CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Harborside Healthcare—Reservoir **Provider** **vs.** **Blue Cross Blue Shield Association/ Empire Medicare Services** **Intermediary**	**Provider Reimbursement for Cost Reporting Period Ending: 12/31/98** **Review of: PRRB Dec. No. 2006-D14 Dated: January 25, 2006**

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 reversed. The parties were then notified of the Administrator's intention to review the Board's decision. Comments were received from the Provider, requesting affirmation of the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue before the Administrator is whether the Intermediary properly denied the Provider's new provider exemption request.

The Board, reversing the Intermediary's adjustment, held that the Provider's "new provider" exemption was improperly rescinded. The Board further held that the Intermediary improperly considered the transfer of bed rights as a continuation of services from the previously facilities. The Board also held that the Provider's documentation was reasonable and acceptable for determining exemption eligibility.

In reaching its decision, the Board identified two sub-issues involved in the case: (1) the allowability of 45 beds that resulted from the transfer of Certificate of Need (CON) bed rights and, (2) the adequacy of documentation in the exception request. With respect to the first sub-issue, the Board found that the purchase of CON rights does not necessarily constitute a change of ownership (CHOW) and does not affect the provider's right to a new provider exemption. The Board noted that there was some dispute over whether section 2604 of the Provider Reimbursement Manual (PRM), which addresses the purchase of CON rights, is applicable to the Provider in this case. However, the Board found that, even if the PRM were applicable, imputing ownership based on the purchase of CON rights is inconsistent with the regulations. The Board cited to several court decisions in support of its decision.[1]

With respect to the adequacy of documentation, the Board noted that CMS' denial was based on lack of adequate documentation for four items for which additional information had been requested. However, the Board found that, although the Provider was unable to furnish all of the requested documentation because it was not available, the Provider did submitted alternative documentation which was sufficient and contained all the pertinent information. The Board found that the Provider's submission of alternative documentation was reasonable. Thus, the Board concluded that the Provider met the required burden of proof for an exemption request.

SUMMARY OF COMMENTS

The Center for Medicare Management (CMM) commented, requesting that the Board's decision be reversed. CMM argued that the Board's finding that the Provider's alternative documentation was reasonable was based on an erroneous conclusion. CMM noted that, contrary to the Board's findings, the documentation requirements set forth in sections 2531 and 2533 of the PRM were issued prior to the Provider's request for an exemption.

With respect to the CHOW issue, CMM pointed out that the Board failed to recognize the effective date of certain policies set forth in the PRM. In addition, CMM noted that, despite the Board's reliance of certain court cases, those cases focused on the definition of what constituted a provider, not whether a transaction was a CHOW. CMM, citing several court decisions in support of its arguments,

[1] See Ashtabula County Medical Center v. Thompson, U.S. Court of Appeals, 6th Cir., Nos. 02-3420/3425 (Dec. 19, 2003); and Maryland General Hospital, Inc. v. Thompson, 308 F.3d 340 (4th Cir. 2002).

asserted that the referenced cases support CMS' interpretation that the purchase of a CON is a CHOW and thus considered in the determination of an exemption request.[2]

The Provider commented, requesting that the Board's decision be affirmed. The Provider argued that, as the Board correctly determined, it supported its request for an exemption with adequate documentation. Further, the Provider claimed that CMS' position to the contrary is not based on substantial evidence or law, and is arbitrary and capricious.

With respect to documentation, the Provider maintained that the Board found that in each instance the Provider satisfied the Intermediary's request for documentation and that such documentation was reasonable and acceptable for determining the eligibility of the Provider for the exemption. Further, the Provider argued that the Intermediary's document requests were for the purpose of determining whether the CON rights obtained by the Provider were "clean" rights (out of state bed inventory or already issued rights. However, the Provider argued that a technical transfer of CON rights that does not add any existing operations to a new provider and does not provide an occasion for disturbing a new provider of services. The Provider maintained that the case law in Ashtabula and Maryland General[3] supports the Board's conclusion.

Moreover, the Provider maintained that the decision in St. Elizabeth's Medical Center of Boston, Inc., v. Thompson (D.C. Cir. Feb. 4, 2005) further supports its argument. The Court ruled in that case that there was no evidentiary basis for the conclusion that the nursing home from which St. Elizabeth's purchased its rights was primarily engaged in providing skilled nursing facility or rehabilitative services. Similarly, there is no substantial evidence in the record that the facilities which were the source of the CON rights were primarily engaged in providing skilled nursing or rehabilitative.

Finally, the Provider asserted that the cases cited by CMM, South Shore and Paragon, involved relocated providers. In each of these cases, the courts' decisions were preceded by a Board finding that, as relocated providers, there was sufficient evidence to attribute the prior ownership of the beds to the new owner. In South Shore, the Board found that the transition care center was a relocated provider. In Paragon, the rights to the beds were from another nearby facility under common ownership. However, in this case, there is no such evidence.

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[2] See South Shore Hospital, Inc. v. Thompson, 308 F.3d 91 (1st Cir. 2002); Paragon Health Network, Inc. v. Thompson, 251 F.3d 1141 (7th Cir. 2001).

[3] See supra.

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.

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.[4] 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 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.

[4] Pub. Law 92-603.

With respect to the process for filing an exemption request, the regulation at 42 CFR 413.30(c) explains that a provider's request must be made to its fiscal intermediary within 180 days of the date of the intermediary's notice of program reimbursement. Further, 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.[5]

With respect to the merits of the Provider's SNF RCL exemption request, 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….

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[5] The Administrator notes that, on November 15, 2002, the Provider appealed to the Board CMS' denial of the Provider's request for an exemption for the fiscal year ending December 31, 1998. At that time, an NPR for FYE 1998 had not been issued. However, the Administrator notes that an NPR was issued on May 12, 2003 for the 1998 cost year and has been made part of the record. See Intermediary's Jurisdictional Brief, Exhibit I-5. Since the record has been supplemented with the appropriate NPR, the Provider's appeal for FYE 1998 was properly before the Board and, thus, is properly before the Administrator on review.

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.[6] When 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.

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> 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….

[6] 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).

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

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

The Administrator notes that §2604.1 was removed by Transmittal No. 400, dated September 1997, prior to the cost year at issue and date of the exception 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.[8]

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." 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 determine if it is eligible for a new provider exemption. Paragraph E.1 explains the transaction types also discussed at sections 1500.1,et seq., of the PRM and sets out specific examples. This includes an example set forth at paragraph E.1.b regarding the disposition of all or some of an institution or its assets used to render patient care. That paragraph states in pertinent part that:

> [A]n institution purchases the right to operate (i.e. a certificate of need) long term care beds from an existing institution … (be it opened or closed)[[9]] that has or is rendering skilled nursing or rehabilitative

[8] 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 beingserved….The normal inpatient population is defined as the health service area (HSA) for long termcare facilities, or its equivalent, as designated by the State planning agency or local planning authorityin which the institution … is located.

[9] Section 2533.1.F also sets forth examples of the effect of decertification, closure, replacement, remodeling or additions to existing institutions for new provider exemptions. Relevant to this case, paragraph F.3 explains that an institution that operates as an SNF or its equivalent must cease operations for three full years prior to the date the institution recommences operation as a SNF or it equivalent to be granted a new provider exemption.

> services to establish (in whole or part) a long term care facility or to enlarge an existing long term care….

The longstanding policy set forth at 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.[10]

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

Likewise, the Court of Appeals in South Shore 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 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

[10] Rev. 332 (1985).

> 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. §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 startup 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.

Applying the above law to the facts of this case, 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 for the FYE 1998. The record shows that the State of Connecticut issued an initial license for 30 chronic and convalescent nursing home beds effective October 2, 1995 to "The Reservoir."[11] CMS granted "The Reservoir" an exemption to the RCLs as a new provider for a total of 30 newly certified beds on November 3, 1995.[12] The exemption was to expire at the end of the October 1, 1998 through September 30, 1999 cost reporting period.

An acquisition agreement was entered into by "The Reservoir" with Carewell Convalescent Home for the purchase of certificate of beds and licenses for 45 beds, dated February 1996.[13] The agreement explained that the seller (Carewell) was also the owner of a 45-bed facility operated by Sunnywood Convalescent Home, Inc. (d/b/a Fairlawn). The parties agreed that the seller had the option to transfer

[11] Intermediary Exhibit 63 at p.1.
[12] Intermediary's Exhibit I-3.
[13] Intermediary Exhibit 64.

Sunnywood beds (d/b/a Fairlawn), in lieu of Carewell beds, pursuant to the final determination of the State of Connecticut.[14]

The State issued an "Agreed Settlement" which recognized "The Reservior" as an existing long term care facility certified and licensed for 30 beds. The Agreement showed that "The Reservoir" filed a certificate of need or CON application on February 19, 1997. The CON application was for the relocation of 41 beds formerly licensed and certified for Carewell and 4 beds formerly licensed and certified for Sunnywood (d/b/a Fairlawn). The Agreement recognized that the relocation of the 45 beds met the State criteria for an exception to the State's Nursing Home Moratorium provided that certain conditions were met. The Agreement also provided that: "The Reservoir's existing 30 beds and proposed 45 beds have been and will be devoted to providing subacute and or short term rehabilitation services." (Emphasis added.) The Agreement was accepted and ordered by the State on April 6, 1997.[15]

The State licensed for "The Reservoir" dated January 7, 1997 shows, inter alia, an increase in bed size, effective April 6, 1997, for a maximum number of beds not to exceed at any time 75 chronic and convalescent beds.[16] Thus, effective April 6, 1997, "The Reservoir" acquired 45 additional previously certified beds pursuant to a State-approved purchase of CON beds, increasing its overall bed size from 30 to 75.[17]

On December 12, 1997, Harborside Healthcare acquired "The Reservoir" and was established as Harborside Healthcare-Reservoir (the Provider in this appeal.) Harborside acquired the 75 bed facility and not just the 30 beds for which the original new provider exemption had been granted. As a result of the acquisition, Harborside requested the previously granted new provider exemption for the 30 beds be extended and that the 45 additional beds be likewise exempted as a new provider. This request triggered an evaluation by CMS of the 75 licensed beds acquired through the various changes of ownership.

A pertinent CHOW transaction that requires evaluation occurred on April 6, 1997 (prior to the December 12, 1997 purchase by Harborside). This transaction involved the purchase and relocation of 45 formerly licensed and certified bed capacity

[14] Intermediary Exhibit 64, pp 14-15.

[15] Provider Exhibit 10.

[16] Intermediary Exhibit 63.

[17] This transaction was apparently not examined at that time by CMS to determine the effect of the change of ownership on Medicare reimbursement.

previously in operation from established Medicare/Medicaid certified SNF/NFs, Carewell and Sunnywood (d/b/a Fairlawn).[18]

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 "affects licensure or certification of the provider entity" thus meeting the criteria of a CHOW for purposes of determining eligibility for new provider exemption. The Administrator finds that the Provider did obtain a portion of Carewell's and Fairlawn'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 expanding operations of the SNF in the State of Connecticut.

The Provider argues that the licenses of the closed facilities cannot by law be transferred and thus suggests that the transfer of CON rights does not affect license and constitute a CHOW requiring the examination of the prior owners' patient services. However, the Administrator notes that the State's Agreed Settlement[19] states that the beds would be allowed to be "relocated" from the closed facilities if certain conditions were met, i.e , "provided that the 41 beds are counted against all 45 of the beds formerly licensed and certified for Carewell…and the four beds are counted against the five remaining beds retained for relocation by Sunny…." In addition, "pursuant to the Determination Report…neither Carewel …nor Sunnywood…have anymore beds available for relocation." It is clear from the agreement that the beds were an asset that affects licensure and that the beds came from two preexisting entities that provided skilled and rehabilitative services. In addition, the Acquisition Agreement shows that the Carewell beds alone were to be transferred for over one million dollars in consideration Thus, the beds were a necessary and critical asset required for expanding the operation of the SNF.[20] Consequently, for purposes of determining whether Harborside qualifies for a new provider exemption, the Administrator must examine whether the 45 beds were transferred from the same type of provider (or equivalent) for which the Provider is

[18] See, e.g., Exhibit P-10, Intermediary's Position paper dated June 30, 2003 p 14, Intermediary Exhibit I-17 (HCFA 1539 showing a participation date of 06/23/1982 through 11/15/1996 for Carewell) Intermediary Exhibit I-18 (list of NF services to patients); Intermediary Exhibit I-19 (HCFA 1539 showing a participation date of December 1, 1991 through May 10, 1996 for Fairlawn), Intermediary Exhibit 20 (showing SNF/NF services to patients.)

[19] Provider Exhibit P-10.

[20] Intermediary Exhibit I-64 p 3.

certified for Medicare participation under present and previous ownership for less than three full years.

Regarding this matter, the Administrator finds that 41 beds were relocated from Carewell Rest Home which had been certified as a Medicaid NF provider from 1982 through 1996, and 4 beds were relocated from Fairlawn certified as a Medicare SNF/Medicaid NF provider from 1991 through 1996. The transfer of the CON rights on April 1, 1997, occurred less than 6 months after the closing of Carewell and less than one year after the closing of Fairlawn. Because the prior owners had not ceased operation for three full years prior to the change of ownership, an examination of the type of services provided by these entities must be considered.

The record shows that, as Medicare and Medicaid certified SNFs/NFs, these facilities provided skilled nursing and related services for more than three years prior to the transfer of ownership. In particular, it is undisputed that Fairlawn was a certified Medicare SNF and thus all services provided are equivalent to the Provider. The record also indicates that Carewell, a NF, likewise provided skilled nursing services.[21] In addition, the Omnibus Reconciliation Act of 1987 included nursing home reform which resulted in both Medicare skilled nursing and Medicaid nursing facilities being required to provide the same basic range of service.[22] Thus under the statute, Medicaid nursing facility services are equivalent to Medicare skilled nursing facility services. The Administrator recognizes that the court in St. Elizabeth's Medicare Center of Boston, Inc. v Thompson, D.C. Cir (Feb. 4, 2005) did not agree with this analysis and required that the NF be "primarily engaged" in the providing of skilled nursing care and rehabilitative services. However, the Administrator notes that one facility in this case from which the beds were transferred, Fairlawn, was a SNF and, therefore, a remand for analysis under St Elizabeth is not necessary.

Thus, the Administrator finds that the beds were transferred from facilities that were 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 year at issue.

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[21] See e.g. Intermediary Exhibit I-17, Intermediary Position Paper, pp 14-15.

[22] See also legislative history at Intermediary Exhibit I-49 (453 USCCAN 1987 at 2313-272, 2313-273).

DECISION

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

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

Date: 3/27/06

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