PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D8

PROVIDER –
Lima Memorial Hospital
Lima, OH

Provider No.: 36-0009

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
CGS Administrators, LLC

DATE OF HEARING -
May 3, 2012

Cost Reporting Periods Ended -
December 31, 2000 and December 31, 2001

CASE NOs.: 04-0376 and 05-1805

INDEX

ISSUE:

Whether the Intermediary improperly calculated reimbursement for the Provider's skilled nursing facility unit during the skilled nursing facility PPS (prospective payment system) transition period.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C., Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payment amounts due providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[3] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[4]

A provider may appeal an intermediary's final determination of total reimbursement (*i.e.*, the NPR) with the Provider Reimbursement Review Board ("Board") provided it meets the following conditions: (1) the provider must be dissatisfied with that final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[5]

Implementation of a per diem prospective payment system (PPS) for skilled nursing facilities ("SNFs") was mandated by § 4432 of the Balanced Budget Act of 1997 ("BBA").[6] Effective for cost reporting periods beginning on or after July 1, 1998, this per diem represents payment for all costs (routine, ancillary, and capital) of covered SNF services for Medicare Part A beneficiaries. Federal per diem rates were established using allowable costs from fiscal year 1995 cost reports.

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.
[6] Pub. L. No. 105-33, 111 Stat. 251 (1997).

The rates are adjusted annually using an SNF market basket index.[7] CMS also established a facility-specific rate based on the historical costs of each SNF.

In order to phase in the SNF PPS, CMS established a transition period over three "cost reporting periods" that blended the facility-specific payment rate with the federal case-mix adjusted rate under SNF PPS. As stated in the implementing regulation at 42 C.F.R. § 413.340(a):

> (a) *Duration of transition period and proportions for the blended transition rate.* Beginning with an SNF's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During this transition phase, SNFs receive a payment rate comprising a blend of the adjusted Federal rate and a facility-specific rate. For the first cost reporting period beginning on or after July 1, 1998, payment is based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. For the subsequent cost reporting period, the rate is comprised of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the final cost reporting period of the transition, the rate is comprised of 25 percent of the facility-specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, payment is based entirely on the Federal rate.[8]

The three "cost reporting periods" as they occur in the transition phase will hereinafter be referred to as the "1st Transition Cost Reporting Period," the "2nd Transition Cost Reporting Period," and the "3rd Transition Cost Reporting Period."

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Lima Memorial Hospital ("LMH") is a not-for-profit, 314 bed hospital facility located in Lima, Ohio. Since February of 1993, LMH has operated a 17 bed Medicare-certified SNF. On December 16, 2000, the CMS Regional Office issued a Provider Tie-In Notice informing LMH that, for purposes of participation in the Medicare program, effective July 1, 2000, a change of ownership of LMH's hospital, SNF and home health agency ("HHA") from LMH to the Lima Memorial Joint Operating Company ("JOC") had occurred.[9] The entity that is legally bound by the participation agreement between the LMH SNF operations and the Medicare program both prior to and following the change of ownership will be referred to as the "Provider." On January 9, 2001, AdminaStar Federal ("Intermediary") sent the LMH notice that a cost report covering the 6-month period January 1, 2000 through June 30, 2000 and a separate cost report covering the 6-month period July 1, 2000 through December 31, 2000 had to be filed for the LMH hospital, SNF and HHA operations.[10]

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[7] *See* 64 Fed. Reg. 41684 (July 30, 1999) (copy included as Intermediary Exhibit I-2 (Case No. 04-0376)). Any citations to Intermediary or Provider exhibits will be from Case No. 04-0376 unless specified otherwise.
[8] (Italics in original) (copy included as Intermediary Exhibit I-9).
[9] Provider Exhibit P-7 at 2-11.
[10] *Id.* at 1.

This appeal concerns the Provider's Medicare program SNF reimbursement for the short cost reporting period ending December 31, 2000 and the full 12-month cost reporting period ending December 31, 2001. The Intermediary issued the NPRs for the Provider's 6-month cost reporting period ending December 31, 2000 and 12-month cost reporting period ending December 31, 2001 on July 14, 2003 and January 12, 2005 respectively. By letters dated December 23, 2003 and January 28, 2005, the Provider timely appealed these Intermediary determinations to the Board pursuant to 42 C.F.R. §§ 405.1835-405.1841. The Provider did not agree with the adjustment that changed the Transition Cost reporting periods from the 2nd Transition Cost Reporting Period to the 3rd Transition Cost Reporting Period for the cost reporting period ending December 31, 2000; and the adjustment that changed the cost reporting period ending December 31, 2001 from the 3rd Transition Cost Reporting Period to 100 percent SNF PPS.[11]

The parties in this case have reached the following pertinent stipulations for use in this hearing:

3. The issue presented in this appeal is whether the Intermediary improperly calculated reimbursement for the Provider's SNF unit during the transition from a cost reimbursed unit to a prospective payment unit.

7. The Provider's first cost reporting period under the SNF phase in covered calendar year 1999. The Provider properly applied the 1st Cost Reporting Period Rate to this period.

8. At all relevant times, Lima Memorial Hospital "LMH" was an Ohio non-for-profit corporation and was the corporate name of the Provider identified in paragraph 1.

9. On March 1, 1999, LMH executed an AFFILIATION AGREEMENT ("AA", Provider Exhibit 5 in both appeals 04-0376 and 05-1805), and a JOINT OPERATING AGREEMENT ("JOA"[,] Provider Exhibit 6 in both appeals).

10. The purpose of the two Agreements was to create an affiliation between LMH and two other existing Ohio Hospital Associations.

11. The vehicle for accomplishing the affiliation was the formation of a new Ohio not-for-profit corporation, the Lima Memorial Joint Operating Company ("JOC"). The JOC was, in fact, incorporated. The Affiliation became effective on July 1, 2000.

[11] *See* Provider Exhibit P-2 (Case Nos. 04-0376 & 05-1805) (Notice of Appeal).

12. The purpose of the JOC was expressed in paragraph 1.3 of the AA:

> 1.3 Tax Exempt Purposes: The JOC has been organized and shall be operated exclusively for charitable, educational, scientific or religious purposes, specifically, to provide for and promote the effective and efficient delivery of quality health care, health-care related services and health promotion services in the primary service area of LMH comprised of Allen County and portions of the counties contiguous thereto, and in the secondary service area of LMH which is comprised of the following nine counties surrounding Allen County, Ohio that are not a part of the primary service area: Mercer, Hardin, Hancock, Auglaize, Putman, Van Wert, Paulding, Logan and Shelby (the "LMH Service Area"), in furtherance and support of the mission and purposes of the JOC and the JOC Members. The parties hereby acknowledge that certain portions of the LMH Service Area overlap with the service are [*sic* area] of BVHA and PHS. The JOC shall promptly seek Federal tax exemption under Section 501(c)(3) of the Code.

13. Certain provisions of the AA and JOA will be identified and summarized to assist the PRRB in deciding this dispute. This identification does not limit the parties in identifying other provisions of the documents to support their respective positions, and the parties are free to go beyond the summary descriptions to support their position.

a. Upon completion of the Affiliation, LMH was to preserve and retain its separate corporate existence (JOA 2.4). After the Affiliation went into effect, LMH was obligated "to use its best efforts to cause its businesses and operations to be carried on as previously conducted in accordance with past practices and policies, to maintain its assets and properties in good condition and working order, to preserve the business organization of LMH intact, to keep available the services of its current respective officers and employees, to preserve its good will in the local and regional communities, and to keep in force all existing insurance policies or to obtain comparable policies without change as to risks covered or amounts of coverage." (AA 10.3) The Hospital's Medicare and Medicaid provider numbers did not change. (AA 2.4) LMH members continued to have sole authority to elect LMH's Board of Trustees. (JOA 2.4) LMH was to be a 'member" of the JOC (JOA 1.10)

with rights to appoint directors of the JOC in accordance with the JOC's Code of Regulations.

b. All employees of LMH remained employees of LMH (JOA ¶4.2).
c. Ownership of all property, plant and equipment remained with LMH (JOA 3.1(a)).
d. The medical staff remained LMH's medical staff, subject to possible transfer to JOC (JOA 4.5).
e. All current assets and investments (*i.e.*, not capital assets) became the property of JOC (JOA 5.1(b)).
f. Subject to the powers reserved to LMH, the JOC assumed total power and authority to operate and manage LMH (see also ¶¶2.2 through 2.4 of the AA).

14. By letter dated December 16, 2000 (Provider Position Paper exhibit 7 in each appeal), HCFA (now CMS) advised LMH's President and CEO that:

> We have been notified that Lima Memorial Hospital changed ownership effective July 1, 2000 and is now operating as Lima Memorial Joint Operating Company dba/Lima Memorial Health System still operating as Lima Memorial Hospital. Regulations at 42 CFR 489.18 require that the existing provider agreements be automatically assigned to the new owner when a provider of services undergoes a change of ownership. The new owner is then subject to all terms and conditions under which the existing agreement was issued.

15. The parties have been unable to locate what was submitted or how HCFA was notified. The Intermediary representative contacted the current CMS office and was advised that the documentation could not be located. Administar Federal, the Intermediary at the time, was a cc recipient of the letter.

16. By letter dated January 9, 2001, an Administar manager notified LMH that separate cost reports were required to be filed for the periods of January 1, 2000 to June 30, 2000 and July 1, 2000 to December 31, 2000 based on information that the hospital had changed ownership effective July 1, 2000. (Provider Position Paper Exhibit P-7).

17. LMH complied with Intermediary's instructions and filed separate cost reports for the first and second half of the calendar year 2000.

18. In its as filed cost reports, the Provider treated the full calendar year 2000 as the 2nd Cost Reporting Period, and applied the 2nd Cost Reporting Period transition rate to both cost reports filed in year 2000. On audit, the Intermediary disagreed with the Provider's application of the SNF transition rules. The Intermediary applied the 2nd Cost Reporting Period transition rate to the cost report filed in the first half of year 2000, and the 3rd Cost Reporting Period transition rate to the cost report filed in the second half of year 2000.

19. The Provider timely filed this appeal, challenging whether the Affiliation Agreement, was a change of ownership and the effect of that determination on the SNF transition rule. The Provider contends that the Affiliation Agreement was not a "change of ownership" under the Medicare rules, and that the Provider should not have been directed to file partial year cost reports in the 2000 year. Therefore, for purposes of the SNF transition rules, calendar year 2000 should have been treated as the 2nd Cost Reporting period and calendar year 2001 should have been treated as the 3rd Cost Reporting Period.

20. The Intermediary contends that the PPS transition was properly applied to the respective cost reports.

21. The Parties stipulate that the amount in controversy in this appeal is approximately $250,000 combined for both appeal years, with more than $10,000 at issue in each year. The Provider and Intermediary agree that the Provider will not be required in this appeal to present evidence of the reimbursement impact should the PRRB rule in its favor. [12]

LMH was part of a Joint Operating Agreement ("JOA") and an Affiliation Agreement ("AA") that were each executed by the same entities on the same day (March 1, 1999) and were each effective July 1, 2000. The purpose of the two agreements was to create an affiliation between LMH and two other existing Ohio health care systems ("Affiliation"). The vehicle for accomplishing the Affiliation was the formation of a new Ohio not-for-profit corporation, the Lima Memorial Joint Operating Company ("JOC"), an incorporated company. The AA formed the JOC and was entered into by the following four parties: LMH, BVPH Ventures, Inc. ("JV"), ProMedica Heath System (PHS), and Blanchard Valley Health Association (BVHA). The JOA was entered into by the following four parties: JOC, JV, LMH, PHS and BVHA. One of the JOA recitals specifies that, in order to enter into this agreement, PHS and BVHA formed JV and LMH and JV formed JOC. Further, the JOA specifes that "LMH hereby appoints the JOC as the

[12] Fact Stipulation dated May 1, 2012 for Case Nos. 04-0376 and 05-1805.

manager and operator of the Hospital and JOC Activities, and the JOC hereby agrees to act as such manager and operator, subject to the terms and conditions of this Agreement."[13]

In its as-filed cost reports, the Provider treated calendar year 2000 as the 2nd Transition Cost Reporting Period under the SNF PPS and, as a result, applied the transition rate for the 2nd Transition Cost Reporting Period to the short cost report covering the 6-month period ending June 30, 2000 and the short cost report covering the 6-month period ending December 31, 2000. For the cost report covering the 12-month period ending December 31, 2001, the Provider applied the transition rate for the 3rd Transition Cost Reporting Period.

On audit, the Intermediary disagreed with the Provider's application of the SNF PPS transition rules. The Intermediary applied the transition rate for the 2nd Transition Cost Reporting Period to the short cost report covering the 6-month period ending June 30, 2000, and the transition rate for the 3rd Transition Cost Reporting Period to the short cost report covering the 6-month period ending December 31, 2000. As a result, for FY 2001, the Intermediary did not apply any transition rate but rather applied the full federal SNF PPS rate.

The Provider was represented by Albert J. Lucas, Esq., of Calfee Halter & Griswold LLP. The Intermediary was represented by Bernard M. Talbert, Esq., Senior Medicare Counsel, Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Affiliation as effectuated by the JOA and AA did not constitute a Change of Ownership (CHOW) and that the Intermediary should not have directed the Provider to file partial-year cost reports in year 2000. Therefore, the Intermediary should be directed to recalculate reimbursement for the Provider's SNF unit by applying the transition rate for the 2nd Transition Cost Reporting Period under the SNF PPS rules to the cost report for the 6-month period ending December 31, 2000 and the transition rate for the 3rd Transition Cost Reporting Period under the SNF PPS rules to cost report for the 12-month period ending December 31, 2001.

The Provider contends that Medicare regulation, 42 CFR § 489.18(a), specifies the four circumstances in which a CHOW occurs:

> (a) *What constitutes change of ownership*—(1) *Partnership.* In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise, as permitted by applicable State law, constitutes change of ownership.
>
> (2) *Unincorporated sole proprietorship.* Transfer of title and property to another party constitutes change of ownership.

[13] JOA ¶ 3.1 (filed under seal as Pro vider Exhibit P-6). *See generally* AA, JOA and Code of Regulation (filed under seal as Provider Exhibits P-5, P-6, and P-8 respectively).

> (3) *Corporation.* The merger of the provider corporation into another corporation or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute change of ownership.
> (4) *Leasing.* The lease of all or part of a provider facility constitutes change of ownership of the leased portion. [14]

As per the Provider, none of the CHOW circumstances specified in the above regulation occurred when LMH entered into the Affiliation Arrangement and, thus, asserts that LMH continues to be the "provider" for purposes of the participation agreement with the Medicare program. Subsection (a)(1) of the regulation applies only to transactions involving partnerships. LMH was an Ohio not-for-profit corporation, not a partnership.[15] Nor did the Affiliation create a partnership relationship. In the AA, the parties agreed and acknowledged that "[n]othing in this Agreement [*i.e.*, the AA] shall constitute or be construed to be or to create a relationship of agency or partnership by, between or among LMH, JV, BVHA, PHS, and/or the JOC."[16]

Subsection (a)(2) of the regulation addresses transactions involving unincorporated sole proprietorships. The Provider contends that the AA and JOC did not create a sole proprietorship.[17]

Subsection (a)(4) of the regulation deals with leases. The Provider contends that the Affiliation did not involve a lease of any of LMH's assets, as LMH retained its assets when the Affiliation took place.[18]

Subsection (a)(3) of the regulation involves mergers and consolidations of corporations. The Provider contends that the Affiliation did not involve either a merger or consolidation as LMH continued to exist as a separate legal entity following the Affiliation.[19] Instead, the Affiliation involved the creation of JOC, which by contract was given the power to control LMH, subject to certain powers reserved to LMH.[20] The Affiliation did not change the legal structure of LMH. After the Affiliation, LMH continued as a separate corporate entity. The existing corporate members for LMH did not change, and these existing corporate members retained sole authority to elect LMH's Board of Trustees.[21] In the AA, the parties also agreed that LMH would continue to carry out its business and operations as previously conducted.[22] To obtain its member interest in the JOC, JV contributed $5 million and other consideration.[23] As a result, the

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[14] (Italics in original.)
[15] *See* AA § 4.1.1 (filed under seal as Provider Exhibit P-5).
[16] *Id.* at ¶ 15.8.
[17] *See id. at* ¶ 4.1.1.
[18] *See* JOA ¶ 3.1(a) (filed under seal as Provider Exhibit P-6).
[19] *See* Transcript ("Tr.") at 17; Provider Final Position Paper at 10 (Case No. 04-0376)..
[20] *See* AA ¶2.2 (filed under seal as Provider Exhibit P-5).
[21] *See* JOA ¶ 2.4 (filed under seal as Provider Exhibit P-6).
[22] *See* AA ¶10.3 (filed under seal as Provider Exhibit P-5).
[23] *See* JOA ¶ 5.3 (filed under seal as Provider Exhibit P-6).

Provider asserts that the Affiliation was a sale of a member interest in JOC to JV, a transaction specifically excluded from the definition of change of ownership.[24]

The Provider also contends that, although the parties agreed under the Affiliation that the JOC would have the right to manage and control certain aspects of the LMH operations, such control over an existing Medicare provider does not constitute a change of ownership from LMH to the JOC under the Medicare rules.[25] In support of this position, the Provider cites to the following excerpt from the State Operations Manual, CMS Pub. No. 100-07 (SOP 100-07):

> The mere sale of any number of shares of an owning corporation does not constitute a Medicare CHOW because the responsible legal entity, the corporation, remains in place. For corporations that do not issue stock but are controlled by a "member" or "members" (which can be individuals, partnerships, or other corporations), the same principle holds true: a change in the individuals or entities controlling or owning the corporation is not relevant for CHOW [*i.e.*, change of ownership] purposes.[26]

The Provider contends that, even if control was relevant for CHOW purposes, the evidence shows that LMH retained sufficient control of the operations to remain as the Medicare provider bound by the Medicare participation agreement. After the Affiliation went into effect, LMH continued to have a Board of Trustees. The existing members of LMH did not change, and neither did those members elected LMH's Board of Trustees. After the Affiliation, LMH was obligated to continue to carry out its business and operations as previously conducted and make decisions about its day to day operations, subject to oversight and direction by JOC. The Provider contends that there was no change in the day-to-day control or ownership of LMH and was, therefore, no CHOW.[27]

The Provider also cites to the following excerpt from SOP 100-7 addressing situations where a management firm is operating a provider for the owners:

> The only case in which operation under a management agreement would constitute a CHOW is when the owner has relinquished all authority and responsibility for the Provider organization.[28]

Again, Provider contends that as one of the two members of the JOC, the LMH had the right to appoint one-half of the Trustees to the JOC Board. As a result, any oversight by the JOC was oversight of itself. Further, as LMH still had sole authority and responsibility to appoint LMH

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[24] *See* Provider Post Hearing Brief at 4.
[25] *See id.* at 3.
[26] *See* SOP 100-07 § 3219.1(E).
[27] *See* Provider Post Hearing Brief at 4.
[28] *See* SOP 100-07 § 3210.1(D)(5) (included as Intermediary Exhibit I-3).

Board of Trustees, it did not relinquish authority or responsibility for its organization. As such, no CHOW occurred for Medicare purposes.[29]

The Provider maintains that the financial arrangement between JOC and LMH does not trigger the Medicare CHOW rules. After the Affiliation went into effect, any changes in the net assets of the LMH became the property of the JOC.[30] The distribution of money or other assets to a related entity does not trigger the Medicare CHOW rules set forth in 42 CFR § 489.18. The fact that CMS transferred the Medicare provider agreement to the JOC does not establish that the parties intended the Affiliation to be a CHOW. Nonetheless, by letter dated December 16, 2000, CMS notified LMH that the provider agreement was transferred to the JOC based upon information that a change of ownership had occurred.

In the alternative, the Provider asserts that, even if the formation of the Affiliation and JOC caused a change of ownership requiring the Provider to file partial year cost reports in 2000, the Intermediary misapplied the SNF PPS transition rules by refusing to treat a cost reporting period as a 12-month period based on the Provider's accounting year.[31] To support its position the Provider cites to the following excerpt from § 2414 of the Provider Reimbursement Manual, CMS Pub. No. 15-1 (PRM 15-1):

> 2414. COST REPORTING PERIOD
>
> For cost reporting purposes, the program will require submission of annual reports covering a 12-month period of operations based upon the provider's accounting year. (See Part II, § 102.)
>
> The provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other programs. Once a provider has made a selection and reported accordingly, it is required thereafter to report annually for periods ending as of the same date unless the intermediary approves a change in the provider's reporting period.
>
> A cost reporting period under the program consisting of one of the following will be considered in compliance with the reporting periods cited above:
>
> A. Twelve (12) successive calendar months, ...

Further, the Provider asserts that 42 C.F.R. § 413.20(b) specifies that a provider's cost report period covers an "annual" period based on the accounting year of that provider:

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[29] *See* Provider Post Hearing Brief at 4; AA¶ 10.3 (filed under seal as Provider Exhibit P-5); JOA¶¶ 2.4, 3.1 (filed under seal as Provider Exhibit P-6).
[30] *See* AA ¶ 5.1(b) (filed under seal as Provider Exhibit P-5).
[31] *See* Provider Final Position Paper at 13-15 (Case No. 04-0376).

> (b) *Frequency of cost reports*: Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. In the interpretation and application of the principles of reimbursement, the fiscal intermediaries will be an important source of consultive assistance to providers and will be available to deal with questions and problems on a day-to-day basis.[32]

Similarly, the Provider asserts that the following excerpt from 42 C.F.R. § 413.24(f) provides that a provider should file cost reports which cover a 12 month period of the provider's operations:

> (f) *Cost reports*. For cost reporting purposes, the Medicare program requires each provider of services to submit periodic reports of its operations that generally cover a consecutive 12-month period of the provider's operations. Amended cost reports to revise cost report information that has been previously submitted by a provider may be permitted or required as determined by CMS.[33]

Thus, the Provider maintains that the Provider's three "cost reporting periods" covered by the SNF PPS transition should have been calendar years 1999, 2000 and 2001 because the Provider operated on a calendar year basis.

Finally, the Provider makes an equitable argument that the Intermediary's interpretation of the SNF transition rules unfairly treats similarly situated providers differently.[34] Specifically, the Provider asserts that, under the Intermediary's interpretation, a provider which is required to file multiple short cost reports during the SNF transition period would lose the benefit of transitional rules for 1 or even 2 years and would unfairly deprive that provider of the full transition period. All providers should get the benefit of the full transition period.

INTERMEDIARY'S CONTENTIONS:

From the Intermediary's perspective, the resolution of this dispute is also embedded in the proper characterization and impact assessment of the JOA and the AA, executed by the same entities on the same day (March 1, 1999), and effective on July 1, 2000. Through these two documents primarily, LMH became affiliated with two other Ohio health care systems which operated acute care hospitals. The Intermediary contends that LMH operated independently of its affiliation partners prior to March 1, 1999. It is the effect of the Affiliation on the Provider's participation agreement with the Medicare program that drives the dispute. The Intermediary maintains that the Affiliation as a whole reflects a significant change in legal responsibility for all hospital activities from LMH to JOC, which was reflected in the reassignment of the Provider's participation agreement from LMH to the JOC and which carried the attendant consequences.

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[32] (Italics in original.)
[33] (Italics in original.)
[34] *See* Provider Final Position Paper at 15-16 (Case No. 04-0376).

The Intermediary further supports the CHOW finding by CMS, suggesting that the language in the AA, itself, provides the most compelling evidence of the intent of the Affiliation participants and the legitimacy of the CMS's CHOW decision:

> 2.1 Joint Operating Agreement. Concurrently herewith, LMH and the HOC have entered into the Joint Operating Agreement ("JOA") in the form attached as Exhibit 2.1
>
> 2.2 JOC Operational Control. Pursuant to the JOA, the JOC shall have complete control of the operations of LMH, subject to the powers reserved to LMH.
>
> 2.3 JOC Financial Responsibility. The JOC shall bear all financial responsibility for the operation of LMH unless otherwise provided herein or in the JOA, except with respect to periods prior to the Effective Date.
>
> 2.4 Use of LMH Assets and Personnel. The JOC, in the JOC's discretion, shall have the right to operate LMH through LMH's existing provider numbers, licenses and personnel, all as the JOC Board shall from time to time determine to be the most efficient method to operate LMH. The JOC, at the sole discretion of JV, shall have the right to lease the assets of LMH for an annual rental of $1 per year and to have the JOC become the provider of services at the LMH facility; provided, however, that all material consents and approvals, including financial, regulatory, and third party payors, have been obtained and all required governmental filings have been made and all applicable waiting periods have expired.[35]

The Intermediary also notes that while the employees may have remained as LMH employees, LMH transferred $5 million to seed the JOC[36] and maintains that the power and authority over the operations of LMH followed the money.[37]

The Intermediary also looks to 42 CFR § 489.18, specifically to paragraph (a)(3), to describe the affiliation:

> *Corporation.* The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes change of ownership. Transfer of corporate stock or the merger of another

[35] AA ¶¶ 2.1-2.4 (filed under seal as Provider Exhibit P-5).
[36] *See* JOA ¶ 5.1(b) (filed under seal as Provider Exhibit P-6).
[37] *See* Intermediary Consolidated Post Hearing Brief at 5-6.

> corporation into the provider corporation does not constitute change of ownership.[38]

The Intermediary dismisses the Provider's analogy to a corporate stock transaction because, here, a new corporation was in fact created with clear authority and limits over operations of the health care provider. The Intermediary also notes that, while the term "merger" used in the federal regulation suggests that any prior corporation goes out of existence, a merger can also continue the existence of the former entity as it did in this case with LMH in a subservient role. The Intermediary contends that, when the AA and JOA are read together, it is clear that a different legal entity was now answerable to HCFA on all matters regarding the Medicare Program after the Affiliation was implemented on July 1, 2000.[39]

The Intermediary also points to the CMS Regional Office's determination that the affiliation resulted in a CHOW and that, pursuant to the regulations, the Provider must file a final cost report prior to the effective date of the change of ownership. The Provider must then file a short period cost report from the effective date of the change of ownership through the remainder of the 2000 calendar year—the period that the Provider had chosen as its cost reporting period. Therefore, based on Federal Register,[40] the Intermediary correctly determined that the Provider's 1st Transition Cost Reporting Period was January 1, 1999 through December 31, 1999; the Provider's 2nd Transition Cost Reporting Period was January 1, 2000 through June 30, 2000; and the Provider's 3rd Transition Cost Reporting Period was July 1, 2000 through December 31, 2000. Further, the cost reporting period January 1, 2001 through December 31, 2001 would no longer be in the transition period and, as such, would be paid 100% of the federal hospital-based SNF PPS payment rate.

The Intermediary also challenges the Provider's contentions that a cost report is intended to cover a twelve month period. The Provider cites to 42 C.F.R. § 412.20(b) to support its contention; however, the Intermediary argues that this regulation simply requires a provider to submit a cost report annually and does not address situations where it may be necessary or appropriate for a provider to submit a cost report for a shorter period. As an example, the Intermediary cites to 42 C.F.R. § 413.24(f)(1) which states:

> (1) *Cost reports—Terminated providers and changes of ownership.* A provider that voluntarily or involuntarily ceases to participate in the Medicare program or experiences a change of ownership must file a cost report for that period under the program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement or change of ownership.[41]

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[38] (Italics in original.)
[39] *See* Intermediary Consolidated Post Hearing Brief at 8-9.
[40] *See* 64 Fed. Reg.41684 (July 30, 1999) (included as Intermediary Exhibit I-2).
[41] *See* 42 CFR 413.24(f)(1) (italics in original) (included as Intermediary Exhibit I-8). Prior to 1994, this rule was codified as 42 C.F.R. § 405.453(f). and been in effect since at least 1985.

It is precisely this regulation which allows CMS to change the "cost reporting period" in cases such as this where there has been a CHOW.[42]

Further, the Intermediary cites to the following excerpt from the preamble of the final rule published on July 30, 1999:

> SNFs may have cost reporting periods that are fewer than 12 months in duration (short period). This may occur, for example, when a provider enters the Medicare program after its selected fiscal year has already begun or when a provider experiences a change of ownership before the end of the cost reporting period. Since short periods affect a small number of providers, relative to the total number of SNFs, and the facility- specific portion of the SNF PPS rate is subject to a transition period, we do not believe consideration of computing a "short period specific" update factor is warranted. Accordingly, we will apply the following rules to short periods.[43]

The Intermediary contends that, throughout the Federal Register and regulations, the transition periods applies to or are synonymous with cost reporting periods. There is no indication that CMS intended for the transition period to be determined based on the number of months in the cost reporting period.[44]

In summary, the CMS Regional Office determined that the Provider changed ownership and must file a final cost report running from the day following the filing of the last cost report up to the date of change of ownership (*i.e.*, January 1, 2000 through June 30, 2000). Accordingly, the Intermediary argues, the Provider must then file a short period cost report from the effective date of the CHOW through the remainder of the Provider's 2000 fiscal year (*i.e.*, July 1, 2000 through December 31, 2000). The Intermediary maintains that it correctly determined that the Provider's 1st Transition Cost Reporting Period was January 1, 1999 through December 31, 1999; the Provider's 2nd Transition Cost Reporting Period was January 1, 2000 through June 30, 2000; and, lastly, the Provider's 3rd Transition Cost Reporting Period was July 1, 2000 through December 31, 2000.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions and stipulations, and the evidence presented at the hearing. Set forth below are the Board's findings and conclusions.

The Board has jurisdiction over this appeal as provided under 42 U.S.C. § 1395oo(a).

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[42] *See* Intermediary Final Position Paper at 8-9 (Case No. 04-0376).
[43] *See* 64 Fed. Reg. at 41699 (included as Intermediary Exhibit I-2).
[44] *See* Intermediary Final Position Paper at 9-10 (Case No. 04-0376).

Both parties agree that the regulation applicable to the resolution of this case is 42 C.F.R. § 489.18 which specifies the criteria in determining whether a CHOW has occurred. This regulation is located in Subpart A of Part 489 which implements 42 U.S.C. § 1395cc(a)(1) and specifies, among other things, the "terms of provider agreements, the grounds for terminating a provider agreement . . . ."[45] The Secretary promulgated regulations at 42 C.F.R. Part 498 that, pursuant to its title, provide "*Appeal Procedures for Determinations that Affect Participation in the Medicare Program* and for Determinations that Affect the Participation of ICFs/MR and Certain NFs in the Medicaid Program."[46] In particular, Part 498 details the hearing procedure and other administrative review of any determination that it is not a provider or any other determination described in § 1395cc(b)(2).[47]

The Board agrees with the Intermediary that the CMS Regional Office ("RO") has the "delegated authority for making the determination if a CHOW actually exists." This delegation is explained in SOP 100-07 § 2005(E) and the Program Integrity Manual, CMS Pub. No. 100-08 (PIM 100-08), Chapter 10, § 5.5.2.[48]

The Manuals also provide review procedures to effectuate CHOWs such as the one at issue in this case. In this regard, during the relevant fiscal years, the Medicare Intermediary Manual, CMS Pub. No. 13, Part 4 (MIM 13-4) stated in pertinent part:

> 4501 CHANGE OF OWNERSHIP REVIEW PROCEDURES
>
> Each potential CHOW transaction is subject to two reviews for Medicare purposes—one for Medicare certification and one for Medicare reimbursement…..
>
> 4501.1 … If a CHOW for certification results, a terminating provider cost report is required from the seller, the Medicare participating agreement is automatically assigned to the new provider.[49]

Similarly, during the relevant fiscal years, PRM 15-1 stated:

> 1500. CHANGE OF OWNERSHIP—GENERAL
>
> When a provider undergoes a change of ownership…for which a Provider Tie-In Notice (Form HCFA-2007) has been issued, a final cost report must be filed by that provider covering the period under the program beginning with the first day not included in a previous cost reporting period and ending with the effective date of

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[45] 42 C.F.R. § 489.1.
[46] (Emphasis added.)
[47] *See also* SOP 100-07 Ch. 3.
[48] Intermediary Final Position Paper at 6 (Case No. 04-0376). *See also*: Intermediary Exhibits I-4 at 2 and I-5 at 1.
[49] Available at http://wayback.archive-it.org/2744/20111201174240/http://www.cms.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021918&intNumPerPage=10 (documenting that this MIM 13-4 section had last been changed in April 1987).

> termination of its provider agreement, change of ownership, or event (42 CFR 405.453(f)(1)).[50]

Thus, consistent with 42 C.F.R. § 413.24(f)(1), CMS issues a Provider Tie-In Notice to notify a provider of the effective date of the CHOW as it relates to continued participation in the Medicare Program.[51] Further, 42 C.F.R. § 413.24(f)(3) allows a provider experiencing a CHOW to change its cost reporting period if that provider requests such a change in writing at least 120 days before the close of the new reporting period requested by the provider and the intermediary determines that good cause for the change exists.[52]

In the case before the Board, CMS issued a Provider Tie-In Notice on December 16, 2000 notifying the Provider that, for purposes of the Medicare participation agreement, the CHOW was effective July 1, 2000 and the provider number was reassigned to the JOC as the new owner.[53] Thus, it is clear that, pursuant to existing regulation and policy, the RO made a determination that a CHOW had occurred and issued a Provider Tie-In Notice. As a result, the filing of a terminating cost report was required as explained in the Provider Tie-In Notice.

Unfortunately for the Provider, during this same period, CMS was transitioning SNF reimbursement from the historical cost-based reimbursement system to SNF PPS. Federal regulations required that this transition period begin with the "cost reporting period" after July 1, 1998.[54] In connection with short cost reporting periods that occur during the transition, CMS provides the following guidance in the preamble to the July 30, 1999 interim final rule implementing SNF PPS:

> The first short period in the initial period is considered the first cost reporting period for the purposes of applying the facility-specific percentage in the transition period. Each subsequent short period, for the same provider, of any duration is considered the second or third cost reporting period for the purposes of applying the facility specific percentage in the transition period.[55]

This is consistent with how the term "cost reporting period" is used in the regulations at 42 C.F.R. § 413.24(f) generally and (f)(1) in particular which requires certain short "cost reporting periods" when a CHOW occurs.[56]

The Board finds that the July 30, 1999 interim final rule and 42 C.F.R. § 413.24(f)(1) make it clear that the term "cost reporting period" as used in the SNF PPS statutory and regulatory provisions at 42 U.S.C. § 1395yy(e) and 42 C.F.R. § 413.340(a) includes short cost reporting periods such as those at issue in this case. As a result, the Intermediary treated the Provider's

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[50] (Emphasis added.)
[51] *See* Form CMS-2007.
[52] 42 CFR § 413.24(f)((3).
[53] Provider's Final Position Paper, Provider Exhibit P-7 at 2 and 7.
[54] 42 CFR § 413.340(a).
[55] Interim final rule, 63 Fed. Reg. 26252, 26294 (May 12, 1998). The final rule published at 64 Fed. Reg. 41684 (July 30, 1999) did not revise this guidance.
[56] *See* 42 C.F.R. § 413.24(f)(1).

cost report for the period, January 1, 1999 to December 31, 1999 as the 1st Transition Cost Reporting Period. The CHOW impacted the Provider's next accounting period and resulted in a short 6-month terminating cost reporting period ending June 30, 2000 that the Intermediary properly treated as the 2nd Transition Cost Reporting Year. The record contains no evidence that the Provider sought to change the cost reporting period following the CHOW as permitted under 42 C.F.R. § 413.24(f)(3). Therefore, the cost reporting period remained on a calendar year basis and the Intermediary properly established the 3rd Transition Cost Reporting Period to be the 6-month period ending December 31, 2000.

Thus, while the Provider complains that the two 6-month cost reporting periods shortened two years of blended transition payments resulting in lower SNF payments during this period, it was the coincidence of the need to file a terminating cost report due to the CHOW and the Provider's continued use of the calendar year as LMH's accounting year that caused the two short cost reporting periods and necessitated the shortened SNF PPS transition periods. Consistent with the regulations, the Intermediary properly determined that the CHOW required a terminating cost report period ending on June 30, 2000. Following the CHOW, LMH did not request a change in the cost reporting period within 120 days of the CHOW as it could have done pursuant to 42 C.F.R. § 413.24(f)(2). As a result, the Intermediary correctly determined that the final SNF transition cost reporting period had to end on December 31, 2000 in this case.

The Board acknowledges that the Provider contends that principles of equity preclude the Provider from being treated differently from similarly situated providers. However, the Board does not have the legal authority to alter the application of the SNF PPS transition based on principles of equity. Pursuant to 42 C.F.R. § 405.1867, the Board is obligated to follow the applicable statutes, regulations, and CMS Rulings when rendering its decision. As previously discussed, the July 30, 1999 interim final rule and 42 C.F.R. § 413.24(f)(1) make it clear that the term "cost reporting period" as used in the SNF PPS statutory and regulatory provisions includes short cost reporting periods such as those at issue in this case. Consequently, for purposes of Medicare reimbursement under SNF PPS, the Board cannot ignore the CHOW and resulting short cost reporting periods for 2000 and must deny the Provider's request for equitable relief.

Finally, the Board finds that it lacks the authority to decide the question raised by the parties in this case: whether or not a CHOW occurred. The Board believes that the determination of whether a CHOW occurred for purposes of 42 C.F.R. § 489.18[57] is one of provider certification found at 42 C.F.R. Part 489 and that the proper appeal of the RO's determination on this issue is established in that 42 C.F.R. Part 498 through appeal to an administrative law judge and the Departmental Appeals Board rather than through the Provider Reimbursement Review Board. While the Board has jurisdiction to determine whether the payment consequence of a CHOW

[57] The Board notes that the parties were unable to provide the Board with a copy of the RO determination that led to the issuance of the Provider Tie-In Notice dated December 16, 2000. Pursuant to 42 C.F.R. § 489.18(b), a provider must notify CMS of a change of ownership; however, it is unclear from the record whether the Provider initiated the CHOW at issue that resulted in that Provider Tie-In Notice as the parties presented no other correspondence related to the CHOW such as CMS Form 855 filings or witnesses to the Affiliation/JOC transactions.

determination is appropriate as it has done in this case, the Board lacks authority to determine whether the CMS decision on the CHOW was correct.[58]

Accordingly, the Board concludes that the RO properly exercised its regulatory authority to determine whether a CHOW had occurred and that the Provider failed to appeal this determination pursuant to 42 CFR Part 498. As a result of the CHOW determination, the Intermediary properly calculated the SNF transition period to include a shortened cost reporting period to coincide with the required filing date for the terminating cost report. The Provider, upon the subsequent issuance of the Provider Tie-In notice, did not request a change in the cost reporting period which resulted in a second shortened cost reporting period to the end of the calendar year.

DECISION AND ORDER:

The Board finds that it has jurisdiction over this appeal; however the Board lacks authority to reverse the CMS's determination that the formation of the Affiliation and JOC caused a change of ownership of the Provider operations from LMH to the JOC for purposes of participation as a provider in the Medicare program. The Board further finds that the Intermediary properly adjusted the SNF PPS transition periods for the Provider's cost reporting periods ending on December 31, 2000 and December 31, 2001.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: MAR 13 2013

[58] The facts of this case further highlights why the Board is not the correct forum to address the CHOW issue. The CHOW determination at issue was dated December 16, 2000 and affected LMH's Medicare participation agreements for its hospital, SNF and HHA operations. Notwithstanding, the Provider is seeking to change the CHOW determination at this late date only in the context of this SNF PPS reimbursement appeal for the cost reporting periods ending December 31, 2000 and December 31, 2001.