PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D45

PROVIDER –
Peninsula Regional Medical Center
Salisbury, Maryland

Provider Nos. 21-5302

vs.

INTERMEDIARY – Blue Cross and Blue Shield Association/ Care First Blue Cross and Blue Shield

DATE OF HEARING-
October 10, 2001

Cost Reporting Period Ended
June 30, 1997

CASE NO. 97-2659

INDEX

ISSUE:

Did the Provider meet the regulatory requirements for approval of the new provider exemption?

FACTS:

Peninsula Regional Medical Center ("Provider") began the operation of its Transitional Care Unit on November 4, 1996. The unit consisted of 30 beds licensed by the State of Maryland as "Comprehensive Care Facility ("CCF") Beds," a state licensure category encompassing both the Medicare categories of "Skilled Nursing Facility" beds as well as "Nursing Facility" beds.

Prior to November 4, 1996, the Provider had never owned or operated, in any form, CCF beds or any other beds that were encompassed by the Medicare categories of "Skilled Nursing Facility" or "Nursing Facility" beds.

The Provider was required by State law to obtain, and did obtain, authority from the health planning agency to establish its sub-acute unit of 30 CCF beds. The authority was conveyed through a document entitled "Amended Certificate of Need."

A neighboring CCF, Wicomico Nursing Home ("WNH"), operator of 82 CCF beds, had obtained in 1992 a Certificate of Need ("CON") for a project that would have, through the building of an addition to that facility, established 52 additional CCF beds at WNH. WNH determined that it was not in a financial position to bring its approved project to fruition. WNH and the Provider agreed that, simultaneously, the following events were to occur:

1. WNH was to seek from Maryland's health planning agency a modification of its CON to establish a smaller expansion project; and
2. The Provider was to seek from Maryland's health planning agency a CON to establish its 30-bed subacute unit.

The Provider paid financial consideration to WNH for the above listed agreement, as the Maryland Health Resources Planning Commission ("MHRPC")was not, at the time, entertaining requests to add to the system's CCF bed capacity inventory but would entertain requests that resulted in the establishment of new projects that did not add to the inventory. The planning agency's inventory consisted of: beds that were licensed, beds that were approved "Waiver" beds that could be added without CON, and beds that were approved through the CON process but had not been implemented through licensure. The Provider's 30 CCF beds originated from the planning agency's pool of existing bed rights that had been CON-approved but were not implemented. The notification to WNH's CON freed-up those bed rights to allow the planning agency to award a CON for the Provider's project.

WNH provided both skilled nursing and related services and rehabilitative services to its patients.

WNH provided these services for more than three years prior to the purchase and relocation of a portion of the nursing home by and to the Provider. Based upon self-reported data found in the records of WNH, it did not solely provide custodial care to its residents, but in fact did provide both skilled nursing and related services.

WNH never, in fact, implemented any portion of its 1992 CON and remains, to date, licensed at 82 beds. The 30 CCF beds that established the Provider's subacute unit were never licensed or certified for Medicare or Medicaid participation, at WNH or any other facility, prior to their licensure at the Provider on November 4, 1996.

The Intermediary determined that the Provider was not entitled to a new provider exemption since the thirty beds did not meet the new provider requirements for an exemption. The Provider was dissatisfied with its Intermediary's determination and requested a hearing at the Provider Reimbursement Review Board ("Board"). The Provider has met the jurisdictional conditions of the regulations at 42 C.F.R. §§ 405.1835-.1845. The amount of Medicare reimbursement in contention is approximately $687,047.

The Provider was represented by Henry E. Schwartz Esquire, of Blank Rome Comisky & McCauley LLP. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider points out that the question at issue in this case is whether, under 42 C.F.R. § 413.30 et seq. the Provider had, prior to establishing its subacute unit, operated as the type of provider (or the equivalent) for which it became certified (i.e., a provider of nursing facility-type services), under present or previous ownership. It is agreed that the answer to that question can only be "yes" if one imputes the operation of WNH to the Provider. If the answer is no, the Provider is entitled to the requested exemption.

The Provider contends that the language of the controlling regulation cannot be read to directly support CMS' interpretation, and CMS does not argue that it does so. The Intermediary's witness testified that CMS' decision was based upon formal federal policy guidance contained in sections 1500 and 2604.1 of CMS Pub. 15-1.[1] Scrutiny of those sections indicates that the decision not to allow the exemption was incorrect.

The Provider points out that the Intermediary's witness presumably relied on CMS Pub. 15-1 § 1500 entitled "Change of Ownership," because she testified that: "there was in fact a change of ownership of 30 beds from their business that had been transferred over to the Provider."[2] It therefore appears that a change of ownership is key to imputing the operation

[1] Tr. at 150-153.
[2] Tr. at 123.

of WNH to the Provider in the eyes of CMS.

The Provider points out that CMS Pub. 15-1 §1500.7 indicates that the relevant portion of the guideline, the portion that relates to the type of transaction occurring in the instant case, states: "Other Disposition of Assets," which defines a "change of ownership" as occurring when there is a "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 Provider contends that if the transactions that brought the 30 CCF beds to the Provider constituted a disposition of the assets of WNH, such activity would be a "change of ownership" if the criteria of CMS Pub. 15-1 § 1500.7 were met. They are, however, not met in this case for the following independent reasons:

1. Section 1500.7 limits "changes of ownership" to assets "used to render patient care." CMS made no such determination. The Intermediary's witness testified that it made no difference whether the "beds" in question were licensed and operational, or whether they were simply representative of a CON-authorized project that had not been implemented.[3] The witness testified later that they weren't.[4] Then again they were.[5] No analysis of any of these conclusions was made available.

2. The assets in question herein were not "used to render patient care." WNH had 82 licensed and operational CCF beds before it obtained its 1992 CON, all the time it held the 1992 CON, after the 1996 modification to its CON was granted, and up to the present. It would be patently irrational to claim that the 30 CCF beds represented by the Provider's CON had ever been "used to render patient care." There have been, and could be, no facts adduced to support such a conclusion.

3. Section 1500.7 further limits "changes of ownership" to "dispositions" of assets where the disposition "affects licensure or certification of the provider entity." The language of this subsection clearly indicates that the licensure and certification of the "disposing" provider is being addressed. The question then is - did CMS conclude that there was a "change of ownership," because a disposition of assets (the CON-approved bed rights) affected WNH's licensure or certification? There are no facts upon which to base such a determination. WNH's licensed, certified and operational bed complement has undergone no change. There has been no disposition of assets impacting WNH's "licensure and

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[3] Tr. at 147-148.

[4] Tr. at 161.

[5] Tr. at 164.

certification" in any manner.

The Provider argues that the only explicatory authority cited by CMS' witness does not support the CMS conclusion in the case. The authority specifically contradicts the CMS decision, and demonstrates that the exemption denial was made without consideration of the applicable authority. Such a decision is not only wrong, it is arbitrary and capricious.

The Provider argues that the Intermediary's witness was not correct when she indicated that WNH's CON was part of its business, and, therefore, the disposition of that part of the business constituted a change of ownership.[6] This is contrary to the literal terms of CMS Pub. 15-1 § 1500.7, which defines change of ownership. The Provider also argues that the Intermediary's witness was not correct in its position that CMS does not specify or count the number of beds that are certified by Medicare for participation.[7] The Provider contends that the CMS State Operations Manual at section 2762 states that "[t]he Medicare/Medicaid program does not actually certify beds. This term means counted beds in the certified provider or supplier facility or in the certified component." The section goes on to state that Medicare will certify a "distinct part" of a provider for participation. Section 3202 of the same manual indicates that the distinct part consists of all the beds within the designated area, and that a provider with a distinct part must identify the location of the rooms and beds certified for participation in the Medicare program.

The Provider argues that the Intermediary is incorrect when it raised the issue that all beds are attributable to the transferring facility for the purpose of determining a change of ownership, whether those beds are licensed or merely a part of a CON approved project that has not been implemented. This is clearly contrary to CMS Pub. 15-1 § 1500.7, which clearly states that the disposition of assets is a change of ownership only if (a) those assets were used to provide patient care, and (b) the disposal of the assets alters the facility's licensure or certification.

INTERMEDIARY' S CONTENTIONS:

The Intermediary points out that the MHRPC issued a Modified CON and an Amended Corrected Modified CON to WNH on July 31, 1996. The purpose of the Amended Corrected Modified CON was to approve a reduction of the total of 52 comprehensive care beds and to allow for the issuance of a 30 bed CON for the remaining beds to the Provider. The MHRPC simultaneously issued a CON and an Amended CON on July 31, 1996 to the Provider to develop 30 comprehensive care beds from the 52 comprehensive care beds previously awarded by the MHRPC to WNH on November 10, 1992.

The Intermediary further points out that after the transfer and sale of the CON for the 30 beds,

[6] Tr. at 149.

[7] Tr. at 127.

the Provider entered into an agreement under section 1866 of the Social Security Act with the Secretary of Health and Human Services to participate in the Medicare program as a skilled nursing facility ("SNF"). This was effective October 26, 1995.

The Intermediary argues that the 30 comprehensive care beds obtained from WNH would have had to have been out of service through November 4, 1999 to meet the requirements of the break in service policy, the Provider re-opened on November 4, 1996. Thus, CMS was required and did seek to determine if WNH had operated as a SNF or its equivalent for three years or more prior to the date that the MHRPC approved the change of ownership and relocation of the right to operate 30 comprehensive care beds from WNH to the Provider. The Intermediary argues that

WNH did provide skilled nursing and related services and rehabilitative services for more than three years since it began operating in 1966.

The Intermediary contends that the Provider did not meet the change of location criteria provision of CMS Pub. 15-1 § 2533.1.B.3. This section's intent is to allow for a new provider exemption wherein an institution undergoes a change in location, even if it has operated in the manner of the "type of provider" for which it had been certified or its equivalent, if the institution can demonstrate that first, "the normal inpatient population can no longer be expected to be served at the new location," and second, that "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. The periods being compared must be at least 3 months in duration." Both criteria must be met by an institution that has undergone a change in location to be granted a new provider status.

The Intermediary contends that based on its analysis of the relocation documents provided by the Provider, CMS determined that the change in location did not change the service area. Seventy percent of the population served in the new location came from the lower Eastern Shore service area and 55 percent came from the same cities and towns as served in the former location. Therefore, the Provider is not entitled to the exemption.

The Intermediary points out that CMS' denial is consistent with other determinations made and that have been upheld by the Board as well as several district and circuit courts. Indian River Memorial Hospital (Florida) v. Blue Cross and Blue Shield Association/ Blue Cross of Florida, PRRB Dec. No. 87-D104, September 24, 1987, Medicare and Medicaid Guide (CCH) ¶ 36,670 decl'd rev., CMS Administrator, November 23, 1987 and 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, Case No. 98-C-553, (E.D. Wisc. August 16, 2000), aff'd, No. 00-3707, (7th Cir. June 5, 2001).

The Intermediary points out that those institutions or institutional complexes that have not

operated in the manner of a SNF are eligible for an exemption. How long the exemption may last is determined based on the date the institution accepted its first patient requiring a skilled

nursing and related service or a rehabilitative service.

The Intermediary points out that the Provider requested and received relief from the effects of the SNF routine service cost limits through the exception provision due to the provision of atypical services in the amount of $108.01 per day, or a total of $379,115, for the cost reporting period ended June 30, 1997. The Provider demonstrated that it provided atypical services since it had a lower than average length of stay compared to its peers, a higher than average ancillary cost per day and higher than average Medicare utilization. All factors it attempts to portray are relevant to an exception request. None of these factors are relevant to a determination of a new provider exemption.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

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

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

§ 1500	-	Change of Ownership
§ 2604.1	-	Definitions – New Provider
§ 1500.7	-	Other Disposition of Assets
§ 2533.1.B.3	-	Definitions – New Providers

3. STATE OPERATIONS MANUAL - CMS PUB-7:

§ 2762	-	Medicare/Medicaid Certification and Transmittal, Form HCFA -1539
§ 3202	-	Charge in Size or Location of Participating SNF or NF

4. Cases:

Indian River Memorial Hospital (Florida) v. Blue Cross and Blue Shield Assoc./Blue Cross of Florida, PRRB Dec. No. 87-D104, September 24, 1987, Medicare and Medicaid Guide (CCH) ¶ 36,670 decl'd rev., CMS Administrator, November 23, 1987.

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, Case No. 98-C-553 (E.D. Wisc. August 16, 2000), aff'd, No. 00-3707 (7th Cir. June 5, 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. 1:00CV1895 (N.D. Ohio, Feb. 8, 2002); (2002 U.S. Dist Lexis 5499).

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) ¶ 80,406; aff'd sub nom, Maryland General Hospital v. Thompson, 155 F. Supp. 2d 459 (D. Md. 2001)

Stouder Memorial Hospital Subacute Unit v. AdminaStar Federal and Anthem Insurance Companies, PRRB Dec. No. 2000-D46, April 18, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,437, rev'd, CMS Administrator, June 15, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,517.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the fact, parties' contentions, and evidence presented finds and concludes as follows:

Peninsula Regional Medical Center purchased a CON from WNH to open a 30 bed Comprehensive Care Center. The CON was acquired from WNH, due to a moratorium restricting the number of new health care beds in the State of Maryland. The Provider's 30 CCF beds originated from the planning agency's pool of existing bed rights that had been CON-approved but not implemented. Subsequently, the Provider requested it be granted an exemption from Medicare's routine service cost limits on the basis of Medicare's "new provider" rules at 42 C.F.R. § 413.30 et seq. In part, these rules state:

> (e) Exemptions. Exemptions from the limits imposed under this section may be granted in the following circumstances:
>
> (2) New Provider. The Provider of inpatient services has

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

42 C.F.R. § 413.30 et seq. (emphasis added).

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

The Board majority also finds, however, that the 30 bed rights acquired by the Provider were not operational and had never been used to render patient care. At the same time, WNH notified the State that it no longer intended to use the bed rights, which were ultimately reported to the State of Maryland.

Upon further analysis, the Board majority finds that it has been confronted several times with the issue of whether or not the acquisition of bed rights (operating rights, certificate of need, determination of need, etc.), in and of itself, constitutes a change of ownership for the purpose of determining whether or not the "present and previous ownership" provision of 42 C.F.R. § 413.30 et seq. is applicable; that is, whether or not a "change of ownership" occurs triggering a review of a relinquishing facility's historical operations that could result in denial of a "new provider" exemption.[8]

With respect to this matter, the Board majority finds that it has followed CMS' interpretation, in most instances, finding that such action does result in a change of ownership. Importantly, however, the Board majority also finds that its deliberations regarding this matter have always contained a measurable degree of disagreement and have resulted in dissenting opinions being rendered in some instances. See e.g., South Shore 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

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

Guide (CCH) 2002-1 ¶ 300,934, Sleep Dissenting; 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) ¶ 80,406; aff'd sub nom, Maryland General Hospital v. Thompson, 155 F. Supp. 2d 459 (D. Md. 2001), Wessman dissenting, Hoover dissenting; and, Stouder Memorial Hospital Subacute Unit v. AdminaStar Federal and Anthem Insurance Companies, PRRB Dec. No. 2000-D46, April 18, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,437, rev'd, CMS Administrator, June 15, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,517, Wessman 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 case. In part, the court states that:

> 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
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> 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 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. 1:00CV1895 (N.D. Ohio, Feb. 8, 2002); (2002 U.S. Dist Lexis 5499), 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 court's analysis of this matter focused on the intent of the "new provider" exemption (to allow providers the opportunity to recoup higher costs associated with low occupancy and start-up), and the basis of the Secretary's position to: "exclude [from such relief] as a class all providers that purchase CON rights from another, unrelated provider that has existed for more than three years. . ." Ashtabula at 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 service limits. Similar to the courts' findings in both South Shore and Ashtabula, the Board majority finds that the Provider's acquisition of bed rights in the instant case does not represent a change of ownership, and that the services that may or may not have been performed by WNH are irrelevant. The Provider meets the program's definition of a "new provider" at 42 C.F.R. § 413.30(e)(2); it is licensed, certified, and accredited as a CCF, and it had operated as this type of provider for less than three full years as required. CMS Pub. 15-1 § 2533.1.

DECISION AND ORDER:

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

reversed.

Board Members Participating:

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

Date of Decision: September 27, 2002

For the Board

Irvin W. Kues
Chairman

Concurring Opinion of Board Member Suzanne Cochran

I concur with the majority's conclusion that Peninsula's acquisition of CON rights from Wicomico 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 Peninsula's acquisition of the CON from WNH was the only transaction between those parties. CMS denied Peninsula's application on the basis that the CON transaction resulted in a provider change of ownership (CHOW). Thus, WNH was treated as a prior owner of the provider applicant, Peninsula, and WNH's history of providing services was used to disqualify Peninsula as being "new." The inescapable logic of CMS' rationale that a transfer of a CON alone is a change of ownership of a provider is that a CON is what substantially constitutes or defines a provider. As the majority aptly points out, both the South Shore[9] and Ashtabula[10] Courts held that denying new provider status based solely on the transfer of CON 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 that involved a transfer of CON 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 CON 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

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

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

between the CON purchaser and seller, including a transfer of patients. Maryland General is similar to Peninsula in that both asserted that rights covered by the CON were for beds that were never put into use and were considered "waiver" beds. However, Maryland General did not challenge the basis of the Agency's denial that the CON 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 CON 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.[11] These authorities provide a highly relevant context for analyzing whether a CON 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:

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[11] 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."[12] (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)
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> 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)
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> 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

[12] Peninsula argues that because the beds represented by the CON were never put into use by WNH, they cannot be found to have been used to render patient care. In addition, because the project for which WNH obtained the CON was never completed, WNH's license and certification were never tied to the CON. Although these may be independent reasons to find the Agency's interpretation incorrect, analysis of these factors is not necessary to the conclusion that the Agency's denial of new provider status was improper.

consequences of the enterprise's operations. (Emphasis added)

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,[13] 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.[14] There is nothing in these provisions that would support the Agency's position that a provider who acquires a single asset, CON rights, from another unrelated provider is the transferor's legal successor. Conversely, there is nothing to support the position that the transferring facility previously had legal responsibility for operation of the provider applicant's business enterprise.

CMS' departure from its prior interpretations is also evidenced by its failing to follow Manual procedures for processing a CHOW if, indeed, one occurred. The State Operations Manual, Pub 7 §3210, requires that when a provider undergoes a CHOW, the Medicare provider agreement is automatically assigned to the new owner unless the new owner rejects assignment. If rejected, the new owner must go through the same process as any new provider to become certified assuming it wants to participate in Medicare. Assignment of the Medicare provider agreement means the new owner is subject to all the terms and conditions under which the existing agreement was issued, including overpayment liabilities, responsibility for meeting all requirements and meeting any time

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[13] See p. 16; fn 8 of the majority opinion. 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.

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

frames imposed on the old provider such as time limits for correcting deficiencies. There is no evidence whatsoever that the Agency considered Peninsula to have been assigned WNH's Medicare provider agreement or that Peninsula was required to reject the assignment. It is undisputed that Peninsula operated under its own provider agreement.

Hospital New Provider Cases

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

Community Hospital of Chandler v. Sullivan, 9th Cir 92 1992 U.S. App. LEXIS 15504, involved new provider status for a hospital under 42 C.F.R. 412.74.[15] Chandler Community Hospital (CCH) was a small, outdated facility with limited services. CCH administration planned and constructed Chandler Regional, a large, state of the art facility. The business operations of CCH were transferred to Regional. The significance of this case is that when Chandler Regional was denied new provider status, it challenged the Secretary's interpretation of "provider" for purposes of the new provider exemption as a legal or business organization. The court found reasonable the Secretary's interpretation that the provider was the same legal entity and therefore did not qualify as a "new hospital" despite the major changes in the facility's physical assets and services.

Three years later, the 9th Circuit heard a similar challenge in Memorial Rehabilitation Hospital of Santa Barbara v. Secretary of HHS, 65 F2d 134 (9th Cir. 1995) . A county government that operated an acute care hospital transferred its entire 45 bed rehab operations to a foundation. The foundation was required to add or upgrade costly physical plant 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."

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 August 15, 2002

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

Dissent - Henry C. Wessman

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

Precedent Ignored

The PRRB Majority finds the rather shallow logic of two (2) recent lower court decisions (South Shore, Ashtabula) to be "instructive" in reversing the Intermediary's adjustment and granting a costly "new" provider exemption to the Provider in the instant case. This in apparent disregard for the significant progeny of at least six (6) PRRB Decisions (Indian River Memorial Hospital (Florida), PRRB Dec. No. 87-104, September 24, 1987; Milwaukee Subacute and Rehabilitation Center, PRRB Dec. No. 98-D40, April 14, 1998; Larkin Chase Nursing and Restorative Center, PRRB Dec. No. 99-D8, November 24, 1998; South Shore Hospital Transitional Care Center, PRRB Dec. No. 99-D38, April 21, 1999; Ashtabula County Medical Center Skilled Nursing Facility, PRRB Dec. No. 2000-D70, June 29, 2000; Providence Yakima Medical Center, PRRB Dec. No. 2001-D32, May 16, 2001), eight (8) CMS Administrator Decisions (affirming the above six (6), plus reversing the PRRB Majority in Maryland General Hospital Transitional Care Center, HCFA Adm. Decision November 22, 1999, Medicare and Medicaid Guide (CCH) ¶80,406, and Stouder Memorial Hospital Subacute Unit, CMS Adm. Decision June 15, 2000, Medicare and Medicaid Guide (CCH) ¶80,517), five (5) lower court decisions (Staff Builders Home Health Care, Inc., April 13, 1988, Medicare and Medicaid Guide (CCH) ¶ 37,133; Mercy St. Teresa Center, U.S. Dist. Ct., S. Dist. Ohio, W. Division, Case No. C-1-98-547, June 16, 1999; Paragon Health Network, Inc., [Milwaukee Subacute and Rehabilitation Center], Case No. 98-C-553, U.S. Dist. Ct. E. Dist. Wisconsin, August 16, 2000; Larkin Chase Nursing and Restorative Center, Civil Action 99-00214(HHK), U.S. Dist. Ct. D.C., February 16, 2001; Maryland General Hospital, Inc. d/b/a Transitional Care Center, Civil Action WNM-00-221, U.S. Dist. Ct. Maryland, June 27, 2001) and one (1) U.S. Court of Appeals decision (Paragon Health Network, Inc., d/b/a Milwaukee Subacute and Rehabilitation Center, No. 00-3707, U.S. Ct. of Appeals, 7th Circuit, June 5, 2001) that all support the Secretary of Health and Human Services in his interpretation of 42 C.F.R. § 413.30(e) and promulgations relevant to Medicare's "new provider" exemption rules.

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

I am not prepared to side with the lower court of either South Shore or Ashtabula, or my liberal colleagues in the Majority opinion who contend that the Bush Administration's DHHS Secretary Tommy Thompson's actions were ". . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law" (South Shore n 23); or that Secretary Thompson's justification in this issue amounts to ". . . little more than a generous amount of conjecture and guesswork." (Ashtabula at 16) Deference toward Agency interpretation of it's own regulations is a critical axiom of Administrative Law. In my opinion, DHHS Secretary Thompson has met both the

standard of Chevron (Chevron U.S.A v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984)) and the standard of Skidmore (Skidmore v. Swift & Co., 323 U.S. 134 (1944)), and deserves more respect then proffered by two (2) lower courts and the PRRB Majority in the instant case.

Provider Paid $150,000 for Nothing According to PRRB Majority

". . . the Board majority finds that the Provider's acquisition of bed rights in the instant case does not represent a change of ownership . . .". supra at 20. I find the above reference along with South Shore and Ashtabula to be an attempt on the part of the lower court and PRRB Majority to parse the meaning of "change of ownership" (CHOW) in such a manner as to exclude what they refer to as "intangibles." In the South Shore and Ashtabula courts, as in the Majority interpretation in the instant case, the sale or transfer of "bed rights", "licensed beds" or "bed operating rights" are apparently not considered germane to the operation of a SNF, and thus not worthy of CHOW designation. In the instant case, the Provider paid $150,000 (Intermediary Exhibit I-33) and received nothing, if the logic of the PRRB Majority is to prevail.
In the real world, I know of nothing of greater SNF germinal import than the "bed license." If you do not agree, try building the most tangible facility, with the most tangible beds and equipment, with the most tangible personnel – but ignore acquisition of the parsed, intangible "bed operating right." Bill Medicare, Medicaid, or any other third party payor for services rendered, and observe the result. All of a sudden, those "intangible" bed operating rights are sine qua non. So, where the PRRB majority in the instant case, and the South Shore and Ashtabula lower courts suggest that the sale, transfer or redemption of "bed rights" does not rise to the level of a CHOW, one can not identify, in the real world, a more essential or highly-prized element of change in ownership, absolutely critical to the successful operation of a SNF. The provider must assume all legal responsibility for the purchase of the "bed right", and no matter what spin you attempt to put on the term "provider" (Cochran Concurrence at_and_), 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 $150,000 for "intangibles" without getting ownership of something is neither a prudent purchase nor a reasonable cost (42 U.S.C. §1395x(v)(1)(A)) whether under Medicare or otherwise.

All Elements of a "CHOW" Present

In the instant case, it is undisputed that there was a Bill of Sale (Intermediary Exhibit I-36) between the purchaser-Provider, Peninsula Regional Medical Center, and the seller, Wicomico Nursing Home, whereby the appealing Provider, Peninsula, acquired the ". . right, title, and interest in and to its [Wicomico County dba Wicomico Nursing Home] license and authority for thirty (30) Nursing Home Beds, established pursuant to a Modified Certificate of Need issued by the Maryland Health Resources Planning Commission dated July 31, 1996." Id. Peninsula paid the sum of $150,000 to Wicomico (Intermediary Exhibit I-33) for the ". . right, title, . . .license and authority for thirty (30) Nursing Home Beds . ." (Intermediary Exhibit I-36), thus unequivocally affecting the licensure and certification of both Peninsula and Wicomico (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 Peninsula) and the seller (Wicomico). 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, Peninsula. 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 Peninsula Regional Medical Center.

Bed Purchase Benefit/Convenience for Provider – not Medicare

If Peninsula Regional Medical Center had attempted to acquire the requisite "licensed beds" or "bed operating rights" through Maryland'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 Maryland 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 P-rovider, (Intermediary Position Paper at 9) not because of a "new bed" need of the public (Intermediary Position Paper at 8). 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 14; Intermediary Exhibits I-4, I-43, I-44) and now sought to be offered by the "new" provider to Medicare recipients, with the additional "exemption" price tag attached, as "new" services; in the instant case at an additional cost of $687,047 to U.S. taxpayers via the Medicare Trust Fund. In my humble opinion, the PRRB Majority's decision is tantamount to paying a $687,047 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 Peninsula Neuters Medicare "Reasonable Cost" Mandate

The question than becomes did the instant Provider, Peninsula Regional Medical Center, claiming "newness" as a provider, come to CMS with truly "new beds", worthy of significant "start-up costs" – or were these acquired beds "used" to the extent that their "start-up cost" had previously been capitalized, amortized, depreciated – already paid for in part by Medicare and other payors in a prior life, and thus not deserving of Medicare Trust Fund payment for a cost that was long ago amortized/depreciated by a prior owner and thus not now a reasonable cost under 42 U.S.C. § 1395x(v)(1)(A), and unworthy of yet a second federal tax dollar subsidy. It is clear to me that the "bed rights" existed in a prior life (Intermediary Exhibit I-20), had inherent value to the seller (but not to the extent of a Medicare windfall as a "new provider"), and that Peninsula was willing to pay for the licensed/certified beds, thus effecting the licensure of both buyer and seller. In my opinion, this takes this Provider and this transaction outside of 42 C.F.R. § 413.30(e) eligibility for a "new provider" exemption.

Appropriate Remedy: Exception – Already Granted

The wording of 42 C.F.R. § 413.30(c) is clear: "A provider may request a reclassification, exception or exemption from the cost limits imposed under this section".
(emphasis added) In my humble common sense view, this means one of the three (3) remedies per provider, but not two (2) or three (3).
A reclassification is a request to change service-orientation, that is not at issue here. The exemption is a broader remedy, less refined, less specific. The exception is surgical – it responds directly to the source of the cost over run, be it due to atypical services/patients, extraordinary circumstances, fluctuating population, education costs, or unusual labor costs. (42 C.F.R. § 413,30(f) et seq) Appropriately, the exception must be verified each year, and employed to dissect out, and pay by Medicare, the specific justifiable cost spike. In the instant case, Peninsula Regional Medical Center appropriately sought, and appropriately received, an exception resulting in a payment of $379,115 for documented "atypical services" in FYE June 30, 1997 (Intermediary Exhibit I-97). 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.

Peninsula Regional Medical Center appropriately sought, and received an exception for FYE 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. Peninsula Regional Medical Center 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