH (Maryland General Hospital) will purchase comprehensive care beds from Villa St. Michael (10 beds), Granada Nursing Home (6 beds), and the Wesley Home, Inc., (8 beds)." The Commission further found that "these beds will be relocated from the nursing homes to the 4 West and 4 South wings of the hospital." The Intermediary insists that the parties must live with the transaction they entered into. The fact that the State, for administrative ease, chose to transfer the waiver beds directly to the Hospital, rather than de-licensing the beds at the three nursing facilities with the subsequent licensing of the replacement waiver beds at those same facilities, has no bearing on the transaction. The plain facts of this case clearly establish that the Hospital bought existing beds from three existing nursing facilities. All three of the facilities had been providing skilled nursing and rehabilitative services for a period of three years or more prior to the certification of the HBSNF at the Hospital. Even the Provider's expert witness testified that the Provider's case rides on the argument that the beds acquired by the Hospital were "Waiver Beds." If the beds were operating beds, as required under the contract between the Hospital and the nursing facilities and as approved by MHRPC, then the witness indicated it would be a different situation, and there would be a transfer of a tangible asset.[27] The Provider should not be allowed to recreate the transaction after the fact in order to bolster its claim for an exemption under 42 C.F.R. §413.30(e)

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[25] Intermediary Exhibit I-12.

[26] Provider Exhibit P-7.

[27] Tr. at 162-163.

In order to implement 42 C.F.R. §413.30(e) the Intermediary advises that you must look back three years from the date the Provider was certified to participate in the Medicare program in order to determine if the Provider was providing the same type of services for which it was certified under Medicare. Because there was a transfer of ownership in the form of a sale of some of the assets, the regulation requires that the three-year look-back include the facility under prior ownership. In this case, the Provider was certified as a skilled nursing facility in March of 1996. Looking back to 1993, the Provider, under prior ownership, was providing skilled and rehabilitative services.[28] The Intermediary further argues that the Provider is not entitled to an exemption based HCFA Pub. 15-1 §2604.1 because the relocation of beds from the three nursing facilities to the Hospital did not result in a substantial change in the population that is served at the new location, and the inpatient days at the new location were not substantially less than at the old location during a comparable period.[29] The Provider is located in the same health service area as the three nursing facilities from which the beds were acquired.

Contrary to the Provider's allegation, the Intermediary asserts that there has been no change in HCFA's longstanding policy on granting new provider exemptions since its inception on June 1, 1979. HCFA has not approved a new provider exemption merely because an institution chose to participate in the Medicare program. In fact, HCFA has denied exemption requests by institutions that have operated as a SNF or its equivalent in the three years prior to Medicare certification since the inception of the new provider exemption.[30] By contrast, other institutions have been granted new provider exemptions where they did not undergo a CHOW transaction and were found to be operating as a SNF or its equivalent for less than three full years prior to Medicare certification. As to the Provider's reference to HCFA's determination in Ann Lee Home, the Intermediary contends that HCFA did address the OBRA 1987 concerns raised by the facility's intermediary in its recommendation to HCFA that Ann Lee Home's request for new provider exemption be denied. The Intermediary based its recommendation for denial on the fact that Ann Lee Home had been in existence for three or more years prior to its Medicare certification, not based on the type of services provided. HCFA granted the new provider exemption since no evidence was presented that contradicted Ann Lee Home's documentation regarding the first date it accepted a resident requiring skilled nursing or rehabilitative services.[31] The Intermediary argues that HCFA's determination was consistent with 42 C.F.R. § 413.30(e) and HCFA Pub 15-1 § 2533.1, which govern new provider status for exemption from the routine cost limits. Contrary to the Provider's contention, HCFA does not use Medicaid certification as an absolute bar to receiving a new provider exemption. HCFA looks at the operation of the institution, not its certification or licensure, prior to its Medicare certification to determine if and when it first provided skilled nursing and rehabilitative services.

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[28] Tr. at 197.

[29] Tr. at 202.

[30] See Intermediary Exhibit I-30.

[31] See Intermediary Exhibits I-31, I-32, I-33 and I-34.

Finally, the Intermediary points out that the Board has confronted the same issue in two prior decisions as follows:

- Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) ¶46,224.

- Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/AdminiStar Federal, PRRB Dec. No. 98-D64, June 16,1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) ¶80,006.

The Intermediary contends that both cases presented similar factual situations, and the Board affirmed HCFA's application of 42 C.F.R. §413.30 (e) in denying the providers' requests for an exemption in both cases. Accordingly, the Board should find that HCFA properly adhered to Medicare law, regulations and program instructions in denying the Provider's new provider exemption request in the instant case.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§1395i-3	-	Requirements For, Assuring Quality of Care In, Skilled Nursing Facilities
§1395i-3(b)(4)	-	Provision of Services and Activities.

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

§§405.1835 - .1841	-	Board Jurisdiction
§409.33	-	Examples of Skillled Nursing and Rehabilitation Services
§409.33(b)	-	Services that Qualify as Skilled Nursing Services
§409.33(c)	-	Services which would Qualify as Skilled Rehabilitation Services.
§412.340(e)	-	SNFs Excluded From the Transition Period
§413.30(e)	-	Limitations on Reimbursable Cost - Exemptions

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

§ 1500 et seq.	-	Change of Ownership
§1500.7	-	Other Disposition of Assets
Chapter 25	-	Limitations on Coverage of Costs Under Medicare
§2533	-	Request for Exemption from SNF Cost Limits
§2533.1	-	Requests Regarding New Provider Exemption
§2533.1.E.1.b	-	Disposition of All or Some of an Institution or Institutional Complex or its Assets Used to Render Patient Care
§2604.1	-	Definitions - New Provider

4. Cases:

Sunshine Health Systems Inc. v. Bowen, 809 F.2d 1390 (9th Cir. 1987).

Milwaukee Subacute and Rehabilitiation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14, 1998, HCFA Admin. Decl. Rev., Medicare and Medicaid Guide (CCH) ¶46,224.

Mercy St. Teresa Center V. Blue Cross and Blue Shield Association/AdminiStar Federal, PRRB Dec. No. 98-D64, June 16, 1998, HCFA Admin, Decl. Rev., Medicare and Medicaid Guide (CCH) ¶ 80,006.

5. Other:

Adminstrative Procedure Act (§553 et seq.) - Rule Making .

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

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post hearing briefs, finds and concludes that the Provider is entitled to an exemption from the Medicare SNF routine cost limits as a new provider under the controlling regulatory provisions of 42 C.F.R. §413.30(e). This regulation defines a new provider as :

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

42 C.F.R. §413.30(e).

The majority of the Board finds that the evidence in the record clearly demonstrates that the beds obtained by the Hospital for the establishment of its HBSNF were not existing, licensed operational beds that were relocated from the three nursing facilities with whom the Hospital had entered into contractual letter agreements. The Board majority is aware that the initial documentation between the parties was indefinite as to the manner by which the right to operate CCF beds would be acquired. However, the record is replete with various contemporaneous documents which explicitly describe the actual and final action taken by the MHRPC and LCA for the establishment of the HBSNF.[32] As the official Maryland state agencies responsible for the authorization, certification and licensure of health care facilities, the MHRPC and LCA handled the establishment of the HBSNF in accordance with their established rules and regulations, and consistent with the existing State Health Plan. On July 11, 1995, the final CON was approved by the MHRPC with the understanding that 24 CCF beds would be obtained from the nursing facilities for the express purpose of establishing a transitional care center at the Hospital. Upon approval of the CON, LCA licensed and certified the Provider's HBSNF as a new provider.

As a result of HCFA's denial of the Provider's exemption request, and the Provider's appeal of that determination in the instant case, the Provider exchanged correspondence with the MHRPC and LCA to clarify the CON approval and the licensing and certification process which effected the establishment of the HBSNF. In its letter of November 20, 1997,[33] the MHRPC confirmed the Hospital's understanding of the CON approval stating the following:

> [i]n its approval of Maryland General's CON application, the Commission approved the transfer of waiver beds [created pursuant to COMAR 10.24.01.02A(2)] to create the new subacute care unit. These beds had not previously been licensed or in service, and so have not been previously included in the State Health Plan inventory. They represent new, additional comprehensive care facility bed capacity in the health care system.

The licensing and certification of the Provider's HBSNF as a new provider was further confirmed in a letter dated March 19, 1998,[34] from the LCA which stated in part:

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[32] See Provider Exhibits P-6, P-16, P-17 and P-53.

[33] Provider Exhibit P-17.

[34] Provider Exhibit P-53.

> [w]here the MHRPC has, in the past, granted approval for a HBSNF to be established through the transfer of what are known as "waiver beds" pursuant to COMAR 10.24.01.02, LCA has not amended the license or Medicare or Medicaid certification of the transferring facility. Rather, the transferring facility's licensed and certified capacity remains unchanged and the new waiver beds are used to establish the new HBSNF.

The majority of Board finds the affirmations of the MHRPC and LCA to be decisive and controlling in establishing what actually transpired, and that such official State pronouncements cannot be disregarded in deciding the central factual issue in this case. Accordingly, it is the Board majority's conclusion that the Hospital purchased the intangible rights to establish beds in the form of "Waiver Beds," and that these bed rights were transferred from the nursing facilities directly to the Hospital for the purpose of establishing the proposed HBSNF. Prior to the establishment of the HBSNF, these beds had never previously been licensed, certified or operational for the purpose of providing patient care services.

The majority of the Board further finds and concludes that this transfer of intangible bed rights between the parties does not constitute a CHOW as defined in HCFA Pub. 15-1 §1500.7. That manual provision states:

> 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.

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

Since the bed rights had never been used for patient care purposes, and there was no change to the licensure or certification of the three nursing facilities from which the bed rights were obtained, the transaction effected between the parties does not constitute a CHOW within the meaning of the manual provision.

The Board majority further notes that HCFA treated the Provider as a "new provider" under the SNF PPS system that was instituted July 1, 1998. Since the SNF PPS system uses the same "present and previous ownership" test as the new provider exemption under the routine cost limits, the majority believes the Provider should be treated the same by HCFA under both tests.

It is the Board majority's conclusion that the Provider's beds were not operational prior to the date it opened in March of 1996, under either present or previous ownership. Accordingly, the Provider is entitled to a new provider exemption to the routine cost limits in accordance with the controlling regulatory provisions of 42 C.F.R. §413.30(e).

DECISION AND ORDER:

HCFA's denial of the Provider's request for an exemption to the routine cost limits as a new provider under 42 C.F.R. §413.30(e) was not proper and is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire (Dissenting Opinion)
Martin W. Hoover, Jr., Esquire (Dissenting Opinion)
Charles R. Barker

Date of Decision: September 20, 1999

For The Board

Irvin W. Kues
Chairman

Dissenting Opinion of Henry C. Wessman and Martin W. Hoover, Jr.:

The Majority decision, while on track, does not account for the "quid pro quo", the essence of mutual consideration critical to the fundamental tenet of a valid and binding contract. The buyer, Maryland General Hospital Transitional Care Center (MGH) most certainly paid for something when it entered into a contract with Villa St. Michael, Granada Nursing Home, and Wesley Home (Provider Exhibit P-5; Intermediary Exhibit I-12) in July, 1994. MGH wished to establish a twenty-four (24) bed hospital-based skilled nursing facility in the same geographic region as the three sellers. MGH had three options for obtaining the necessary certification and operationalization of it's proposed facility: two required coming in the front door of the Certificate of Need (CON) process, either by a traditional CON application/approval before the Maryland State Health Plan Section on Long Term Care, or by a CON application to acquire the beds via the "pool" of additional beds (at 175 at that time) specifically available for hospital-based SNFs. The third option, which MGH chose, was back door, that of acquiring the 24 beds first (in this case, via contract with the three existing nursing homes to purchase their "waiver", or "creep" beds), and then obtaining the CON after the fact. In my opinion, the first two options would most certainly qualify MGH for the "new provider exemption" under 42 C.F.R. §413.30(e), having first met the up-front rigors of Maryland's CON screening process. The option chosen, however, circumvented that up-front test (and, I suspect, much of the up-front costs that ultimately make up a portion of the justification for the "new" provider exemption) via the purchase of some "quid" for the "quo" - in this case, beds which MGH could not have obtained had they not belonged to another party (the three contracting SNFs), and had not the contracting party been willing to sell those already-available beds(and thus, not "new" - for the three contracting SNFs owned those beds, and could have "operationalized" them themselves, thus changing their licensure or bed-certification number without securing additional approval [thus refuting, Majority's CHOW argument, supra, at 21-22; because the "waiver" or "creep" beds belonged only to the three sellers, they "gave up" something when they sold the beds to MGH - part of what they "gave up" was their ability to enhance, in a positive manner, their certified bed numbers], but with the caveat that it would not have cost U.S. taxpayers $1.5 million in additional Medicare "new" provider exemption costs). Because of this failure to account for the basic reality of contract law, I respectfully dissent.

Henry C. Wessman, Esquire

Martin W. Hoover, Jr., Esquire