CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Jordan Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/ Associated Hospital Services** **Intermediary**	**Provider Reimbursement for Cost Reporting Period Ending: 9/30/98** **Review of:** **PRRB Dec. No. 2007-D23** **Dated: February 28, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. Comments were received from the Center for Medicare Management (CMM), requesting reversal of the Board's decision. The parties were then notified of the Administrator intention to review. The Provider submitted comments requesting affirmance of the Board's decision. Accordingly, the case is now before the Administrator for final administrative review.

BACKGROUND

The Provider, Peter Chapman Transitional Care Unit (PCTCU), is a twenty-five bed hospital-based skilled nursing facility (HB-SNF), opened in December of 1995. The skilled nursing facility (SNF) was located in a former acute care ward on the third floor of the Hospital.

Massachusetts law required that providers obtain a Determination of Need (DON),[1] before constructing new facilities. The Massachusetts Department of Public Health (MDPH) imposed a moratorium on DON applications for new nursing facility beds in 1992. The MDPH developed an exception process to this moratorium under which a healthcare facility could be granted a DON to open a new Level II SNF so long as it first arranged, by contract, for the closure of a Level III nursing home.[2] To take advantage of this exception, a healthcare facility had to locate a nursing facility that was interested in closing its beds and apply to move the rights to operate that Level III facility.[3] Pursuant to the Provider acquiring the DON from Greenlawn Nursing Facility, the MDPH licensed the Provider as a skilled nursing facility (SNF) in 1995.[4] The Provider completed construction of a twenty-five bed hospital-based SNF in December of 1995. The first patient was admitted to the Provider's facility on December 11, 1995, and CMS certified the Provider for Medicare participation effective December 15, 1995.

In July 1996, the Massachusetts legislature established an alternative basis for the issuance of DONs. Under the 1996 Mass. Acts Ch. 203 § 31, any healthcare facility which was issued a DON under the previous process would have its prior DON superseded and replaced by authorization under the 1996 DON Act. Accordingly, on September 20, 1996, the MDPH superseded the prior licensure that the Provider had obtained and operated under since December of 1995, and replaced it with a DON under the 1996 DON Act.[5]

The Provider requested a new provider exemption from the routine cost limits (RCLs) in December 1997.[6] By letter to the Intermediary, CMS denied the exemption request, and the Intermediary notified the Provider of the denial by letter dated July 15, 1998.[7] CMS stated that the Provider does not qualify for a new provider exemption because its distinct part unit has operated in a manner equivalent to a SNF, under past or present ownership, as evidence by the fact that it provided skilled nursing and rehabilitative services as a nursing facility (NF) for

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[1] Per Provider Post-Hearing Brief, page 13, the DON is commonly referred to in other states as a Certificate of Need, or "CON."

[2] See MDPH letter to CMS explaining this policy in a letter dated February 27. 1996, Exhibit P-8.

[3] See Transcript of Oral Hearing at 75-77.

[4] See Provider Position Paper, Exhibit P-12.

[5] See Transcript at 67-69. The Provider's witness testified that the new state statute superseded the previous practice of transferring of beds.

[6] See Provider Exhibit P-18.

[7] See Provider Exhibit P-23.

three or more years under past ownership prior to its current Medicare certification.[8] The Provider filed a timely appeal of it's FYE 9/30/98 cost report NPR on March 22, 2001, and added the RCL issue to the open appeal on April 7, 2005.

In regard to jurisdiction, the Intermediary contended that, although the Provider appealed the 1998 cost report adjustment, it also requested relief for cost reporting periods ended September 30, 1996 and September 30, 1997. The Intermediary asserted that the Board lacks jurisdiction over the Provider's request related to the FY 1996 and 1997 cost reporting periods because the Provider did not appeal the NPR for the cost reporting period ended September 30, 1996; (although the Provider did file an appeal (Case No. 00-0762) was closed in June 2001). In addition, the Provider also failed to appeal the initial CMS denial of its new provider exemption dated July 15, 1998. The Intermediary contended that for the cost reporting years ended September 30, 1996 and September 30, 1997, the Provider was well beyond the 180-day period in which an appeal can be filed. The Provider asserted that it filed a timely and valid appeal of the September 30, 1998 cost report in accordance with the requirements of 42. U.S.C. §1395oo(a). The Provider argued that the central issue in this case was whether the Provider is entitled to an exemption from the routine cost limits as a new provider. If the Board agreed that the Provider has established, by substantial evidence presented in the record at hearing, that it is entitled to a new provider exemption, then it is entitled to that exemption for all three years covered by its exemption application.

The Board found that it has jurisdiction over the three cost reporting periods covered under a new provider exemption, which includes FYs 1996, 1997, and 1998. The Board majority found that the new provider exemption regulation unambiguously applies to multiple years as it "… expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient." 42 C.F.R. §413.30(e). Therefore, the Board concluded that if it is determined in any one year that the Provider meets the requirements to be granted a new provider exemption, the exemption is deemed granted for all applicable years.

ISSUE AND BOARD DECISION

The issue was whether the Intermediary's denial of the Provider's request for a new provider exemption from the routine cost limits (RCLs) was proper.

The Board found that the Provider is entitled to an exemption from the routine cost limits pursuant to 42 C.F.R. §413.30(e). Moreover, the Board noted that the exemption proves for obtaining a DON in the State of Massachusetts in 1995

[8] Id.

required a provider to find another entity willing to close so that the "rights to operate" could be transferred. The Board reasoned that the Provider contracted with another facility to close, and made payment to that facility for its closure, in order to obtain bed rights to open the PCTCU, as this was the only available avenue for the Provider to obtain a license to operate during the relevant time period. The Board concluded that the purchase of the "rights to operate" does not, in itself, constitute a chance of ownership (CHOW) and does not affect the Provider's rights to a new provider exemption.

The Board further observed that the issue has been addressed in various other PRRB decisions and in U.S. District and Circuit Court decisions. Most recently, the Board addressed a very similar issue regarding the purchase of CON bed rights in Harborside Healthcare-Resevoir v. Blue Cross and Blue Shield Association/Empire Medicare Services.[9] In that case the Board found that "the purchase of bed rights, in and of itself, does not constitute a change of ownership (CHOW) and does not affect the [p]rovider's right to a new provider exception," and "imputing ownership based on the purchase of CON rights is inconsistent with the Medicare regulations." In Ashtabula County Medical Center v. Thompson,[10] the District Court found that the Secretary's interpretation of a new provider exemption regulation was arbitrary, capricious, and erroneous. The Secretary maintained that when a provider acquires CON bed rights from an unrelated party, a CHOW has occurred, and when a CHOW occurs, there must be a "look back" to determine whether the relinquishing provider had operated for more than three years. The Provider noted that the Fourth Circuit also held that the term "provider" in the new provider exemption regulation unambiguously refers to an institution, not a single asset such as a CON.[11]

The Board found that the instant case is unique when compared to similar cases heard on this issue, as the Provider claims that it followed the DON exception process in place in the State of Massachusetts in 1995 by negotiating with a level III facility that was willing to close so its bed rights could be transferred to Jordan Hospital and a new Level II hospital-based SNF could be established. The Board recognized that due to a subsequent retroactive change in Massachusetts law in July 1996, the approval of the DON the Provider secured through this process was suspended and replaced by a new DON, as if the beds rights surrendered by the close facility first reverted to the state and were then reissued to the Provider. The

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[9] PRRB Dec. No. 2006-D14, January 25, 2006, Medicare and Medicaid Guide (CCH) ¶81,462.

[10] Ashtabula County Medical Center v. Thompson,[10], 191 F. Supp. 2d 884, 897 (N.D. Ohio 2002), aff'd 352 F.3d 1090 (6th Cir. 2003).

[11] Maryland General Hospital, Inc. v. Thompson, 308 F.3d 340 (4th Cir. 2002).

Board agreed with the Provider's contention that any question as to whether the Provider "purchased" the closed facility became moot.

Moreover, the Board continued, that the statute change that had the effect of granting the Provider operating rights directly from the State distinguishes this case from others in which the Secretary's interpretation has been upheld.[12] However, the Board further noted that in South Shore, the provider did not present factual evidence that a change in State statute altered the entity from which the Provider received its DON. The Board concluded that in the instant case, the 1996 change in Massachusetts' statute resulted in a new DON being issued by the State on September 20, 1996 that superseded the DON granted as a result of the transfer of beds from Greenlawn. Consequently, the Board found that there was "no previous owner" of the DON, and the South Shore decision, although issued in the First Circuit, was not controlling.

The Board concluded that the Intermediary improperly denied the Provider a new provider exemption from the RCLs for it's provider-based skilled nursing facility. The Board majority found that the exemption is granted for the FY 1996, 1997, and 1998 cost reporting periods by operation of law.

Two Board members dissented. The Dissenters disagreed with the majority's conclusion that when a provider is granted a new provider exemption for any one year, the exemption is deemed granted for all applicable years. They argued that the Provider never appealed CMS' July 15, 1998 denial of its new provider exemption request until April 2005, when the Provider added the new provider exemption denial to its pending PRRB case for FYE 09/30/98. They additionally noted that, as of April 2005, the Provider did not have an appeal pending before the Board for either 1996 or 1997. The Dissenters contended that individual cost report appeals are specific to the cost reporting year in dispute. Had the Provider wished to protect its appeal rights relative to CMS' denial of its new provider exemption for fiscal years 1996 and 1997, it should have filed an appeal for those years from the notice it received regarding CMS' denial. The Dissenters argued that when the Provider failed to timely appeal the denial, which is a final determination that can be appealed to the Board, it missed its opportunity to have fiscal years 1996 and 1997 covered in the three years envisioned by the new provider exemption regulation. The

[12] In South Shore Hospital, Inc. v. Thompson, 308 F.3d 91 (1st Cir. 2002), the First Circuit granted deference to the Secretary's interpretation of the term "provider," as it found that the term, as used in 42. C.F.R. §413.30(e), was "manifestly ambiguous." The Court explained that the precise issue in that case, like the present case, turned on the meanings of "previous ownership," "provider," and "institution," none of which are unambiguous.

Dissenters believe that the Provider is precluded from simply appending 1996 and 1997 to its 1998 individual cost report appeal, as the 1998 appeal is specific to fiscal year 1998 only. Therefore, since the Provider failed to timely appeal CMS' denial of its request for a new provider exemption for fiscal years 1996 and 1997, the Dissenters maintained that the Board does not have jurisdiction over the 1996 and 1997 cost reporting periods. However, based on the merits of the case, the Dissenters concurred with the Board's majority decision that the Provider is entitled to a new provider exemption, but only for FYE 09/30/98.

SUMMARY OF COMMENTS

CMM commented, requesting that the Board's decision be reversed. CMM argued that the Board's finding that the Provider's purchase of the "rights to operate" does not, in itself, constitute a change of ownership is incorrect. CMM noted that, Mercy Medical Skilled Nursing Facility, PRRB No. 2002-D-31 decided on October 8, 2002, shows that a CON is an asset used to render patient care and that once transferred constitutes a CHOW for purposes of determining whether the Provider qualifies for an exemption as a new provider.

With respect to the CHOW issue, CMM pointed out that the Board failed to recognize the regulations set forth in Sections 1500 and 2533.1E(b) of the Provider Reimbursement Manual (PRM). In addition, CMM noted that the Request to Temporarily Discontinue Operation of the Facility, which was submitted by Greenlawn on behalf of both itself and the Provider, was not a request for a discontinuance of operation, hence was not to be deemed an abandonment of license. CMM emphasized the facts surrounding this issue and pointed to the Agreement between Greenlawn and the Provider and relevant state laws. CMM pointed to the fact that on May 19, 1995 the Provider completed a License Application for what was formerly Greenlawn Nursing Home and would now be known as the Jordan Hospital Transitional Care Unit, Provider's SNF. According to Massachusetts law, the purchasing entity that files the application as a result of a transfer of ownership will have the effect of a license from the date of transfer. Hence, the right to operate the facility remains intact and continues under the new owner. CMM asserts that this fact, in conjunction with others, serve as proof that the Provider acquired the license to operate Greenlawn and a CHOW did exist.

Moreover, CMM argued that the Board's decision was incorrect in distinguishing the facts here, where the Provider obtained a retroactive DON, from those cases in which the Secretary's interpretation had been upheld. CMM also asserted the fact that CMS was correct in applying Medicare provisions whereas the Board placed too much emphasis on the laws of Massachusetts. Since CMS must interpret

transactions in accordance with the principles of Federal Medicare law and it found a CHOW in this situation, its decision must be upheld since the revised State law has no effect on the application of Medicare law by the Secretary.

Finally, CMM asserted that individual cost report appeals are specific to the cost reporting year in dispute and that exemptions for the cost reporting periods in question, those ending at 9/30/96 and 9/30/97, are not mandated by law. CMM pointed out that the Provider was notified that its requests were denied by CMS. Citing Section 1878(a)(1)(A)(i), CMM pointed out that there was nothing interfering with the Provider's right to request a hearing and instead opted to not appeal its Notice for Program Reimbursement (NPR) for the cost reporting period for 9/30/96 but did appeal its NPR for 9/30/97. The appeal of the NPR for 9/30/97 was closed on 6/11/01 and all issues were deemed moot as a result of a settlement agreement that was entered into between the Intermediary and the Provider, dated June 11, 2001. Therefore, CMM asserted that the Board cannot assert jurisdiction over the 1996 and 1997 cost reporting periods since it is in direct conflict with the statutory and regulatory laws that apply to the appeals process.

The Intermediary commented and recommended that the Administrator review the adverse decision by the Board. The Intermediary maintained that the Provider did not meet the necessary regulatory requirements granting the Provider's new provider exemption request, and stand by the position articulated in its post hearing memorandum.

The Provider commented, requesting that the Board's decision be affirmed. The Provider argued that the transaction between the Provider and the operator of Greenlawn did not constitute a CHOW. Further, the Provider claimed that CMS' position to the contrary is based on a misunderstanding of the transaction between the Provider and Greenlawn and a misconstruction of Massachusetts DON law.

With respect the Provider's purchase of Greenlawn, the Provider maintained that it did not purchase any assets from Greenlawn and that the purchase of "rights to operate" did not affect the Provider's right to a new provider exemption. Further, the Provider asserted that the plain language of the agreement between the Provider and Greenlawn shows that it was a contract for services and included no transfer of DON rights or any other asset. Citing the contract as proof of the transfer, the Provider pointed to the language of the agreement to show that the Provider would not acquire "any interest in the real estate, license, furnishings, equipment, receivables, notes or other assets" of Greenlawn. Also, the Provider argued that under Massachusetts law, it received its DON from MDPH and that even if it had wanted to transfer Greenlawn's DON, the State's law prohibited such a transfer. The Provider obtained a new DON under the 1996 Act that retroactively replaced its

prior one. Once Greenlawn surrendered the license to operate, it relinquished an asset to the Commonwealth of Massachusetts and created a new asset, DON rights which were subsequently granted to the Provider. Citing Chevron U.S.A. v. Natural Resources Defense Council, Inc, 467 U.S. 837, 844 (1984) the Provider argued that while Federal agencies are normally afforded some deference, deference is inappropriate where a Federal agency construes State law. Hence, CMS' denial of the Provider's new provider exemption request was erroneous because it disregarded the relevant state law.

Moreover, regarding transfer of rights, the Provider maintained that the Board correctly held that a transfer of "rights to operate" is not a transfer of ownership and does not trigger a review of services furnished by Greenlawn. The Provider asserted that the term under 42 C.F.R. § 413.30(c) unambiguously refers to an institution and not a DON. The Provider argued that CMS' interpretation of the term "provider" is erroneous and contradicts the definition in the Medicare statute since there is nothing within the statutory language that suggests that a provider or SNF equates to a DON only. A DON simply grants an institution the right to eventually secure a license which will allow a facility to provide health care services. Citing Astabula County Med. Ctr. V. Thompson, 352 F.3d 1090 (6th Cir. 2003) and Maryland Gen. Hosp. V. Thompson, 308 F.3d 340 (4th Cir. 2002) the Provider asserted that the term "provider" does not refer to a single asset, such as a DON. Furthermore, the Provider argued that CMS' interpretation of the term "provider" is inconsistent with its own published applications of the term. The Provider noted that the Medicare Intermediary Manual (MIM) states that a purchase of stock does not constitute a change of ownership for Medicare certification purposes unless there is a change in the entity that is legally responsible to the program. Also, the Provider asserted that the Chairman of the Provider Reimbursement Review Board stated in St. Elizabeth's Med. Ctr., PRRB Dec. No. 2002-D49 that the provisions of MIM show that the Medicare program views a provider as a business entity and that acquisition of DON rights alone do not represent a transfer.

Furthermore, the Provider maintained that CMS has reinterpreted the new provider exemption without notice and this constitutes a violation of due process rights and the Administrative Procedure Act (APA). With respect to the violation of due process rights, the Provider contended that the Fourteenth Amendment requires that an agency provide fair notice to those whom it regulates. Citing Shalala v. Guernsey Mem'l Hosp., 514 U.S. 87, 100 (1995), the Provider argued that if an agency changes its interpretation of a regulation or policy in a way that drastically impacts the rights of those that are regulated, the agency must provide notice and comment rulemaking under the provisions of the APA. Given that there is nothing in the Medicare statute, regulations or manual language that states that ownership would be imputed to a new provider simply by acquisition of a DON, CMS has created a

new interpretation while disregarding the APA and the due process clause of the Fourteenth Amendment.

The Provider noted that even if, for the sake of argument, there were a transfer of DON rights, CMS' past administrative decisions indicate that the transfer of DON rights do not constitute the sale of a provider. The Provider pointed to a letter dated May 23, 1994 where CMS granted a new provider exemption to Meridian Healthcare Center at Spa Creek, which had obtained some of its DON bed rights from another facility. Moreover, according to the Provider, CMS has approved new provider exemption requests by SNFs where the facility had converted from an NF. Hence, CMS' decision is inconsistent and conflicts with previous decisions thereby making it improper. In addition to this inconsistency, the Provider argued that CMS's reinterpretation of the new provider exemption goes against the Congressional intent of the Medicare statute, especially since the general goal is uniformity. CMS thwarts Congressional intent by its reinterpretation, which would bifurcate the reimbursement system into DON states and non-DON states. Hospitals in DON States would be denied exemptions because they would be forced to purchase DONs from another facility whereas States without a DON regime would automatically be granted an exemption because it would be a new provider of SNF services.

Also, the Provider claimed that CMS' interpretation is inconsistent with the purpose of the new provider exemption. CMS' interpretation of § 413.30(e)(1997) equates a provider with a DON. The purpose of the new provider exemption is to allow a provider to recover the higher costs that result from start up costs and low occupancy rates that occur while the provider attempts to build its patient population.[13] In the instant case, the Provider never operated a SNF and incurred a great deal of start up costs and had to undergo a great deal of construction, hiring of staff, and working to get Medicare certified. Moreover, the Provider's occupancy rate was low. By denying the Provider the exemption, CMS' actions were inconsistent with the purpose of the regulation. Despite the fact that CMS cites PRM § 2553.1 as the basis for its decision, the Provider argued that it cannot apply this provision retroactively. This provision did not become effective until September 1997. The Provider entered into its agreement with Greenlawn in March 1995 and submitted its new provider exemption request in June of 1997. Given that both of these dates were prior to the effective date of the provision, the Provider argued that CMS is engaging in retroactive rulemaking by applying this provision to the Provider. Citing Maryland General Hospital, the Provider asserted that this same

[13] See Astabula, 191 F. Supp.2d at 895.

provision was deemed inapplicable because it did not exist at the time of the transaction, which gave rise to the case.[14]

Notwithstanding the fact that the Board did not address the issue of whether Greenlawn operated as a SNF, the Provider maintained that CMS' determination that Greenlawn operated as such was erroneous. First, the Provider argued that SNFs and NFs are defined differently under Federal law and CMS' denial letter ignores this fact. The Medicare statute defines a Medicare-certified SNF as an institution that is primarily engaged in providing skilled nursing or rehabilitation services. 42 U.S.C. § 1395i-3(a). The Medicaid statute defines an NF as an institution that may be primarily engaged in either skilled nursing, rehabilitative care or "custodial care." In order for an NF to be equivalent to a SNF, the NF must provide primarily skilled or rehabilitation services. 42 U.S.C. § 1395i-3(a)(1). According to the Provider, CMS' assertion that Greenlawn existed as a SNF fails to acknowledge the Medicare statute since Greenlawn must have been "primarily" engaged in providing skilled nursing care or rehabilitative services in order to be considered a SNF.

Moreover, the Provider argued that CMS implemented an incorrect standard for determining new provider exemption applications. The Provider pointed out that CMS' stated practice was to deny a new provider exemption if it determined that a previous owner of the facility had provided a single skilled service to a patient during the look back period. As a result, CMS ignored definitions of SNFs and NFs and denied exemptions where the prior owner was not "primarily" engaged in providing skilled nursing or rehabilitation services. Despite the Provider having complied with all of the requirements for a new provider exemption, CMS used an erroneous standard when evaluating the Provider's request. The Provider also noted that Massachusetts law prohibited Greenlawn from operating as a SNF. As a Level III facility, Greenlawn was not licensed to provide regular skilled care especially since Massachusetts law would not allow it. If Greenlawn were to operate beyond the Level III it would have to obtain written approval from the MDPH and would require a new DON to be issued, but the Provider submitted evidence showing that Greenlawn never made such a request. In addition to ignoring Massachusetts law, the Provider accused CMS of relying on unreliable evidence in its claims that Greenlawn operated as a SNF. CMS cited reports from single dates in the years 1991-1993 respectively derived from the On-Line Survey and Certification System (OSCAR). The three year look back period precludes CMS from relying on reports from 1991 and 1992 and the OSCAR system lacks reliability as a basis for deriving the type of services rendered by a nursing facility, especially since the OSCAR reports cited by CMS do not represent ongoing services. In fact, according to the

[14] Maryland General Hospital, Inc. v. Thompson, 308 F.3d 340 (4th Cir. 2002).

Provider, the available evidence shows that Greenlawn was primarily engaged in custodial care and not skilled nursing care.

The Provider asserted that it was primarily engaged in providing skilled services. The Provider intended to serve many of its joint replacement patients as well as surgical patients, patients with fractures and cardiac problems, oncology patients and respiratory patients. The care received was from skilled professionals and all patients were seen at least daily by a physician. Moreover, the Provider contended that it did not engage in a great deal of unskilled, personal care services. Furthermore, the Provider argued that the exception requests indicate that it was primarily engaged in providing skilled services. The exception requests show that the average length of stay was 10.7 days in 1996 and 9.79 days in 1998. Furthermore, in 1996, 76 percent of the patients were discharged to their homes and in 1998, 78 percent were discharged to their homes. Given the short length of stay and that the majority of patients were discharged to their homes, the Provider argued that these facts show the intensity and purpose of the services it provided, which was that skilled care was being given to its patients. Since Greenlawn did not operate as a SNF, its operations cannot be imputed to the Provider since it was engaging in skilled services.

While the Provider admitted that the aforementioned arguments do not require further inquiry, the Provider sought to show that it was also entitled to a new provider examination based on relocation. Citing PRM § 2604.1, the Provider argued that it meets the requirements for an exemption based on relocation. The Provider noted the provision that requires that a new inpatient population be served and argued that the discharge of Greenlawn's entire inpatient population before it opened served as proof that the Provider was servicing a new group of people. Moreover, the Massachusetts licensure law precluded the two facilities from serving the same types of patients. The Provider also argued that this difference is proven by the fact that Greenlawn served patients with chronic conditions, generally mental illness, while its patients required short-term, skilled nursing and rehabilitation services so that the patients could return home. Although CMS' denial of the relocation decision was based on § 2533.1, the Provider maintained that this was improper. CMS' denial letter stated that the Provider did not qualify for a relocation based exemption because the Provider and Greenlawn are both located in HSA V and most of the patients in both facilities came from HSA V. The Provider asserted that § 2533.1 implements a new set of standards for exemption based relocation that were not included in the prior PRM provision. Also, the Provider argued that § 2533.1 cannot be applied retroactively. The Provider reasoned that even if the exemption were based solely on geography, it would still qualify for one. The Provider cited to St. Elizabeth's Medical Center of Boston v. BlueCross BlueShield

Association/Associated Hospital Services of Maine, [15] for the test articulated for an exemption. First, if the two locations are in the same HSA, CMS looks to the extent of the overlap in the cities and towns served by the old and new providers. While the Provider and Greenlawn were both located in HSA V, the patients that the two had in common came from only a small percentage within the towns served. Greenlawn served 24 towns, and the Provider served 29 of those towns. Of those towns, there were only three that overlapped. Although a large number of the Provider's patients came from the three overlapping towns, these patients only made up 49.8 percent of it's population. Even if this overlap percentage was considered substantial, the Provider contended that it should not be used in comparing the two facilities. The Provider asserted that § 2604.1 requires CMS to look at the patient population of the old facility to determine whether those patients will be served at the new location and not the other way around. In this instance, the Provider stated that the disparity would show, if anything, that a majority of Greenlawn's patients would not be served by the Provider.

With respect to jurisdiction over the years in question, the Provider argued that the Board correctly determined that it had jurisdiction over the issue of whether the Provider qualified for exemptions in fiscal years 1996, 1997 and 1998. The Provider maintained that the Medicare statute grants the Board jurisdiction that is broader than its prerequisites for an appeal. Citing Maine General Med. Center,[16] the Provider stated that the Board has the authority to decide matters beyond those enumerated in subsection (a). Even though the typical scenario would involve only the cost report from which the Provider appealed, the plain language of the statute does not require the Board to limit its review only to the single cost report being appealed by the provider. Furthermore, in prior decisions the Board has accepted jurisdiction over multiple years of a new provider exemption application, even though the provider only appealed a single cost year. Citing St. Elizabeth's Medical Center of Boston, the Provider argued that the Board has the right to look at other cost reporting years if it is relevant to the substance of the issue under dispute.[17] The Provider asserted that the new provider exemption regulation applies to multiple years. The Provider's annual cost reporting period runs from October 1 through September 30 and the first patient was accepted on December 11, 1995. Consequently, the exemption period would be from December 11, 1995 through the end of the fiscal year 1999, which represents the first cost reporting period beginning at least two years after the first patient was accepted.[18] The Provider maintained that it would be inefficient to require the Provider to appeal each NPR affected by the

[15] 396 F.3d 1228 (D.C.Cir. 2005).
[16] Maine General Medical Center v. Shalala, No. 98-1065, (1st Cir. 2000).
[17] 396 F.3d 1228 (D.C.Cir. 2005).
[18] See 42 C.F.R. § 413.30(c).

Provider's exemption application. There are no facts that distinguish one year from the other thereby it would be unnecessary and a waste of the Board's resources.

Finally, the Provider responded to CMM's comments which argued that the Administrator should reverse the Board's holdings. First, the Provider noted that CMM's assertion that the facts and the law support the finding of a CHOW thereby requiring the three year look back are erroneous. The Provider maintained that CMM mischaracterizes the actual transaction between the parties and ignored that the contract is for services and nothing else. Furthermore, the Provider argued that CMM cannot contend that the 1996 Massachusetts DON Act is inapplicable. The Provider reasoned that if CMM asserted that State law has no impact on the application of Medicare law, then all of Massachusetts DON law has no effect on the application of Medicare law, thereby precluding the Secretary from considering whether Medicare certification requirements when a Medicare provider changes ownership. Also, the Provider pointed to the fact that Greenlawn was not a Medicare provider and that CMM cannot support its argument by referencing CHOW regulations. Lastly, the Provider asserted that CMM misinterpreted the Board's authority to determine whether a new provider exemption determination should apply to multiple years. The Provider reiterated the fact that Medicare regulations allow the Board to consider cost reporting periods at the end of the SNFs first cost reporting period beginning at least two years after the provider accepts its first patient.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments are included in the record and have been considered.

Since its inception in 1966, Medicare's reimbursement of health care providers was governed by § 1861(v)(1)(A) of the Act. Section 1861(v)(1)(A), provides that, "reasonable cost shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services."

However, the Secretary has also been granted authority under § 1861(v)(1)(A) of the Act to establish:

> limits on the direct and indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in

> the efficient delivery of needed health services to individuals covered by the insurance programs established under this title....

Implementing § 1861(v)(1)(A) of the Act, the Secretary has promulgated the regulation at 42 CFR 413.30 which sets forth the general rules under which CMS may establish routine cost limits on the reasonable costs of providers. The regulation further establishes rules which govern exemptions from and exceptions to limits on cost reimbursement in order to address the special needs of certain situations and certain providers. In this case, the Provider requested an exemption from the routine cost limits for new providers. This exemption is set forth in the regulation at section 413.30(e), which reads:

> Exemptions from the limits imposed under this section may be granted to a new provider. A new provider is a provider of inpatient services that has operated as the type of provider (or the equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years. An exemption granted under this paragraph expires at the end of the provider's first cost reporting period beginning at least two years after the provider accepts its first patient.

In this case, the issue is whether the Provider was operating 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." When determining whether a SNF provider has operated as a SNF or its equivalent for three years, CMS looks at the services of the institution as a whole prior to certification.

Notably, the U.S. Court of Appeals for the District of Columbia recently rendered St. Elizabeth's v. Thompson.[19] In St. Elizabeth's, a SNF had requested a new provider exemption after purchasing operating rights from a Medicaid nursing facility (NF). CMS determined that, under the law, both NFs and SNFs are required to provide the same fundamental range of services, i.e., nursing and specialized rehabilitative services meeting a certain standard. Thus, CMS found that the Provider was not a "new provider" for purposes of the 42 CFR 413.30(e) exemption. However, on review, the Court of Appeals found that the record did not show that the NF was "primarily engaged"[20] in providing skilled nursing or rehabilitative

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[19] 396 F.3d 1228 (D.C.Cir. 2005).

[20] The Act defines a SNF at §1819(a)(1) as an institution which: "is primarily engaged in providing to residents – (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the

services. Thus, the Court reversed CMS' determination that the NF operated as a SNF or equivalent provider of services.

The Administrator continues to maintain the validity of CMS policy as set forth in the CMS determination litigated in St. Elizabeth's.[21] However, under §1878(f)(1), the District of Columbia is a judicial district in which this Provider may file suit and, thus, St. Elizabeth's is binding case law here. Accordingly, the Administrator finds it proper to remand the instant case to CMS to apply the Court's criteria in St. Elizabeth's to the particular facts of this Provider's exemption request and to determine whether the Provider's request for a new provider exemption should be allowed under the St. Elizabeth's criteria.[22] This remand is limited to the facts, circumstances, and cost year presented in this specific case.[23]

Accordingly, the Administrator orders:

THAT the decision of the Provider Reimbursement Review Board be vacated; and

THAT this case is remanded to CMS to apply the Court's criteria in St. Elizabeth's Medical Center of Boston v. Thompson to the Provider's exemption request; and

THAT a CMS decision on the Provider's exemption request will be rendered as expeditiously as possible; and

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rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases." 42 CFR 409.33 of the regulations also sets forth examples of skilled nursing and rehabilitative services.

[21] Admr. Dec. 2002-D49; 396 F.3d 1228 (D.C.Cir. 2005).

[22] The Provider has pointed out that a CMS analyst responsible for staff work on provider exemptions testified before the Board. However, this staff person does not have the delegated authority to make new provider exemption determinations. As no determination has been made by CMS as to whether the prior owner was "primarily engaged" in providing SNF or rehabilitative services, remanding the case to CMS for such determination is appropriate.

[23] The Administrator agrees with the Dissenters that this case is limited to the FYE 9/30/98 cost report appeal of the new provider exemption. See also Larkin Chase Nursing and Restorative Care Center, PRRB Nos. 98-0388 and 00-3079 (12/12/00)(a provider is required to challenge a CMS determination on a RCL request pursuant to its appeal of its NPR). Moreover, Section 1878 (a)(1) of the Act refers to appeals of final determinations "for which payment may be made under this Title for the period covered by such report." Thus, as the right to a Board hearing is specifically for a cost reporting period, the proper appeal of one cost report does not confer to the Board jurisdiction to review other cost reports not otherwise appealed.

THAT the CMS decision on the Provider's exemption request pursuant to the criteria set forth in St. Elizabeth will follow the provisions of 42 CFR 413.30(c).

Date: 4/30/07 /s/

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services

THAT the CMS decision on the Provider's exemption request pursuant to the criteria set forth in St. Elizabeth will follow the provisions of 42 CFR 413.30(c).

Date: _____ _____

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services