CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
St. Gertrude's Health Center **Provider** **vs.** **Blue Cross Blue Shield Association/ Noridian Administrative Services** **Intermediary**	**Provider Reimbursement for Cost Reporting Period Ending: June 30, 1997 and June 30, 1998** **Review of: PRRB Dec. No. 2007-D38 Dated: May 23, 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. The parties were notified of the Administrator intention to review. Comments were received from the Center for Medicare Management (CMM), requesting reversal of the Board's decision. 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, St. Gertrude's Health Center, is a fifty-one bed[1] skilled nursing facility (SNF), located in Shakopee, Minnesota. The Provider's newly-constructed facility opened on November 4, 1996. The Provider became Medicare-certified on November 8, 1996.

[1] The Provider subsequently obtained 24 additional beds from Valley View Health Care Center. See Transcript of Oral Hearing (Tr.) at pp. 47-49.

The State of Minnesota had a moratorium on the licensure and medical assistance certification of new nursing home beds and construction projects.[2] Hence, there was no Certificate of Need (CON) process available to permit the new facility to be built. However, the moratorium allowed exceptions for replacement beds.[3] Valley View Health Care Center, Inc. (Valley View), a skilled nursing facility located in Jordan, Minnesota, applied for an exception to the nursing home moratorium to replace its entire 102-bed facility on a new site in the City of Jordan. Valley View's request was approved by the State of Minnesota Department of Health on January 12, 1994, but the plans to replace the existing facility went unfulfilled and a special request was subsequently made to the State Legislature. This request was approved by the Governor in 1995 to allow Valley View to relocate up to 50 percent of its existing 102 beds to another location. In November 1996, Valley View relocated 51 of its beds to the Provider pursuant to the special legislation. Valley View continued to operate as a nursing home until its closure on May 9, 2000.[4]

The Provider and Valley View, inter alia, both utilized the same long-term care management company, Health Dimensions, Inc., (also referred to as HDI), to manage their long-term care facilities. On January 7, 1997, the Provider submitted a request to be exempted from the SNF RCLs for cost reporting periods ending June 30, 1997 and June 30, 1998. A final determination was rendered by CMS in August 1997, denying the Provider's request because the transfer of bed rights was considered a change of ownership; Valley View had operated as a SNF during the three years prior to the transfer; and the population served or primary service area did not substantially change.[5]

ISSUE AND BOARD DECISION

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

The Board recognized that the State of Minnesota had a moratorium on the licensure and certification of new nursing home beds and construction projects. The Provider

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[2] See Minnesota Statute, §144A.071, Exhibit I-15.
[3] Id. at §144A.073, Exhibit I-16.
[4] An additional request was made to and approved by the State Legislature in 1999 allowing for up to 75 beds to be relocated. See Minnesota Statute, §144A.073, Subdivision 5, Replacement restrictions, subsection (g). See Intermediary Exhibit I-16 at 285.
[5] See Intermediary Exhibit I-12.

obtained bed rights under special legislation that permitted Valley View, an unrelated SNF, to transfer 51 of its beds to the Provider. The Board noted that the Provider was a newly-constructed facility that had not previously operated, and other than bed rights, did not obtain any other assets from Valley View.

The Board observed that the issue has been addressed in various other Board decisions. The Board has previously found that the acquisition of bed rights alone from an unrelated provider through the purchase of a CON, or other mechanism used to transfer bed rights does not, in itself, constitute a CHOW, nor does it affect the "new" provider's right to an exemption.[6] The Board found that CMS' guidelines, that impute ownership of an unrelated provider to a provider that purchases a CON or obtains bed rights through other mechanisms, are inconsistent with the Medicare regulation at 42 C.F.R. §413.30(3).

The Board noted that this issue has also been addressed in a number of court decisions. In Ashtabula County Medical Center v. Thompson, 191 F. Supp. 2nd 884 (N.D. Ohio, Feb. 8, 2002), (Ashtabula), aff'd, 352 F.3d 1090 (6th Cir. 2003), the Court found that the Secretary's interpretation of the new provider regulation was arbitrary, capricious, and erroneous with respect to the Secretary's position that the acquisition of bed rights from another provider is a completely different situation than when bed rights are acquired, for example, from a State authority. Under CMS' position, in the first situation the acquisition causes an immediate "lookback" into the services furnished by the relinquishing provider and the potential denial of a new provider exemption. In the second situation, there is no lookback and a new provider exemption is granted. The Court in Ashtabula found that providers in moratorium States that purchase CON rights from unrelated providers fit comfortably within the language and purpose of the new provider exemption.

The Board also cited to the case of Maryland General Hospital, Inc. v. Thompson, 308 F.3d 340 (4th Cir. 2002), where the court found that the term "provider," as used in 42 C.F.R.§413.30(e), unambiguously refers to the business institution providing the skilled nursing services. The Court further noted that the regulation permits the consideration of the institution's past and current ownership, but not the past and current ownership of a particular asset [the CON rights] of that institution. The Court explained that the Secretary's interpretation equates the ownership of an institution providing skilled nursing services, with the ownership of a particular asset of that institution. The Court concluded that there is no language in the regulation that would permit the denial of the exemption, based on an asset of the new

[6] See St. Elizabeth's Medical Center, PRRB Dec. No. 2002-D49, September 30, 2002, Harborside Healthcare-Reservoir, PRRB Dec. No 2006-D14, January 25, 2006.

institution was previously owned by an unrelated SNF. Thus, the Court found that the Secretary's interpretation was inconsistent with the plain language of the regulation.

The Board relied on the decisions in the above-referenced cases. The Board noted that the Provider was not located in the judicial circuits that have held the Secretary's interpretation of the regulation permissible.[7] The Board found that there was no common ownership of the Provider and Valley View and, therefore, Valley View cannot be considered a past or present owner of the Provider. The Board further noted that the Provider did not purchase bed rights from Valley View, but merely received, from the State, the beds that Valley View relinquished.

The Board found that based upon the facts, CMS improperly denied the Provider's request for an exemption to the SNF's RCLs. The Board reasoned that the Provider's acquisition of bed rights from Valley View through special State legislation did not constitute a change in ownership or CHOW, and the types of services that were provided by Valley View were not relevant. The Board found that the Provider met the definition of a "new" provider as set forth at 42 C.F.R. §413.30(e) in that it is a licensed and Medicare-certified SNF that has operated as this type of provider for less than three years. The Board also found that, because the Provider met the threshold test for entitlement to a new provider exemption, it obviated the need to address whether the Provider qualified for an exemption under other criteria. The Board concluded that the CMS' denial of the new provider exemption was improper.

SUMMARY OF COMMENTS

CMM commented, requesting that the Board's decision be reversed. CMM argued that the plain language of the regulation at 42 CFR 413.30(f) requires that CMS look at the operation of the facility under past and present ownership in order to render a determination as to whether or not a facility is eligible for an exemption. CMM emphasized that the facts in this case indicated that Health Dimensions, Inc., or HDI was the owner of Valley View, a 102-bed skilled nursing facility located in Jordan, Minnesota, and was also the owner of the Provider, St. Gertrude's Health Center. St. Gertrude's was established as a replacement facility for Valley View by ultimately relocating and re-licensing 75 beds from Valley View to the South Valley Health Campus, Shakopee, Minnesota (future home of St. Gertrude's). CMM argued that the application for an exception submitted by Valley View to the State of

[7] See South Shore Hospital, Inc. v. Thompson, 308 F.3d 91 (1st Cir. 2002), Paragon Health Network v. Thompson, 251 F.3d 1141 (7th Cir. 2001), and Providence Health System v. Thompson, 351 F.3d 661 (9th Cir. 2003).

Minnesota clearly established that Valley View requested, and the State simply approved, a replacement facility for Valley View due to its demonstrated need for a new building to replace the current facility. CMM maintained that no new nursing home beds were added to the system, and instead, the existing licensed capacity was moved from one location to another, along with the residents, to provide for a new building.

CMM disagreed with the Board's finding that St. Gertrude did not purchase bed rights from Valley View, but merely received from the State the beds that Valley View relinquished. CMM alleged that Valley View never relinquished the bed rights to the State. Instead, Health Dimensions, Inc., the owner of Valley View, initially built a 51 bed replacement facility which was later expanded to 75 beds. At that time, the original facility was closed, the remaining population at Valley View was transferred to St. Gertrude's, and the remaining beds were de-licensed.

Moreover, CMM argued that the Board's was incorrect to find that the types of services that were provided by Valley View were not relevant. The type of facility (the types of services provided), is highly relevant to a determination as to whether or not a facility is eligible for an exemption. Valley View was a Medicare-certified SNF, both before and after its replacement by the South Valley campus [i.e., St. Gertrude]. CMM alleged that the fact that Valley View was primarily engaged in the provision of skilled nursing and related services or rehabilitative services for more than three years prior to its replacement is crucial to the new provider exemption determination. CMM argued that, for the following reasons, the Board's decision regarding the merits of the case should be reversed.

The Provider commented, requesting that the Board's decision be affirmed. The Provider agreed with the Board's decision that there was no common ownership and that St. Gertrude's did not purchase beds from Valley View. The Provider argued that no assets changed hands between the privately-owned, for–profit facility and the non-profit owned, non-profit facility, St. Gertrude's. The Provider noted that Valley View continued in operation as a long-term care facility, under separate ownership and its same provider number, for approximately five more years. The Provider claimed that the only "link" between the facilities is that both utilized Health Dimensions, Inc., to manage their facilities. Further, the Provider noted that, when it opened, no residents of Valley View moved over to the new facility because the type of care was significantly different and aimed at different populations. The Provider was "new" as it was issued a separate provider number, no staff was shared between the entities, no beds were leased from any other facility, and St. Gertrude's building was new. The Provider argued that it did not accept Medicaid patients until 2000, and Valley View closed in 2000.

The Provider reasoned that, because there is no common ownership, Valley View cannot be considered a "past or present" owner of St. Gertrude's. The Provider noted that ownership is a key factor in determining "new provider" status. The Board, in Rogue Valley Medical Center Medford, PRRB No: 97-2174 (2005), denied the exemption because the new facility's owner had provided SNF services under past and present ownership at the time the hospital-based SNF was licensed. The new facility had been created by the delisting of beds at another facility; however, the facilities were both owned by the same entity. The Provider argued that St. Gertrude's was created by similar legislation to Rogue Valley, but St. Gertrude's served a very different population than Valley View with significantly different inpatient days.

The Provider pointed out that the Board has recognized that acquisition of beds alone from an unrelated party does not constitute a CHOW. The Provider supported the Board's holding that any other interpretation which imputes ownership to be inconsistent with Medicare regulations.

Furthermore, the Provider referenced the Board's decision granting the exemption to a provider in St. Joseph's Health Services of R.I, PRRB No. 00-2981 (May 13, 2005). The Provider noted that St. Joseph's, like St. Gertrude's, provided "skilled nursing care and rehabilitative services to patients with relatively intense post-acute needs." As with St. Gertrude's, the length of stay between the new facility and the "old" facility were quite dissimilar, ranging from days to several years. The Provider pointed out that St. Gertrude's patient stays averaged 15 days, while Valley View patients were residents for many years requiring different types of services. The Provider argued that under both St. Joseph's and Rouge Valley, St. Gertrude's qualified for the exemption because the populations served are distinct and the ownership is different.

The Provider also referenced the Board's decision in Spalding Rehabilitation Hospital Englewood, PRRB Case No. 99-0321 (March 7, 2003), which it asserted is factually similar to the case at bar. The Provider argued that, since the facilities were not part of the same institution, the exemption was appropriate as the facilities shared no employees, medical staff or administrators; operated under separate Medicare certifications and separate licenses; and there was no significant overlap of patients served. The Provider maintained that, in addition to that, Valley View and St. Gertrude's were not owned by the same institution, as Valley View was owned by individuals in a for-profit setting and St. Gertrude's was owned by Benedictine Health System (BHS), a not-for-profit entity.

The Provider claimed that it was not owned by the same entity as Valley View; there was no past or present ownership of the St. Gertrude's beds; and there was no asset

purchase, even of the intangible right to operate. The Provider opened under a new provider number after receiving an award of beds through State legislation, had no tangible or intangible connection to Valley View or any of its assets, and Valley View continued to operate after the Provider opened.

Finally, the Provider argued that, in States like Minnesota with a moratorium, providers are penalized by CMS. In moratorium States, no new beds are created, which means that beds must be eliminated from one facility for a new facility to open. The Provider claimed the Intermediary's analysis was flawed as it would mean that no provider in a moratorium State could ever receive a new provider exemption status. However, States that operate under a CON system create new beds and, thus, are eligible for the exemption. In summary, the Provider maintained that the Intermediary broadly swept the legislation required in a moratorium State into the category of asset transfer, while in fact, the transaction to create St. Gertrude's was anything but an asset transfer. The Provider claimed that there was no transfer of a license; there was no transfer of assets; no staffing crossed over; and no patients migrated to St. Gertrude's. The Provider concluded that the regulations are not designed to eliminate the exemption and certainly are not meant to discriminate against States that operate under a moratorium system. Thus, the Board's position should be affirmed.

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), which provides that:

> reasonable cost of any services shall be the cost actually incurred, excluding there from 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 or 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….

Section 223 of the Social Security Act of 1972 amended section 1861(v)(1)(A) to authorize the Secretary to set prospective limits on the costs reimbursement by Medicare.[8] These limits are referred to as the "223 limits" or "routine cost limits" (RCL), and were based on the costs necessary in the efficient delivery of services. Beginning in 1974, the Secretary published routine cost limits in the Federal Register. These "routine cost limits" initially covered only inpatient general routine operating costs.

In 1982, in an effort to further curb hospital cost increases and encourage greater efficiency, Congress established broader cost limits than those authorized under section 1861(v)(1)(A), the existing routine cost limits. The Tax Equity and Fiscal Responsibility Act (TEFRA) added section 1886(a) to the Act, which expanded the existing cost limits to include ancillary services operating costs and special care unit operating costs in addition to routine operating costs. Pursuant to section 1886(a)(1)(ii) of the Act, these expanded cost limits, referred to as the "inpatient operating cost limits," applied to cost reporting periods beginning after October 1, 1982. Relevant to this case, exceptions and exemptions to the "routine cost limits" or RCLs were promulgated at 42 CFR 413.30.

The Secretary's regulation at 42 CFR 413.30 sets forth the general rules under which CMS may establish payment 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 cost limits for new providers. The exemption is set forth in the regulation at §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 [Emphasis added.](1996)

[8] Pub. Law 92-603.

As applicable to the issue in this case, the term "equivalent" in the regulation refers to whether, prior to certification, the institutional complex was providing skilled nursing care and related services for residents who required medical or nursing care, or rehabilitative services for injured, disabled or sick individuals.[9]

In promulgating the new provider exemption, the Secretary recognized that "new" providers serving inpatients could face difficulties in meeting the application of the cost limits during the initial years of development due to underutilization.[10] Consistent with this regulation, the Provider Reimbursement Manual (PRM) at section 2604.1 (1994) states:

> A new provider is an institution that has operated in the manner for which it is certified in the program (or the equivalent thereof) under present and previous ownership for less than three full years. For example, an institution that has been furnishing only custodial care to patients for two full years prior to its becoming certified as a hospital furnishing covered services to Medicare beneficiaries shall be considered a "new provider" for three years from the effective date of certification. However, if an institution has been furnishing hospital health care services for two full years prior to its certification it shall only be considered a "new provider" in its third full year of operation, which is its first full year of participation in the program.
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> ….
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> Although a complete change in the operation of the institution …shall affect whether and how long a provider shall be considered a "new provider", changes of institution ownership or geographic location do not itself alter the type of health care furnished and shall not be considered in the determination of the length of operation.
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> ….

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[9] See also Section 2533.1 of the PRM ("The term 'equivalent' refers to whether or not, prior to certification, the institutional complex engaged in providing either (1) skilled nursing care and related services for residents who request medical or nursing care; or (2) rehabilitation services for the injured, disabled, or sick persons identified in 42 CFR 409.33(b) and (c).) The term "equivalent" services was also addressed by the court in St. Elizabeth's Medical Center of Boston, Inc., v. Thompson (D.C. Cir. Feb. 4, 2005).

[10] See 44 FR 15745, March 15, 1979 (Proposed Rule) and 44 FR 31802, June 1, 1979 (Final Rule).

> However, for purposes of this provision, a provider which relocates may be granted new provider status where the inpatient population can no longer be expected to be served at the new location. The distance moved from the old location will be considered but will not be the determining factor in granting a new provider status…. A provider seeking such new provider status must …demonstrate that in the new location a substantially different inpatient population is being served. In addition, the provider must demonstrate that the total inpatient days at the new location were substantially less than at the old location for a comparable period during the year prior to the relocation. The periods being compared must be at least 3 months in duration. (Emphasis added.)

The Administrator notes that Section 2604.1 was removed by Transmittal No. 400, dated September 1997, after the January 1, 1997 date of the Provider's exemption request, but prior to the end of the Provider's requested exemption period. The Transmittal stated that new §2533.1.A of the PRM set forth, *inter alia*, longstanding Medicare policy and explained that a new provider is an inpatient facility that has operated as the type of provider (or the equivalent) for which it is certified for Medicare under present and/or previous ownership for less than three years. Section 2533.1.B.1 explains that if the institution has operated as a SNF, or its equivalent, for three or more years, under past and/or present ownership, prior to Medicare certification, it will not be considered a new provider.[11]

Furthermore, when determining whether a provider is in fact, a "new" provider under the regulation, CMS considers whether the SNF in question was established through a change of ownership or "CHOW." Notably, Section 2533.1 looks to the pre-existing and longstanding definition of a CHOW set forth in Section 1500, et seq., of the PRM, which was in effect at the time of the Provider's request in this case. Section 2533.1.E of the PRM explains that 42 CFR 413.30(e) requires CMS to examine the operations of the institution both under past, and present, ownership to

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[11] The PRM at §2533.1B3 also addresses the relocation exemption, stating in part that: (a)n institution … that has undergone a change in location may be granted new provider status when the normal inpatient population can no longer be expected to be served at the new location. In this case, the institution … must demonstrate that in the new location a substantially different inpatient population is being served…. The normal inpatient population is defined as the health service area (HSA) for long term care facilities, or its equivalent, as designated by the State planning agency or local planning authority in which the institution …. is located."

determine if it is eligible for a new provider exemption. Paragraph E.1 explains the transaction types also discussed at section 1500.,et seq., of the PRM and sets out specific examples. Section E states in pertinent part that:

> 42 CFR 413.30(e) requires [CMS] to examine the operations of the institution … both under past and present ownership to determine if an institution … is eligible for a new provider exemption. The mere existence of a CHOW does not in itself make an institution or institutional complex eligible for a new provider exemption.
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> 1. Transaction types - The Medicare program polices pertaining to the various types of CHOW transactions may be different from the treatment under generally accepted accounting principles. Sections 15001, 1500.2, 1500.3, 1500.4, 1500.5, 1500.6, 1500.7 and 1500.8 discuss, in general the most frequent types of transactions which affect the ownership of provider organizational structures. The events described below represent specific examples of CHOW transactions that will be considered in determining eligibility for a new provider exemption, but are not intended to represent all possible situations…
> ….
> b. Disposition of all or some of an institution … or its assets used to render patient care (see 1500.7).—Disposition of all or some portion of an institution … or its assets (used to render patient care) through sale, scrapping, involuntary conversion, demolition or abandonment, if the disposition affects licensure or certification of the institutional complex, is considered a CHOW. For example, an institution… purchases the right to operate (i.e.; certificate of need) long term care beds from an existing institution…that has or is rendering skilled nursing or rehabilitative services to establish (in whole or part) a long-term care facility or to enlarge an existing long-term care facility.
> c. Reallocation or consolidation of long term care beds from an existing institution...to another institution…..

The longstanding policy set forth at PRM at section 1500, et seq., gives several examples of CHOW transactions and explains that:

> Most of the events described represent common forms of changes of ownership, but are not intended to represent an exhaustive list of all possible situations….The described events are not intended to define

> changes of ownership for purposes of determining historical costs of an assets or the continuation of the provider agreement.[12]

Notably, Sections 1500.1 through 9 addresses, the change of ownership through change in the composition of partnership, sale of unincorporated sole proprietorship, merger or consolidation, leasing, transfer of government owned institution, donation, "other disposition of assets" and bankruptcy. For example, Section 1500.6, explains when a change in ownership of ownership occurs with respect to a donation and states that:

> A donation of all or part of a provider's facility used to render patient care, if the donation affects licensure or certification of the provider entity.

Similarly, section 1500.7 of the PRM describes an example of other CHOW transaction as the:

> Disposition of all or some portion of a provider's facility or assets (used to render patient care) through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity.

The Court of Appeals in South Shore Hospital, Inc. v. Thompson, supra, determined that in order for a CHOW to be found, the transfer of the assets must "affect" licensure or certification, "not that it be the dispositive factor." The Court found that: "Here the DON rights were a *sine qua non* for the operation of a nursing home…."

In finding that a CHOW occurs when the beds are transferred, the Secretary has explained that a transfer of the license or certification for certain beds does not result in the provision of any new services. Even though the transferee might have new equipment, staff, etc., it will provide the same kind of services as the transferor of the beds, just at a different location. The Court of Appeals in Paragon Health Network, Inc., v. Thomspon, supra, refused to find unreasonable the Secretary's interpretation that, where the licenses or certification for the beds are transferred, there are no new services being provided and, thus, there is no new provider. In addition, the Court of Appeals aptly stated in South Shore that:

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[12] Rev. 332 (1985).

> To sum up, we find no plausible reason to discredit the Secretary's rationale that, when a facility purchases another's [CON] rights in a moratorium state, lessened competition will enhance initial utilization …. On that rationale it makes sense, for purposes of construing the new provider exemption, to attribute the operations of the seller to the acquirer of the DON rights.

The Administrator finds that CMS' policy regarding CHOWs in the new provider exemption context is also related to the purpose of the exemption, e.g., to grant relief for underutilization. As the Secretary reasoned and the Court of Appeals concurred in Paragon:

> At the time in question, SNFs were reimbursed under Medicare the lesser of the reasonable cost of or the customary charge for the service in question…. The definition of "reasonable cost" excludes any "cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. § 1395*x*(v)(1)(A). The Secretary contends, as with the textual argument above, that the transfer of CON rights simply shifts around SNF services. Creating a new facility and moving services to it, ... is costly, but no benefit is gained in the overall delivery of health services if the new facility is providing the same services to the same populace as the old one. Thus, the Secretary's judgment that the high start-up costs of [the provider] were "unnecessary in the efficient delivery of needed health services" is a reasonable one that will not be disturbed by this court. *Id*. at 1150-1151.

In the instant case, the State of Minnesota enacted a certificate of need program (CON) in 1979. However, in 1983 a moratorium was added, and in 1984 the CON program was removed. The purpose of the moratorium on the licensure and medical assistance certification of new nursing home beds and construction project in excess of $1,000,000 was to control nursing home expenditure growth and enable the State to meet the needs of its elderly.[13]

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[13] See Minnesota Statutes, §144.071 Subdivision 1. Under this Statute, the Commissioner of Health must deny each request for new licensed or certified nursing home beds except as authorized by exception. See Minnesota Statutes, §144.071 Subdivision 2. Pursuant to §144A.073, subdivision 5, for proposals approved on January 13, 1995 involving the replacement of 102 licensed and certified beds, the relocation of the existing first facility to the new location may include the relocation of up to 75 beds of the existing facility, as the six-mile limit does not apply to this relocation.

Valley View was certified as a Medicare SNF provider from 1985 onward.[14] Valley View submitted an application for an exception to the nursing home moratorium to the State Interagency Long-Term Care Planning Committee, dated October 12, 1993.[15] The sole purpose of this application was to replace the entire 102-bed skilled nursing facility. The application detailed the construction of the new facility and included a cost estimate for a new 46,000 square foot facility that was projected to cost just over six million dollars. The application claimed that in 1993, Valley View was the only nursing home in Jordan and it serviced the communities of Jordan, Chaska, and Shakopee. Seventy-five of the beds were certified to participate in the Medicare program. The Minnesota Department of Health notified Valley View on January 12, 1994, that its proposal for a project requiring an exception to the nursing home moratorium was approved.[16] The Commissioner approved the Valley View project due to the demonstrated need for a new building to replace the current facility.

Subsequently, in 1995, the Governor approved a provision that allowed "for proposals approved on January 13, 1994,… involving the replacement of 102-licensed and certified beds, the relocation of the existing first facility [Valley View] to the second and third locations… may include the relocation of up to 50 percent of the beds of the existing first facility [Valley View] to each of the locations. The six mile limit… does not apply to this relocation to the third location."[17]

In July 2006, St. Francis Regional Medical Center relocated to what is referred to as the "South Valley Health Campus" (the future St. Gertrude's Campus) in Shakopee, Minnesota.[18] Prior to construction, the hospital worked with one of its clinics and an area developer to build a one-stop medical campus now called South Valley Health Campus. The St. Francis Regional Medical Center has been a Member Institution of the Benedictine Health System (BHS) since October 8, 1987. On August 5, 1996, the BHS entered an agreement with Health Dimensions, Inc. (HDI) resulting in BHS committing to lend HDI $6,000,000 over the next three years for various healthcare projects. It gave BHS the right to purchase the full equity interest of HDI on September 30, 1996 at fair market value.[19] As a result, BHS acquired St. Gertrude's Health Center, which was owned by HDI. Notably, the record does not show when or how HDI established or acquired the entity called St.

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[14] See Intermediary Exhibit I-62.
[15] See Intermediary Exhibit I-10, pp. 165-242.
[16] See Intermediary Exhibit I-10, pp. 163-164.
[17] See Minnesota Statutes, §144.073, Subdivision 5, subsection (g).
[18] See Intermediary Exhibit I-18, p. 290.
[19] See Intermediary Exhibit I-18, pp. 290-291.

Gertrude's Health Center or its assets. St. Gertrude filed Articles of Incorporation on August 19, 1996 with the Minnesota Secretary of State to operate as a non-profit corporation.[20] The transaction involved the acquisition of certain assets and the assumption of certain liabilities of St. Gertrude's Health Center.

On September 28, 1996, HDI filed an application for Medicare certification for St. Gertrude's with the CMS.[21] HDI and BHS subsequently entered into an "Agreement to Provider Management Services" to South Valley Transitional Care Center (renamed St. Gertrude's Health Center), noting in the agreement that BHS is the owner of a long term care facility on the South Valley Campus, Shakopee, Minnesota.[22]

The State of Minnesota, Minnesota Department of Health licensed St. Gertrude's to operate 51 nursing home beds effective November 4, 1996.[23] The State Survey Agency submitted to the Department of Health and Human Services, a CMS-1539, Medicare/Medicaid Certification and Transmittal for initial SNF certification, recommended effective November 8, 1996, for a total of 35 beds located in the West and East Units on December 27, 1996.[24] Subsequently, CMS notified St. Gertrude's that it was accepted to participate in the Medicare program as an SNF, effective November 8, 1996 on December 30, 1996.[25] The Minnesota Department of Health notified Valley View that its Medicare-certified area consisted of all 51 licensed nursing home beds, effective December 12, 1996.[26] Valley View had its capacity reduced from 102 licensed beds to 51 licensed beds on the license effective January 27, 1997.[27]

The Governor then approved an amendment to the Statute (chapter 245, S.F.No.2225) relating to 144A.073 Subd. 5(g) in 1999, to state that the replacement of Valley View's 102 licensed and certified beds, and "the relocation of the existing first facility [Valley View] to the new location [St. Gertrude's] may include the relocation of up to 75 beds of existing facility [Valley View]." The relocation of an additional 24 beds to St. Gertrude's from Valley View, and the transfer of Valley View's Medicaid-eligible patient population to St. Gertrude's prior to Valley View's closure on May 9, 2000 occurred as a direct result of this legislation. At this

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[20] See Intermediary Exhibit I-6, pp. 59-67.
[21] See Intermediary Exhibit I-6.
[22] See Intermediary Exhibit I-20, pp. 323-327.
[23] See Intermediary Exhibit I-6, pp. 18-22.
[24] See Intermediary Exhibit I-6, pp. 71-72.
[25] See Intermediary Exhibit I-6, pp. 151-152.
[26] See Intermediary Exhibit I-74.
[27] See Intermediary Exhibit I-21, p.329.

time, the former owner of the beds was no longer licensed as a nursing home and became licensed as an assisted living facility.[28]

In a letter dated September 21, 1999, the Provider now called, St. Gertrude's, as a Benedictine Transitional Care Facility, described its intention of transitioning residents from Valley View to St. Gertrude's and stated that the transition would be completed no later than March 1, 2000.[29] It went on to further state that "effective January 1, 2000 patient/residents of St. Gertrude's Health Center will be eligible to receive Medical Assistance [MA] reimbursement… this will allow an incremental downsizing of Valley View and orderly transfer of MA residents from Valley View to St. Gertrude's."[30] It later stated that "the MA certification would be transferred to St. Gertrude's because of the common ownership and control inside a single corporation and the "merger" nature of this coming together."[31]

After a review of the record and applicable law and policy, the Administrator finds that the Board's was incorrect to find that their was no common ownership of the Provider, St. Gertrude's Health Center, and the former owner of the beds, Valley View. The record contains limited evidence with respect to the ownership of Valley View. The Provider's witness (a former consultant to Valley View) alleged that Valley View was owned by two individuals and that HDI (later purchased by BHS) acted only as a management company.[32] However, the Intermediary memorialized a statement from the State staff that HDI had purchased Valley View from the private owners and sought the relocation of the entire facility, which ultimately resulted in the creation of St. Gertrude's.[33] Further, the Provider's own letter, dated September 21, 1999, in discussing the transfer of Medicaid patients from Valley View, refers to the smooth transfer of the medical assistance certification to St. Gertrude's because of the common ownership and control of the two facilities.[34] Therefore, the Administrator finds that, based on this evidence in the record, the HDI and Valley View appeared to be indistinguishable. Moreover, the record is devoid of any explanation as to the reason the beds were transferred to the Provider, allegedly without any monetary consideration.[35] The lobbying by Valley View for

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[28] See Intermediary Exhibits I-23 and I-24.
[29] See Intermediary Exhibit I-22, pp. 330-331.
[30] Id. at 330.
[31] Id. at 330.
[32] See Transcript at 25, 27, and 31.
[33] See Intermediary's Supplemental Position Paper, n.1.
[34] Supra, n.30.
[35] Notably, the documentation relating to HDI's establishment or creation of the Provider, St. Gertrude's, is also not in the record. The record only shows that BHS ultimately purchased the Provider from HDI.

the beds to be transferred to the entity that would eventually be named St Gerturde's, allegedly without consideration, is consistent with common ownership. Thus, given the evidence in the record, as a whole, it is a reasonable assumption that HDI (later subsumed into BHS) was the owner of Valley View when the transaction to relocate the beds occurred. In the least, the evidence does not allow for a definite finding that they were not commonly-owned facilities.

However, regardless of whether there was common ownership of Valley View and St. Gertrude's, the Administrator disagrees with the Board's finding that St. Gertrude's did not obtain bed rights from Valley View, but merely received Valley View's relinquished beds from the State. The application for an exception submitted by Valley View to the State of Minnesota is evidence of Valley View's request to transfer the beds to the entity that was eventually named St Gertrude's. The State approved a replacement facility for Valley View due to its need for a new building for its current facility. The record shows that no new nursing home beds were added to the system, but rather, the existing licensed capacity was moved from one location to another. Valley View never relinquished its beds rights to the State. Instead, St. Gertrude's was built as a replacement facility and received the de-licensed 51 beds from the original Valley View location when the new building opened. The Provider later expanded to 75 beds at which time the original facility Valley View was closed and the remaining beds were de-licensed.[36] Thus, regardless of whether HDI can be determined to be the owner of Valley View, the record clearly demonstrates that the beds were relocated from Valley View to the Provider, St. Gertrude's. The Administrator finds that the relocation of Valley View's beds to St. Gertrude's constitutes a CHOW under Section 1500, et seq,[37] of the PRM, thus, requiring an examination of the services provided by the prior owner Valley View.

The Administrator also disagrees with the Board's finding that the types of services provided by Valley View were not relevant. As the relocation of the beds from Valley View to the Provider constitute a CHOW under Section 1500, et seq., of the PRM, the type of facility and the types of services provided are highly relevant to a determination as to whether or not a facility is eligible for an exemption. Regarding this matter, the Administrator finds that 75 beds were relocated from Valley View which had been certified as a Medicare SNF provider from 1985 onward.[38] The record shows that, as a SNF the facility was certified to provide skilled nursing and

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[36] See Intermediary Exhibit I-22, p. 330.

[37] Even if, as the Provider alleges, the Provider and Valley View were not commonly-owed and the beds were not sold, a donation of the beds to the Provider would still constitute a change of ownership.

[38] See Intermediary Exhibit I-62.

related services and had been so certified for more than three years prior to the relocation of the beds.[39] Thus, the Administrator finds that the beds were transferred from a facility that operated as the type of provider, for which the Provider is certified for Medicare, under present and previous ownership for more than three full years. Consequently, the Provider does not qualify as a "new provider" for purposes of an exemption from the RCL for the cost years at issue.

Finally, Section 2604.1 of the PRM allows an exemption based upon a relocation whereby the normal inpatient population can no longer be expected to be served by the new location. However, in this case, the record shows that CMS properly found that this exemption basis does not apply to the facts in this case. The State has not designated a service area for the Provider. Therefore, CMS compared documentation of the home addresses of all admissions and residents of the two facilities provided by the Provider to determine if the population serviced at Valley View was continuing to be served by the Provider. As CMS explained in its denial letter, a review of the admissions at the Provider indicated that 73 percent of the population is of the same service area as the prior owner, Valley View. There was sufficient evidence for CMS to conclude that the patient population served at the prior owner can continue to expect to be served at the Provider's location. In fact, in proposing to relocate the beds to the new facility, Valley View/HDI assured that the beds would continue to serve the same population served by Valley View.[40] In sum, the Provider cannot demonstrate that, in the new location, a substantially different inpatient population is being served and, therefore cannot be recognized as a new provider under the criteria of Section 2604.1 of the PRM.

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[39] The Administrator notes that the court in St. Elizabeth's Medicare Center of Boston, Inc. v Thompson, D.C. Cir (Feb. 4, 2005), which addresses the determination of the type of services provided by a prior owner, involved beds transferred from a NF and required that the NF be "primarily engaged" in the providing of skilled nursing care and rehabilitative services. However, the Administrator notes that Valley View, the facility from which the beds were relocated in this case, was a SNF and, therefore, a remand for analysis under St. Elizabeth is not necessary.

[40] There is conflicting evidence submitted by the Provider on whether the exact same patients were served by the Provider and the prior owner of the beds. The Provider claimed that none of the patients from Valley View were relocated to it, while also maintaining in letters that, when relocating the beds, patients would be transferred from Valley View to the Provider. However, the criteria of section 2604.1 of the PRM is not whether the same patients are served in the new location, but whether patients from the same service area as the former owner are served by the new location and whether the normal inpatient population can be expected to be served at the new location.

In sum, the Administrator finds that, based on the record, there is evidence of common ownership of the Provider (St. Gertrude's) and the prior owner of the beds (Valley View). In addition, the record supports CMS' determination that the Provider obtained beds as a result of a CHOW, when beds were relocated from Valley View to the Provider. Further, the Administrator finds that the record supports CMS' determination that the types of services that were provided by the prior owner, Valley View, were the same services for which the Provider is certified, and that such services were provided by the prior owner for more than three years. Thus, the Administrator finds that the record supports CMS' decision that the Provider does not qualify for an exemption to the RCLs as a new provider.

DECISION

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 7/18/07 /s/

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