CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Rogue Valley Medical Center **Provider** **vs.** **Blue Cross Blue Shield Association/ Medicare Northwest** **Intermediary**	**Provider Reimbursement for Cost Reporting Periods Ending: 09/30/95; 09/30/96; 09/30/97 And 09/30/98** **Review of: PRRB Dec. No. 2005-D26 Dated: March 15, 2005**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). Comments were received from the CMS' Center for Medicare Management (CMM) requesting that the Board's decision be vacated. The parties were then notified of the Administrator's intention to review the Board's decision. Comments were received from the Provider. All comments were timely received. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issues before the Administrator are whether the Board properly accepted jurisdiction over a new provider exemption; whether the jurisdiction extended to multiple years and whether CMS' denial of the new provider exemption was proper.

With respect to Board jurisdiction, the Board held that it had jurisdiction over the Provider's appeal of its new provider exemption determination and that the Provider's appeal covered the cost years at issue. The Board, citing to Washington Hospital

Center v. Bowen,[1] found that consistent with that Court's decision, a notice of program reimbursement (NPR) is not the only final determination appealable to the Board. Thus, the Board concluded that the new provider exemption determination is a final determination as defined in 42 CFR 405.1801 request, and the appeal in this case was timely filed. In addition, the Board found that consistent with the relevant regulation a new provider exemption covers multiple cost years. Thus, the Board's jurisdiction also applies to the cost years presented in this case.

With respect to whether the Provider is entitled to a new provider exemption, the Board held that CMS properly denied the new provider exemption. The Board found that Asante Health System owned both the Provider and Hearthstone Manor as the time of the application by the Provider for a skilled nursing facility (SNF) license. The Board noted that Hearthstone Manor was licensed as both an intermediate care facility and a SNF and that the Provider's witness referred to he Provider and Hearthstone as a division of the same company. The Board also noted that the Provider and Hearthstone Manor had different provider numbers. However, the Board found that even though the Provider and Hearthstone Manor had different provider numbers, the same corporate owner was providing SNF services under past and present ownership at the time the hospital-based SNF was licensed. Thus, the Board concluded that the Provider was not entitled to a new provider exemption.

SUMMARY OF COMMENTS

The Center for Medicare Management (CMM) commented, requesting that the Board's decision be vacated with respect to the September 30, 1995 cost reporting period. CMM argued that, contrary to the Board's opinion, a decision regarding the exemption provisions can only be appealed to the Board through an NPR. CMM noted that the case cited by the Board for support, Washington Hospital Center, dealt with the implementation of the hospital inpatient prospective payment system (IPPS), and not the exemption provisions. CMM noted that an NPR sets the amounts arrived at by an intermediary in its determination, including any underpayment or overpayment made to the provider. The NPR is considered a final determination for purposes of any future appeal rights.

CMM stated that section 1878 of the Social Security Act codifies the requirements for Board jurisdiction. Among the statutory requirements, a provider must be dissatisfied with a final determination of its fiscal intermediary as to the amount of total program reimbursement due the provider for the items and services furnished to Medicare beneficiaries for which payment may be made for the period covered by

[1] 795 F.2d 139 (D.C.Cir. 1986).

such report. The regulation, at 42 CFR 405, Subpart R regarding the procedures of the Board, follows the same requirements. Further, CMM noted that as specified in the regulations at 42 CFR 413.30, appeal of an exception, exemption or reclassification are controlled by the provisions found in 42 CFR 405, Subpart R. CMM argued that these provisions provide that the vehicle to the Board is an appeal of the affected NPR, not CMS' decision unless that decision is rendered over 180 days following the issuance of the NPR for the affected cost reporting period. CMM noted that the regulation provides that when CMS renders a decision on an exception, exemption or reclassification after 180 days of the affected NPR which a request is made, the provider may request "good cause" for late Board filing resulting in an extension of the time limit for Board review. Moreover, CMM pointed out that where a SNF has filed multiple requests to be exempt from the SNF routine cost limits (RCLs) and received decisions from CMS on the request, the Provider is required to file an appeal for each cost reporting period within 180 days of the issuance of the applicable NPR.

In this case, CMM noted that CMS rendered a decision on the Provider's request for an exemption from the SNF RCLs for the cost reporting period ended September 30, 1995 on November 6, 1996. The Provider, in this case, appealed that decision to the Board on March 26, 1997 prior to the issuance of the NPR for that period. The NPR was not issued until September 24, 1997. Thus, CMM argued that the Provider's appeal was nothing less than a protective filing, which is not a legitimate appeal under the statute or regulations. The Provider's failure to file an appeal of the affected NPR in accordance with the statute and regulation renders the Board without jurisdiction.

Moreover, CMM asserted that the Board's prior acceptance of jurisdiction of subsequent NPRs is without support. Contrary to the Board's belief, the regulation is not "automatic." Under 42 CFR 413.30(e), exemptions are not automatically applied to subsequent cost reporting periods. In addition, nothing in the regulation explicitly states that an exemption, if approved, "continues" for three full years as implied by the Board. Rather, CMM noted, the regulation as explicated more fully in the Provider Reimbursement Manual provides that a provider may request an exemption from the SNF RCLs for a single cost period, two cost periods or even three cost periods. It is up to a provider to determine which cost periods it will seek relief from the effects of the SNF RCLs. CMS cannot consider a request for relief where none exists, or authorize unwarranted payments. However, CMM argued that the Board's interpretation would require such a result.

In sum, CMM stated that the Provider did not appeal the September 30, 1995 NPR. Yet, the Board accepted jurisdiction over that exemption issue and "automatically" applied its decision to the NPRs for cost reporting period ended September 30, 1996,

1997 and 1998 contrary to the statute and regulations. CMM concluded that as with the appeal process, the requests process for a reclassification, exception or exemption always requires identification of the affected cost period for which relief is sought, for such a request is tied directly to the NPR.

The Providers commented, requesting that the Board's decision be affirmed with respect to jurisdiction. The Provider argued that, based on applicable regulations and manual provisions, a provider may file for a new provider exemption before, during, or after the close of the affected cost reporting year, but must file no later than 180 days from the date of the NPR. The Provider pointed out that it filed its appeal on April 5, 1996, after the close of the September 30, 1995 cost year, but before the issuance of the FYE 1995 NPR. Thus, the Provider complied with all the requirements for Board jurisdiction.

Moreover, the Provider asserted that, contrary to CMM's argument, it was not required to submit a separate SNF new provider exemption request for each cost year to which the exemption applied. The regulation specifically identifies the cost reporting periods to which the new provider exemption, if approved, applies. In this case, because the Provider's SNF was approved on April 24, 1995, the exemption would apply to part of FYE 1995 and to all of FYEs 1996, 1997 and 1998. Thus, as the duration of the exemption is determined as a matter of law, the Board has jurisdiction over all the years affected by the exemption request.

In addition, the Provider stated that, assuming arguendo, that the Board does not have jurisdiction over the FYE 1995 because the Provider did not appeal its FYE 1995 NPR, the Provider filed appeals for each of its NPRs for FYEs 1996 through 1998 with respect to the denial of its new provider exemption request. In this case, the Provider claimed that by letter dated April 4, 2002, the Board consolidated the Provider's Yes 1996 and 1997 into this case. Further, by letter dated November 8, 2002, the Board consolidated the new provider exemption issue for the FYE 1998 in this case. Thus, even if the Board did not have jurisdiction over FYE 1995 because the Provider did not file an appeal of the FYE 1995 NPR, the record clearly establishes that the Provider did file timely appeals with respect to the FYEs 1996, 1997 and 1998 NPRs and that the Board has jurisdiction over those years. The Provider also pointed out that the Intermediary, as the agent for CMS, jointly agreed with the Provider that there were no impediments to PRRB jurisdiction.

DISCUSSION

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

Section 1878(a) of the Act [42 USC 1395oo] sets for the requirements for Board jurisdiction. Any provider of services which has filed a required cost report within the time specified may obtain a hearing before the Board with respect to such cost report:

> (1)(A) if such provider:
>
> > (i) Is dissatisfied with a final determination of the … intermediary … as to the amount of total program reimbursement due the provider for the items and services furnished to individual for which payment may be made under this title for the period covered by such report, or
> >
> > (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under (b) or (d) of section 1886
>
> (2) the amount in controversy is $10, 00 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination …

Consistent with the statutory language of section 1878 of the Act, the regulation at 42 CFR 405.1835(a) sets forth that a provider has a right to a hearing before the Board, if:

> (1) An intermediary determination has been made with respect to the provider; and
>
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in 405.1841 (a)(1) …

Generally, an intermediary determination is reflected in a notice of program reimbursement or NPR. According to 42 CFR 405.1801(a)(1), an "intermediary determination" is defined as:

> A determination of the amount of total reimbursement due the provider, pursuant to section 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for

> which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

Under 42 CFR 405.1841:

> (a)(1) General Requirements. The request for a Board's hearing must be filed in writing within 180 days of the date the notice of the intermediary's determination was mailed to the provider…. Prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof.

Regarding the matters in dispute before the Board, from the beginning of the Medicare program, Medicare reimbursed hospitals and other health care providers on the basis of reasonable costs of covered services. Section 1861(v)(1)(A) of the Act defines "reasonable cost" as the "cost actually incurred," excluding amounts not necessary to the efficient provision of health care. 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.[2] 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(1)(A)(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 regulation at 42 CFR 413.30 provides for exemptions to the RCLs if certain criteria are met. Specifically, the regulation at 42 CFR 413.30(e)(2) provides that a provider may request an

---

[2] Pub. Law 92-603.

exemption to the RCLs if it meets the criteria of a new provider. In order to qualify for an exemption as a new provider, the provider must have operated as the type of provider, or its equivalent for which it is certified for Medicare, under present and prior ownership for less than three full years. In addition, section 2531.1 of the PRM points out that a request for an exemption may be filed prior to the beginning of, during, or after the close of the affected cost reporting period. Consequently, under this provision, it is possible for a provider to file one exemption for multiple cost years.

With respect to the process for filing an exemption request, the regulation at 42 CFR 413.30(c) explains that:

> The providers' request must be made to its fiscal intermediary within 180 days of the date of the intermediary's notice of program reimbursement. The intermediary makes a recommendation on the provider's request to CMS [formerly HCFA] which makes the decision. CMS responds within 180 days from the date CMS receives the request from the Intermediary. The intermediary notifies the provider of CMS' decision. The time required for CMS to review the request is considered good cause for the granting of an extension of time to apply for Board review as specified in 405.1841 of this chapter. CMS' decision is subject to review under subpart R of part 405 of this chapter.

Because the appeal of the NPR is the vehicle for Board jurisdiction under the reasonable cost methodology, the regulation at 42 CFR 413.30 explains that the time required for CMS to review the request is good cause for granting an extension of time for appealing the subject NPR. Furthermore, as a prerequisite for a Board hearing on a new provider exemption, a CMS determination on the new provider exemption is required. Thus, a provider's appeal of CMS' determination on an RCL exemption request, is reflected in both statutory and regulatory scheme, as ultimately an appeal from an NPR for a particular cost year.[3]

In this case, the Board found that it had jurisdiction over the Provider's appeal for the Provider's 1995, 1996, 1997 and 1998 cost years pursuant to CMS' exemption denial.[4] The Administrator notes the Board's reliance on the circuit court's opinion

---

[3] See, e.g., Twin Rivers Regional Medical Center, PRRB Case No. 96-0211, 97-1061, 98-2080, Administrator's Remand (05/29/02); and Citrus Health Nursing and Rehabilitation Center, Admin. Dec. No. 2003-D40 (09/11/03).

[4] The three years for which the Provider claims it is entitled to a new provider exemption involves four cost reporting periods.

in the case of Washington Hospital Center v. Bowen, 795 F. 2d 139 (D.C. Cir 1986) to establish Board jurisdiction. However, the Administrator finds that that case is not dispositive of the jurisdiction issues presented in this case. The Washington case involved an appeal of a final determination of the Secretary under §1878(a)(1)(A)(ii) of the Act for §1886(d) payment. CMS' RCL exemption denial is not a final Secretary determination described under §1878(a)(1)(A)(ii) of the Act.

The Administrator finds that a provider may request a Board hearing if it is dissatisfied with a final determination of the intermediary as to the amount of total program reimbursement, otherwise referred to as its NPR. A CMS decision denying an RCL exemption, while a prerequisite for Board review, is not a final determination described under §1878(a) of the Act.

CMM argued that the Board lacks jurisdiction over the appeal because the Provider did not appeal pursuant to the NPR for FYE 1995. However, the Administrator notes that the Provider requested the new provider exemption as required by the regulation and received a denial. While prematurely appealing the denial, the Provider ultimately cured its request for hearing by providing its NPR for FYE 1995.[5] Thus, the Administrator finds that the Board has jurisdiction to hear the Provider's appeal of its RCL exemption denial for the FYE 1995.

CMM also objected to Board review of this issue for the Provider's FYEs 1996, 1997, and 1998. As noted above, with respect to whether the Board has jurisdiction over FYEs 1996, 1997, and 1998, in this case, a review of the record shows that by letter dated April 5, 1996, the Provider requested a SNF RCL exemption which CMS denied.[6] The Provider appealed its NPRs for FYEs 1996, 1997, and 1998, which were consolidated into the subject case. Thus, the Administrator finds that the Board also has jurisdiction to review the Provider's appeal of CMS' denial of its new provider exemption request for its cost reporting periods ending 1996, 1997 and 1998.

In addition, the Administrator affirms the Board's decision with respect to the merits of the Provider's SNF RCL exemption request as set forth below. Since its inception in 1966, Medicare's reimbursement of health care providers was governed by §1861(v)(1)(A), which provides that:

---

[5] See Provider's Jurisdictional Brief, Exhibit P-8.

[6] See Intermediary's Final Position Paper, Exhibit I-3. The Administrator also notes the CMS' denial did not identify a specific cost period (Exhibit I-12).

> 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….

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 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)

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.[7] When

[7] 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).)

determining the character of a provider's present and previous ownership, CMS looks at the services of the institution as a whole prior to certification.

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.[8] Consistent with this regulation, PRM §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.
>
> ….
> 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.
> ….
>
> 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

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

> relocation. The periods being compared must be at least 3 months in duration. (Emphasis added.)

The Administrator notes that §2604.1 was removed by Transmittal No. 400, dated September 1997, after the date of the Provider's exemption request. 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.

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.

Furthermore, when determining whether a provider is in fact, a "new" provider under the regulations, CMS considers whether the SNF in question was established through a change of ownership or "CHOW." The PRM at §1500 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.[9]

Notably, §1500.7 describes an example of a 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

---

[9] Rev. 332 (1985).

> conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity.

In addition, the effect of a change of ownership for purposes of the new provider exemption is addressed at new §2533.1.E.1 of the PRM.[10] Section 2533.1E of the PRM explains that "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."

In addition, §2533.1E.1(b) of the PRM, consistent with the foregoing long standing policy addresses the "disposition of all or some of an institution … or its assets used to render patient care" as referenced at §1500.7. Paragraph (b) states that: "For example, where an institution purchases the right to operate long-term care beds from an existing facility which is or has been providing skilled nursing care or rehabilitative services, this transaction will be considered a CHOW for new provider exemption purposes." Also consistent with §1500.7 and paragraph (b), paragraph (d) identifies a CHOW when there is a "[r]eallocation or consolidation of long term beds from an existing institution … to another institution."

Applying the above law to the facts of this case, the Administrator finds that the record supports CMS' decision that the Provider, referred to as Rogue Valley Medical Center (Provider No. 38-5249) was established pursuant to the State approved transfer and relocation of ten beds from an established Medicare/Medicaid certified SNF/NF, Hearthstone Manor, (Provider No. 38-5091). The record supports the determination that the Provider was established through a CHOW meeting all of the elements of §1500.7 of the PRM.[11] The Administrator finds that the transfer of the beds represents the "[d]isposition of all or some portion of a provider's facility or assets (used to render patient care)" of assets which

---

[10] Trans. 400 (Sept. 1997).

[11] In addition, the Administrator notes that, similar to the situation in this case and the example set forth at §2533.1E.1(d) of the PRM, CMS has always recognized the concept of a "partial relocation" where the original provider does not close its doors (see e.g. Paragon Health Network v. Thompson, 251 F. 3d 1141, 1146, 1148 (7th 2001). The court in Paragon also found that "relying on the operating history of the transferor of CON rights to deny new provider exemption to the transferee is not plainly erroneous." Id. at 1152.

"affects licensure or certification of the provider entity" thus meeting the criteria of a CHOW for purposes of the new provider exemption.[12]

The Administrator finds that the Provider did obtain a portion of Hearthstone's assets necessary to rendering patient care and that the transfer of these beds affected the licensure or certification of the provider entity. The beds were a critical and necessary asset required for operating the SNF in the State of Oregon. As the Court of Appeals in South Shore determined, 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." Similar to the facts in this case, 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 such rights 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 certificate of need or CON rights, just at a different location. The Court of Appeals in Paragon Health Network, Inc., 251 F.3d 1141 (2001), refused to find unreasonable the Secretary's interpretation that, where bed rights 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:

> 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:

---

[12] The Administrator notes that the Provider and Hearthstone have a common parent company. The record, while showing that the beds were transferred from Hearthstone Manor to Rogue Valley, does not show that the transfer was made pursuant to a sale. However, the nature of the transfer (sale, donation, etc.,) is not the relevant event, but rather what is relevant is that the beds were transferred from an established Medicare-certified SNF.

> 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. §1395x(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.

The Administrator similarly finds that, in this instance, the transfer of operation rights constitutes a change of ownership transaction for purposes of determining whether the Provider qualifies for an exemption as a new provider.

Because the Administrator finds that the Provider was established through a CHOW, the issue is whether the beds were transferred from the same type of provider (or equivalent) for which the Provider is certified for Medicare participation under present and previous ownership for less than three full years.[13] Regarding this matter, the Administrator finds that ten beds were relocated from Hearthstone Manor which had been certified as a Medicare and Medicaid certified SNF/NF since March 31, 1974, to the Provider. As a Medicare-certified SNF since 1974, Hearthstone Manor had provided skilled nursing and related services for more than three years prior to the transfer of ownership.[14] Thus, the Administrator finds that the beds were

---

[13] The Administrator rejects the Provider's suggestion it be evaluated under the new provider exemption using only the eight new certified beds of the 18 bed facility. This would essentially require two distinct part SNFs, contrary to Medicare policy and law.

[14] See, e.g., Hearthstone's cost reports showing different therapy costs provided by the participating SNF for cost reporting periods beginning 10/1/92 through 9/30/96.(Intermediary Exhibit 1-67.) This case is thus distinguished from the facts presented in St. Elizabeth Medical Center v. Thompson, 396 F. 3d 1228 (D.C. 2005). In that case the court determined that, where the services had been provided by a NF, "the bare fact that an institution has gained NF status or is operating as a NF, without more, is not sufficient to qualify the NF as a SNF or it equivalent." Id. 1234. In this case, among other things, the beds were transferred from a Medicare/Medicaid dually certified and commonly-owned SNF/NF.

transferred from a facility that was 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.

Finally, §2604.1 of the PRM allows for an exemption based upon a relocation whereby the normal inpatient population can no longer be expected to be served at the new location. However, in this case, the Administrator finds that CMS properly found that this exemption basis does not apply to the facts of this case. Under this provision, "a provider which relocates may be granted new provider status where the normal inpatient population can no longer be expected to be served at the new location." The record shows that the Provider, Rogue Valley, is located adjacent and on the same street as the Hearthstone Manor, the entity from where the beds were transferred. Thus, both facilities are located in the same health service area, which includes all of Jackson County. The record indicates that the 77.4 percent of the population served in the new location came from this service area. In addition, the record shows that 89 percent of the patients came from the same cities and towns as patients from Hearthstone Manor.[15] Thus, the Administrator finds that CMS properly concluded that the normal inpatient population served in the old location could continue to expected to be served in the new location and that the Provider does not qualify for a new provider exemption based on relocation.

[15] Intermediary Exhibit I-71.

DECISION

The decision of the Board is affirmed in accordance with the foregoing opinion.

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

Date: 5/16/05

/s/
Leslie V. Norwalk, Esq.
Deputy Administrator
Centers for Medicare & Medicaid Services