PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

99-D38

PROVIDER - South Shore Hospital
Transitional Care
Center, South
Weymouth, MA

Provider No. 22-5664

vs.

INTERMEDIARY -Blue Cross and Blue Shield Association/C&S Administrative Services

DATE OF HEARING-
July 10, 1998

Cost Reporting Period Ended -
September 30, 1995

CASE NO. 96-2150

INDEX

ISSUE:

Was the Provider entitled to an exemption from the skilled nursing facility routine service cost limits as a "new provider?"

STATMENT OF THE CASE AND PROCEDURAL HISTORY:

The Transitional Care Center unit ("Provider"/"TCC") is a 25-bed skilled nursing facility ("SNF") distinct-part unit at the South Shore Hospital ("SSH") facility. TCC was constructed within SSH for a total project cost of $871,000, and opened on January 19, 1995.[1] On February 1, 1995, TCC was certified to participate in the Medicare program with a new agreement and provider number.[2] SSH had never provided SNF services previously.

SSH decided to expand the scope of its patient services to expedite the transition from the acute medical/surgical area of the hospital to home by opening a SNF. Since Massachusetts regulations had a cap on the number of nursing home beds that could be operated in the state, SSH was required to either acquire a determination of need ("DON") for more beds for a long-term care ("LTC") facility and/or SNF in the same health service area ("HSA") or to decertify existing medical/surgical beds.[3]
In view of these state requirements, SSH elected to purchase only the DON rights of Prospect Hill Manor ("PHM"), a once certified Medicaid nursing facility ("NF") located in the same HSA. PHM was a minimal care 40-bed Level III Medicaid custodial NF that had been closed since December 17, 1993 because it could not meet the physical plant certification requirements.[4] No tangible assets were purchased and no patients were transferred because PHM was closed. PHM was under Massachusetts State Court Receivership proceedings for

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1 Tr.at pp. 23-25.

2 Provider Exh. P-2, and Tr. at p. 25.

3 Tr. at pp. 18-19. The decertification option was only available to hospitals with medical/surgical occupancy rates of less than 70%; and SSHs occupancy rate was about 75%. Id.

4 Massachusetts LTC facility classification system:
Level I is a Medicare-certified distinct part unit; Level II is a Medicare-certified SNF;
Level III is a Medicaid intermediate care facility; Level IV is a rest home, or assisted living type of facility, that cannot be certified as a provider under either Medicare or Medicaid. (Tr. at pp. 81-82).

over a year before TCC opened.[5] A Receiver had been appointed because the owner abandoned the facility and left the state. Although the state Department of Public Health approved the transfer of the DON rights to the site of the Provider on March 22, 1994,[6] the TCC had to be constructed and did not open until January 19, 1995.

On May 17, 1995, SSH requested the Health Care Financing Administration ("HCFA") to grant a new provider exemption ("NPE") for the TCC regarding the routine cost limits ("RCL") pursuant to 42 C.F.R. § 413.30(e) for its first fiscal year.[7] This regulation defines a new provider as:

> 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.

42 C.F.R. § 413.30(e)

On November 20, 1995,[8] HCFA denied the NPE request because it was determined that SSH purchased the assets (DON) of PHM which constituted a change of ownership ("CHOW") under the provisions of the Provider Reimbursement Manual ("HCFA Pub. 15-1"), section 1500; and that PHM had furnished skilled nursing services within the previous 3 year period under prior ownership. The Provider's request for reconsideration was denied on May 15, 1995 which reiterated the original denial.[9] The denial letter stated the Omnibus Budget Reconciliation Act of 1987 ("OBRA 1987") included the Nursing Home Reform provisions that regulate the certification of long-term care facilities under Medicare and Medicaid, effective for services on or after October 1, 1990:

> The result is that both Medicare SNFs and Medicaid nursing facilities (NFs) are required to provide, directly or under arrangements, the same basic range of services .... Therefore, the range of services for which a Medicaid NF is responsible includes the same types of services as are offered in a Medicare SNF. Consequently, a NF, operating as of October 1, 1990,

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5 Tr. at pp. 83-85.

6 Provider Exhibit P-1 to P-10.

7 Provider Exhibit P-5.

8 Provider Ex P-6.

9 Provider Ex P-7.

> would have already incurred the start-up costs associated with the development of the capacity to furnish inpatient SNF services, by meeting the requirements for participation, effective October 1, 1990 .....

Furthermore, skilled nursing and rehabilitative services were provided at Prospect Hill, regardless of the change in the law, and are now provided at South Shore TCU. These services included, but were not exclusive of, care of pressure ulcers, special rehab services and injections. This information was retrieved from the Prospect Hill's self-reported resident census reports from its October 24, 1989, December 12, 1990, ...

Provider Ex. P-6.

On May 28, 1995, the Provider appealed HCFA's denial to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and has met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is approximately $876,000.

The Provider was represented by James M. Gaynor, Esquire, and Peter R. Leone, Esquire, of the McDermott, Will & Emery law firm. The Intermediary was represented by James Grimes, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider makes five primary contentions:

- Contentions 1-3 pertain to the Provider's compliance of satisfying the regulation definition of a new provider under § 413.30(e);

- The fourth contention rebuts HCFA's argument that TCC is the relocation of another provider under manual provision § 2604.1 is flawed; and

- The fifth contention demonstrates that HCFA's denial is not in compliance with the purpose and intent of the regulations and is inconsistent with other NPE decisions.

The Provider maintains the HCFA denial was erroneous and unsupportable, and makes three contentions that it meets the regulation definition of a new provider. Namely, that:

I. There was no change of ownership;

II. The alleged predecessor, PHM, did not meet the regulatory requirement of being "operated as the type of provider (or the equivalent) for which it is certified for Medicare."

III. Neither TCC or PHM furnished skilled nursing services within the 3 year period prior to certification.

HCFAs determination that there was a change of ownership ("CHOW") is flawed and incorrect. There was no CHOW as contemplated by the regulations. There was only the purchase of a closed facility's DON rights to about 40 beds which was an intangible asset. Additionally, there was no CHOW because:

a. SSH did not purchase: i) the facility itself, i.e., land or building; ii) PHMs corporate entity or its stock; iii) its operations; or iv) any other tangible assets such as the beds, equipment, etc.

b. There was no ongoing contractual relationship in any respect.

c. There was no transfer of any patients or employees nor was there ever any involvement with the operations since PHM was closed.

d. SSH was granted a new license on January 19, 1995 for 25 Level II beds for the TCC; PHM was a level III facility.[10]

e. Although SSH purchased DON rights to PHMs 40 beds, the State only permitted SSH to construct 25 beds for the TCC. SSH was also required to de-license 25 medical/surgical beds by the Department of Public Health as if it were converting beds under the 500 nursing home bed cap. The DON rights to the other 15 nursing home beds were eliminated by order of the Commonwealth.[11]

The Provider maintains that the mere acquisition of Intangible DON rights is not a CHOW in accordance with HCFA Pub. 15-1 § 1500 which states:

> Change of Ownership--General.
> When a provider undergoes a change of ownership, ceases to participate in the program, or experiences an event otherwise described below, for which a Provider Tie-In Notice (Form HCFA-2007) has been issued, a final cost report must be filed by that provider covering the period under the program beginning with the first day not included in a previous cost reporting period

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10 Tr. at p. 24; Provider Ex. P-5.

11 Tr. at pp. 23-24.

> and ending with the effective date of termination of its provider agreement, change of ownership, or event (42 C.F.R. § 405.453(f) (1)).

HCFA Pub. 15-1 § 1500.

The Provider states various subsections of Section 1500 of HCFA Pub. 15-1 describe events representing common forms of changes of ownership. In the case of a corporation, as PHM was, that section states:

> 1500.3 Corporations. -- The statutory merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation. The sale or transfer of corporate stock does not require a final cost report since the corporation continues to exist. (42 C.F.R. § 489.18(a)(3).

HCFA Pub. 15-1 § 1500.3.

The Provider asserted HCFA has not contended that the Provider's acquisition of the DON rights of PHM was a CHOW under this section because there simply would be no supportable basis. SSH did not acquire the stock of the PHM corporation nor was it merged into a not-for-profit hospital corporation.

At the hearing, HCFA contended that since the intangible DON rights were an asset, the purchase of this single intangible asset was a CHOW of PHM;[12] thus enabling HCFA to impute the operating history of PHM to the TCC. The Provider states the manual section cited by the HCFA witness does not support this contention:

> 1500.7 Other Disposition of Assets.-Disposition of all or some portion of a provider's facility or assets <u>(used to render patient care)</u> through sale, scrapping, involuntary conversion, demolition or abandonment if the disposition affects licensure or certification of the provider entity.

HCFA Pub. 15-1 § 1500.7 (emphasis added).

The Provider asserts the meaning of this provision is clear. If a participating <u>Medicare</u> provider sells or otherwise disposes of its assets used <u>to render patient</u> care such that it affects licensure or certification of that Medicare provider, a Medicare closing cost report will be due. The ultimate effect is to trigger certain required Medicare reimbursement adjustments

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12 Tr. at p.168.

when a provider ceases participation in Medicare, such as gains or losses on disposal of depreciable assets and adjustments for accelerated depreciation.

Other sections in § 1500 provide guidance to Medicare providers and Intermediaries as to what is a CHOW requiring a final Medicare cost report.

Thus, this particular CHOW provision cited by HCFA, § 1500.7, was applicable to Medicare providers only, for the purpose of determining whether a final or "closing" Medicare cost report was due for a Medicare provider. Since PHM was never a Medicare participant, HCFA Pub. 15-1 § 1500.7 had no relevance to this case.
Further, Section 1500.7 does not support the HCFA witness' statement that SSHs acquisition of intangible DON rights means that PHM becomes a successor. Under this theory, a new facility that might purchase any asset, such as used beds or walkers from a closed facility, would become that facility's successor and ineligible for a new provider exemption. Such a proposition is simply absurd. The Provider concludes that the Medicare CHOW provisions were not a factual or legal basis for treating the transaction in this case as a CHOW or that TCC was the successor to PHM.

The Provider asserts an attempted clarification by HCFA of its reference to the CHOW provisions in the HCFA denial letter[13] was not helpful.

The Provider maintains that PHM did not meet the regulatory requirement of being "operated as the type of provider (or the equivalent) for which it is certified for Medicare." The Provider states TCC was certified as a SNF in February 1995; and PHM never "operated as" the equivalent of a skilled nursing facility because it did not render skilled nursing services.

The Provider states PHM was a closed facility in receivership; and it was only a level III Medicaid facility providing only minimal nursing care primarily of a custodial nature. Most of PHMs patients had mental and psychiatric conditions (31 of the 36 residents had psychiatric diagnoses when PHM closed)[14]; and most patients were never rehabilitated nor returned to their home. In fact, PHM did not provide any restorative care or therapy services, and its 1992 Medicaid cost report did not include any costs for such services.[15]

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13 Provider Ex P-7.

14 Tr. at p. 90; Provider Ex. P-15.

15 Tr. at pp. 90, 95, 107, 131-132.

TCC, on the other hand, provided high level skilled nursing and rehabilitative services to complex medical patients who rank in the highest rehabilitation categories of the Minimum Data Set(MDS).[16]

TCC represents a state-of-the-art facility. Patient rooms are a combination of private and semi-private accommodations with piped in gases to the wall, oxygen and suction; and all 25 beds are electric hospital-type beds.[17] On the other hand, PHM was forced to close because of the inability to meet physical plant survey requirements. PHMs facility was a converted old Victorian three story wood-frame house, with 2-6 beds in a room on the first and second floors, one common bathroom on the first floor, no elevator or air conditioning, and small corridors.[18]
PHM was not JCAHCO accredited.[19] PHM was only certified under the Massachusetts Medicaid program as a level III facility; it had never been a Medicare-certified facility; and due to the physical plant and Life Safety Code deficiencies, it could not have secured Medicare certification.[20] Thus, there was never a determination by Medicare surveyors, based upon an actual, on-site survey, that PHM "operated as" a SNF by meeting the Medicare Conditions of Participation.

The Provider's expert witness[21] acted as PHM's administrator under the court-appointed receivership and had actual knowledge of the needs of the residents and the services which they received.[22] The evidence and testimony of this witness demonstrated that PHM never "operated as" the equivalent of a skilled nursing facility. PHM did not, and could not, treat residents who required skilled nursing or restorative care, and the requirements under OBRA 1987 did not change this fact. The witness compiled Provider Exhibit P-15 based upon an analysis of the patients discharge summaries. The witness concluded that PHM did not and could not provide skilled services. She testified that the services reported in the April 1993 OSCAR as "skilled" were not skilled but rather custodial. No patients received therapy from the facility but rather were sent to outside vendors who billed the state directly. There was no special care provided by PHM; however, one patient cared for her own ilia loop. There were

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16 Tr. at pp. 58-60.

17 Tr. at pp. 51-52; Provider Ex. P-19 and P-20.

18 Tr. at pp. 85-89.

19 Tr. at p. 142.

20 Tr. at p. 89.

21 Gail King, a registered nurse and licensed nursing home administrator, had the clinical training and experience to evaluate PHMs services while serving as its administrator.

22 Tr. At p. 83.

no pressure sores, only patients with reddened skin who had lotion applied. The witness testified[23] that, in her opinion:

> 1) there were injections of vitamin B 12, insulin and some medications which were not skilled services, and the Provider believes HCFA now agrees these items were not skilled services.
> 2) the patients at the facility in 1993 would not have required skilled care in 1992, because they were likely healthier then than in 1993.
> 3) based upon many years of experience in nursing home operations, that an organization that operated a Level III nursing facility like PHM would not have the necessary background and experience to operate a Level II facility providing care at the level of the TCC.
> 4) the residents received primarily custodial care, i.e., they were clothed, fed, bathed, and given some regular type medications. There were no clinical management programs for the residents.

Tr. at pp. 113-114.
In contrast, the Provider asserts there is no substantial evidence supporting HCFA's underlying factual assumption that PHM provided skilled care. Therefore, HCFA's deeming PHM to be the equivalent of a SNF in the three year "look-back" period was incorrect and unsupportable.

The Provider asserts that when its NPE request was submitted, HCFA immediately requested completion of a form entitled "SNF Exemption Request Information Needs." In completing this form, the Provider documented: i) its status as a "new provider" with no previous Medicare or Medicaid provider numbers; ii) the initial state licensure date of the TCC was noted on the form -- January 19, 1995; iii) the fact that the facility had not been relocated; and iv) with respect to questions on the Provider Services Survey portion of the form as to when various "skilled services" were initiated at the TCC, the dates were all after January 19, 1995, i.e. when the TCC opened.

In addition, HCFA requested, through the Intermediary and without explanation,[24] that the Provider quickly complete a SNF Exemption Request Information Needs form on PHM, the closed Medicaid NF. Compliance with the HCFA request presented Provider's personnel with a dilemma, since PHM had been closed since December 17, 1993, its employees long gone, and the SSH had no role in the operations of the defunct PHM. The request was forwarded to

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23 Tr. at pp. 113-114.

24 The Intermediary was unable to cite any regulatory basis for requesting completion of this form in connection with the "new provider" exemption request, nor why HCFA sought data on this form for a closed custodial Medicaid facility.

the Court-appointed Receiver, Mr. Roush, who closed the operations of PHM and made the following response to HCFA:

> The Receiver closed Prospect Hill in late 1993. The residents of the facility were relocated to other nursing facilities under a DPH approved relocation plan. Prospect Hill never participated in Medicare. It was licensed and certified as an ICF. It did not care for residents with Level II or skilled nursing needs.
>
> After the Receiver closed the facility we sold the property and building. The receivership remains in effect, but solely for the purpose of winding down the affairs of the old business.

Provider Exhibit P-3, page 1.

The Receiver further advised HCFA that he executed an agreement with the Provider in 1994 which granted the opportunity for the Provider to seek DON approval from the Massachusetts Department of Public Health stating:

> In essence, [the Transitional Care Center] acquired the residual DON rights of Prospect. [The Transitional Care Center] did not acquire the assets, residents, employees, property, financial, or the provider agreement for the old nursing home business.... The Receiver is responsible for the vestiges of Prospect Hill and its business. To be cooperative we have enclosed responses to the inquiries in the Exemption Packet.

Provider Exhibit P-3, pages 1-2.

Further, the Receiver answered "no" to each of form's ten questions concerning whether various "skilled services" were offered at Prospect Hill.[25] The form also requested a contact person at the facility, the Receiver noted: "Closed. Contact Receiver at (617) 494-1118", his telephone number on the letterhead for A-D-S Consulting, Inc.[26]

The Provider contends that HCFAs determination that skilled nursing services were provided during the 3-year "look back" period is incorrect and unsupportable.

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25 As Administrator of PHM, Ms King's testimony corrected Mr. Roush's answer to the first question on the Form; and with her amendment to Provider Ex P-3, confirmed that this Exhibit was accurate as to the services provided at PHM. (See Tr. at p. 101).

26 Provider Ex. P-3.

The Provider makes three primary arguments:

1. There was no CHOW and HCFA can not impute PHMs operations to TCC)as discussed in I above).

2. With respect to the 3-year period, PHM was not even operating for the immediate 13 months preceding TCCs Medicare certification. 3. PHM did not provide skilled nursing or rehabilitative services [as discussed in II above].

In support of this contention the Provider asserts:

a. To expand SSH's operation to encompass a LTC facility and/or SNF (TCC), SSH had to either close its medical/surgical beds or purchase the DON rights from another entity within the same HSA.

b. SSH had no connection with the operation of PHM other than the purchase of the DON rights after PHM was closed.

c. PHM was a Level-III Medicaid nursing facility which served primarily long-term residents with psychiatric disorders.

d. TCC is a completely different type of facility which provides intensive skilled and rehabilitative services with a wide range of therapies to complex medical patients. For example, TCC:

> i) is staffed with 7.66 full-time equivalents of nursing staff, compared to the industry average of about 4.15 F.T.E.'s.[27]
>
> ii) provides physical therapy, occupational therapy, speech/language pathology, respiratory therapy, and cardiac rehabilitative therapy. The rehabilitative services are provided by hospital employees dedicated to the TCC, and the rehabilitation services are lead by a physiatrist.[28]
>
> iii. The rehabilitation staff have additional training since they are involved in the evaluation as well as the treatment of the patient, with the goal of providing a high level of rehabilitation so that the patient can be returned to a functional state and discharged to home quickly. The TCC treats very complex medical

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27 Tr. at pp. 51, 70, & 74.

28 A physiatrist is a medical doctor that is board certified in rehabilitative medicine. (Tr. at p. 54).

patients who fit into the highest categories of rehabilitation in the Minimum Data Set (MDS).[29]

iv) performs intravenous therapy and complicated wound care.

v) is atypical in both nursing services and rehabilitation services, and it has received reimbursement exceptions for atypical services.[30]

vi) does not serve custodial patients or patients with primary diagnoses of psychiatric or mental disorders [like PHM]; and TCCs patients are typically discharged to their home.[31]

The Provider maintains that with respect to the 3-year "look back" period [Jan. 1995 to Jan. 1992], PHM was not even operating for the immediate 13 months before certification since it was closed on December 17, 1993; and for the other 23 months, it did not "operate as" the equivalent provider of skilled nursing or rehabilitation services to the TCC because it was only a level III facility, i.e., Medicaid nursing facility, furnishing minimal care, as discussed in II above.

The Provider argues that HCFAs conclusion that PHM provided skilled nursing services was incorrect in several respects. The Provider's expert witness testified from personal knowledge that the services actually provided during the three year "look-back" period were not equivalent to skilled nursing care, as discussed in II above. The Provider states HCFA relied on inappropriate information from reports that were not designed to report skilled nursing data, and these reports did not have instructions for preparation or definition of terms for requested data.

The Provider avers that PHM did not render skilled nursing services as defined by Medicare. In addition to the discussion in II above, the only reported information about the services PHM furnished was its own self-reported Medicaid survey information, which would have been reported on HCFA Form-672, as revised April, 1992 (Provider Exhibit P-13), and Form-672, as revised January, 1990. (Provider Exhibit P-14). The information reported on these forms, and the actual clinical assessment of the residents provided by the Provider's expert witness at the hearing confirms that the care provided was primarily custodial care to an ambulatory population with mainly psychiatric and mental disorders. (Provider Exhibit P-15). PHM did not and could not treat patients requiring skilled nursing or restorative care per the testimony of the Provider's expert witness as discussed in II above.

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29 Tr. at pp. 58-60.

30 Tr. at pp. 53-54, 58, & 154.

31 Tr. at p. 57.

The Provider maintains that HCFAs denial was primarily based on the data reported in Intermediary Exhibit I-36 which contained the results of PHMs self reported annual patient survey information for 1989, 1990, 1991 and 1993. Massachusetts Department of Public Health survey team requires each Medicaid NF to complete an annual resident characteristics form.[32] For the period 1989 through 1993, this information would have been reported on the "Resident Census and Conditions of Residents" HCFA Form-672, as revised by HCFA in January 1, 1990 (Provider Ex P-14);[33] and revised again in April 1992 (Provider Ex P-13).[34] [35] Apart from definitions about independent supervision and assistance to residents, the Form-672 was in use in the period from 1989 to July, 1995 and did not contain any definition of terms.[36] Therefore, the Provider asserts the preparer could misinterpret the requested information. From PHMs self reported survey reports seventeen categories of nursing

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32 Tr. at p. 108; Provider Exhibit P-14.

33 Tr. at pp. 108-109.

34 Id.

35 Intermediary's Ex I-8 is the version of HCFA Forum-672 as it was revised in July, 1995. Forum-672 as it was used for resident assessment by PHM through the period 1989-1993 does not contsin any examples of skilled services as enumerated at F144-145 of Intermediary's Ex I-8. The Provider asserts the Intermediary's inclusion of Exhibit I-8 was misleading because it is premised upon the assumption that Forum 672 was completed with instructions and examples tha t did not exist until July 1995.

36 Tr. at p. 109.

services[37] was then compiled into the OSCAR format, corresponding to each survey date.[38] The OSCAR for PHM, Intermediary Ex I-36, shows that of the seventeen categories of nursing services reported over the period of 1989, 1990, 1991, and 1993,[39] services were provided in only four categories: i) pressure sores; ii) special ostomy care; iii) special care injections; and iv) special care rehab services (Intermediary Ex I-36).

With respect to the four reported categories, the Provider states the expert witness testified that the reported information was inaccurate and/or was not skilled services. The witness cited the following examples and explanations:

> i) Pressure Sores--in 1993 a facility would have reported any level of a pressure sore (stages one through four) on the HCFA Form-672.[40] It was not until the July, 1995 change in instructions to Form-672 when HCFA clarified that treatment of a stage one pressure sore was not a skilled service. A stage one pressure sore is a reddened area of the skin that is not broken.[41] All of the PHMs patients who were treated for pressure sores in

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37 There are seventeen categories of nursing or restorative services listed on the most recent OSCAR report introduced as Intermediary Ex I-36 at the hearing. The earlier OSCAR report, Intermediary Ex I-9, contains only thirteen categories of services. These categories listed on the OSCAR form prepared in 1995 are not necessarily skilled services, as they were reported on the Form-672, in the period from 1989 until the form was revised by HCFA in 1995. The Form-672, as used for the reporting periods of PHM, predated the October 1, 1990 effective date of the OBRA 1987 certification standards for Medicare "skilled nursing facilities" and Medicaid "nursing facilities." Form-672 collected information to characterize resident population of Medicaid intermediate care facilities like PHM. Medicaid intermediate care facilities were not reporting "skilled" or restorative services when they completed the Form-672 for survey purposes, since they were intermediate care facilities, and the form was not designed for that purpose. As noted, it was not until July, 1995 that Form-672 appears in the form of Intermediary Ex 1-8. (See Tr. at p. 129).

38 Tr. at pp. 161-162, 185-186.

39 Even if PHMs operations can be used in the 3-year "look-back" period, only the 1993 survey falls within the 3-year period. The surveys in 1989, 1990 and 1991 fall outside the look back period.

40 Tr. at pp. 109-110.

41 Tr. at p. 96.

1993 only had stage one pressure sores. These residents had preventive skin care so the skin would not open.[42] The simple treatment involved the application of some cream or A&D ointment which was not the delivery of a skilled service.[43] Since PHM had no bedridden patients, there could not have been any other stages of pressure sores.[44] Thus, the treatment of pressure sores reported on the HCFA Form 672 by PHM was not the provision of a "skilled service."

ii) "Special Care Ostomy" The expert witness testified that one resident (Number 17 on Provider Ex P-15) had an ilia loop which she took care of herself, and she did not receive assistance from the nursing staff.[45] Self-care ostomy is not skilled care.[46]

iii) "Special Care Injections" The expert witness testified that there were only three types of injections given to patients which were not skilled services. Two residents received insulin, two received vitamin B-12, and one received Prolixin Decanoway every two weeks.[47] Insulin injections and Vitamin B-12 injections HCFA no longer considers to be a skilled service.[48] It is noted that HCFA stated in the Prospective Payment System regulations for skilled nursing facilities -
"We also believe that the ordering of subcutaneous injections can no longer be considered sufficient in itself to justify the designation of a covered SNF level of care. We note that the most frequently administered type of subcutaneous medication is insulin, which has long been defined as a non-skilled service with respect to any beneficiary who is capable of self-administration. Further, with the evolving state of clinical practice over time, the administration of a subcutaneous injection

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42 Tr. at pp. 95-97.

43 Tr. at pp. 95-96, 141-142.

44 Tr. at p. 97.

45 Tr. at pp. 96-97.

46 Tr. at p. 189.

47 Tr. at p. 99.

48 Tr. at p. 195.

> has now become commonly accepted as a nonskilled service even in less intensive settings such as physician office and home health agencies, making its continued categorization as a skilled service in the SNF context increasing anomalous."

Federal Register, 63 Fed. Reg. 26284 (May 12, 1998).

In 1995, the Provider states HCFA clarified the instructions for HCFA Form-672 that vitamin B-12 injections are not a skilled service.[49] Additionally, the expert witness testified these types of injections were not regarded as skilled services; and that residents of rest homes [Level IV facilities in Massachusetts] can, if capable, give their own injections.[50] PHMs patients could not administer their own injections either because of psychiatric problems where they could not be trusted with a sharp needle, or because of mental retardation.[51] Thus, the injections listed on the HCFA Form-672 by PHM were not evidence of rendering skilled services as recognized by HCFA.

iv) "Special Care Rehab Services" Most of PHMs residents had psychiatric or mental disorders which required active counseling by outside psychologists, psychiatrists, or social workers and other professionals who came to the facility professionals.[52] These services were not provided by the nursing staff of PHM nor paid for by PHM "under arrangements."[53]

The Provider contends that HCFA's relocation argument of a provider under HCFA Pub. 15-1 § 2604.1 is groundless because i) the underlying premise of a CHOW was erroneous, ii) there was no relocation of PHMs operations, and iii) TCC and PHM do serve different populations geographically.

The manual provision grants new provider status where there has been a complete change in the operations of a facility that has been relocated geographically. This provision states:

> 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. ... ... a provider ... must ... demonstrate that in the new location a substantially different

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49 Tr. at pp. 120, 130.

50 Tr. at p. 100.

51 Id.

52 Tr. at pp. 98-99; Provider Ex P-15.

53 Id.

> inpatient population is being served. In addition, ... 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.

HCFA Pub. 15-1 § 2604.1.

The Provider assets the mere acquisition of the DON intangible rights to 40-beds was not the same thing as relocating a provider and/or its operations for purposes of a "new provider" exemption. The Provider states that when a provider is actually relocated, there would be a transfer of an ongoing operation, including management, personnel, clinical operations, patient records, facilities, equipment, and physicians referral sources, etc. Moreover, the acquisition of DON rights does not carry with it the clinical and operational know-how to run the relocated facility. In the case of PHM, none of the operational expertise, know-how, employees, or patients were transferred to the TCC. In fact, it was not possible because PHM was closed over 13 months before the TCC opened; and there was no management expertise of PHM to be transferred to TCC since the owner/administrator had abandoned the facility.

The Provider also disagrees with HCFA's allegation that the provisions under HCFA Pub. 15-1 § 2604.1 were not met because TCC and PHM serve the same basic geographical area.

The Provider states that although SSH and PHM serve the same general HSA of greater Boston, each served vastly different local communities. PHM served the local community around Summerville, Massachusetts, while SSH served the local community around South Weymouth, Massachusetts. Even though those communities were not a great distance apart, the logistics and difficulties of travel in Boston itself resulted in service areas that were much smaller and dissimilar for the two institutions. The driving time could range from 45 minutes to 3 hours depending upon the time of day and the road renovations in progress. SSH was located in the extreme southeastern corner of HSA IV only a few miles from HSA V, southeastern Massachusetts. Thus, its service area was the southeastern part of HSA IV and the northern part of HSA V.[54] PHM was located and served patients in the mid to northern end of HSA IV. TCC was not considered a part of the Boston hospital community; and in fact, it was a community hospital, serving its local community.[55]

The Provider asserts even if HCFA could factually support the conclusion that the TCC was a relocation of PHMs operations, it cannot support the determination that the Provider has "operated as" the equivalent of a SNF based upon PHM's self reported survey information. The mere fact that PHM provided insulin and vitamin B 12 injections does not mean it had already incurred the costs necessary to provide skilled care and rehabilitation services, as

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54 Tr. at pp. 26-28, 61-63; and Provider Ex. P-8.

55 Tr. at p. 63.

testified and evidenced by the expert witness.[56] The overwhelming evidence in this case demonstrates that PHM was not capable of, and did not operate as, a skilled nursing facility in the three year look-back period.

The Provider maintains that HCFA's review standards for NPE requests do not follow the basic tenet of the stated purpose and intent of the regulations in the Federal Register, Vol. 44, No. 52, p. 15746, which was stated in HCFA letters granting NPE:[57]

> [t]he purpose of the "new provider" exemption is to recognize the costs associated with the initial periods of development. For this reason, a "new provider" is defined as "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."

(Emphasis added.) Id.

The Provider asserts the overreaching phrase in the regulation is "operated as". If the provider has in the past "operated as" the "type of provider" or the equivalent, then it will not be incurring the costs associated with the initial periods of development of the ability to provide the inpatient services, and the "new provider" exemption would not be appropriate. Presumably, the facility having "operated as" the equivalent provider would not need to build up a new patient case load since it could draw upon its existing inpatient population base and would continue to serve the same inpatient population. Consistent with the purposes of the new provider exemption, the focus should be on whether the predecessor facility and the current facility truly operate as the same types of providers or the equivalent. A primarily custodial Medicaid nursing home providing minimal care to residents with psychiatric disorders does not constitute operating a Medicare skilled nursing facility like TCC.

The Provider states its expert witness who served as the administrator of PHM during the receivership period testified, from first-hand experience in the facility five days a week, regarding the nursing care needs of the residents (as compiled in Provider Ex P-15). PHM did not and could not provide SNF type services. The witness also explained that the services reported in the April 1993 OSCAR as "skilled" were not skilled but rather custodial. Therefore, PHM did not "operate as" the type of provider for which TCC was certified.

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56 Tr. at pp. 120 and 130.

57 Provider Ex P-10, and P-11, and with Attachments A and B--HCFA letters granting, "new provider" exemptions.

TCC did incur significant costs and did not have a patient case load or an existing inpatient population to draw upon. TCCs admissions were predominately from the medical/surgical units of the hospital.
The Provider claims a legitimate reason for disqualifying a particular facility from qualifying as a "new provider" is that the Medicare program should not incur expenses that have already been incurred by an existing NF capable of providing skilled nursing and rehabilitative services. The Provider states even granting this Provider an exemption would not result in Medicare paying the new facility for costs that had already been incurred.

Review of HCFA Policy and Precedent Cases

The Provider alleges there was no long-standing HCFA policy of treating transference of intangible DON or CON rights as relevant to the new provider exemption process. In fact, HCFA only recently began analyzing CON rights in cases before the Board in Milwaukee Subacute and Rehabilitation Center and in Mercy St. Teresa Center.[58] These cases represent a departure by HCFA from its own established precedent on new provider exemptions.

In reviewing other precedent cases, the Provider states the HCFA witness was unable to explain the inconsistency between this case and the "new provider" exemption granted to Meridian Healthcare -Spa Creek[59] that incorporated CON rights to 40 relocated beds into the Spa Creek project. In fact, the exemption granted to Spa Creek was consistent with Medicare program regulations that had not been changed in many years at the time TCC requested a "new provider" exemption. In the case of Meridian Healthcare - Spa Creek (Provider No. 21-5258) in Annapolis, Maryland, 40 beds were relocated to Spa Creek from other Meridian comprehensive care facilities in Anne Arundel County, Maryland pursuant to a CON issued to Meridian Healthcare. (See Provider Ex. P-10, Modified Certificate of Need, June 11, 1991.) One patient was even transferred from Meridian Nursing Center - Severna Park to the Meridian Spa Creek facility. Contrary to the position that HCFA has taken in the instant case of the TCC, HCFA granted a "new provider" exemption for the Spa Creek facility through cost reporting period ending September 30, 1997.

The Provider states there is precedent for granting "new provider" exemptions based upon a Provider becoming certified for the first time under the Medicare program.

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58 Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40 (April 14, 1998).
Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/AdminiStar Federal, PRRB Dec. No. 98-D64 (June 16,1998).

59 Provider Ex. P-10.

HCFA Precedent Granting "New Provider " Exemptions

The Provider asserts there is ample HCFA precedent for granting "new provider" exemptions based upon a provider becoming certified for the first time under the Medicare program. Exemptions have been granted by HCFA in numerous instances after October 1, 1990, the effective date of the OBRA 1987 common certification standards for Medicaid nursing facilities and Medicare skilled nursing facilities, including where the Medicaid facility has simply become certified for the Medicare program. See Provider Ex P-10, P-11 and P-12[60]; and Attachment A for a partial listing of Medicaid nursing facilities that were granted "new provider" exemptions simply upon becoming certified for participation in the Medicare program, with attached examples of HCFA approval letters for such exemptions. In addition, Attachment B, is a partial listing of SNF "New Provider Exemptions" granted by HCFA to Transitional Care Units or Hospital-Based SNF Units, with attached samples of "new provider" exemptions granted.

Review of Recent PRRB Decisions

The Board's recent ruling in the Mercy St. Teresa Center case overlooked the underlying purpose of the "new provider" regulations by focusing so narrowly upon the OSCAR information. A Medicaid facility that operates primarily as a custodial facility while occasionally providing low level skilled services is not incurring the costs nor operating the programs or therapies associated with the operation of a new SNF. The decision also overlooked the fact that the Medicaid facility in the Mercy St. Teresa Center case provided only episodic skilled services and primarily operated as a custodial facility.

The Provider disagreed with the testimony of the HCFA witness in this case that if a Medicaid facility provided one injection in the three year look-back period, it was "operating as" the same type of facility as a Medicare SNF. The Provider states this is not a consistent policy as evidenced by Provider Ex P-10, P-11, and the HCFA letters granting "new provider" exemptions included with Attachments A and B, where no reference is made to this test. The Provider states there should be no mistake that this is a wide departure from established HCFA precedent granting "new provider" exemptions. The Provider maintains that HCFA cannot claim that the decision made in this case, disqualifying a "new provider" exemption based upon episodic provision of certain nursing services by older Medicaid facilities that are not even tangentially related to the operation of the new provider is consistent. In fact, HCFA personnel dealing with "new providers" did not use the Medicaid survey information, and later OSCAR reports, for purposes of reviewing "new provider" exemptions, until some time in 1995 because they were unaware of its existence until then as evidenced by HCFA's exemption letters before this time.

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60 Provider Ex P-12 shows HCFA precedents on Attachment A and B were furnished by HCFA pursuant to Provider's Freedom of Information Request.

The Provider states the questionnaire entitled "Information needed for the review of SNF Exemption Requests to the Cost Limits," (Provider Ex P-9), is not referenced in HCFA Pub. 15-1 provisions that were in force at the time that TCC requested its exemption. The Provider avers the origin and use of this form under the Medicare program in connection with exemptions prior to the 1997 revision to the Manual is really a retroactive change in policy which exceeds HCFA's authority. Bowen vs. Georgetown University Hospital, 488 U.S. 204 (1988). Neither the regulation nor the relevant manual section, 2604.1, makes any reference to the use of survey information in reviewing "new provider" exemption requests. The regulation uses the more generalized test of "operated as," and the test was made in line with the then operative language of the manual § 2604.1 defining "new providers."

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that HCFA's denial of the NPE was proper. The Intermediary asserts the Provider does not qualify for the NPE from the RCL because the Provider failed to meet the definition requirements stated at 42 C.F.R. § 413.30(e) nor does the Provider qualify under HCFA Pub. 15-1 § 2604.1.

The regulation definition states a new provider exemption is only available to 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."

42 C.F.R. § 413.30(e).

The Intermediary stated the Provider failed to meet three critical aspects of section 413.30(e). Namely, that the Provider:

I. operated as the type of provider for which it is certified for Medicare under past or present ownership;

II. provided skilled nursing services; and

III. for less than three full years.

The Intermediary contends that HCFA properly determined that there was a CHOW when SSH purchased the DON rights from PHM. Therefore, in applying the regulation phrase "... has operated as the type of provider..." refers to whether or not, prior to certification, the institution had engaged in providing residents skilled nursing care "under past or present ownership," PHMs operations must be considered as under "prior ownership."

The Intermediary claims that although the Provider was initially certified in February of 1995, PHM operated under prior ownership for several years, going back at least until 1990 providing skilled nursing care. In this case, it was determined that there was a CHOW under the provisions of HCFA Pub. 15-1 § 1500 when SSH purchased the DON rights to the 40-beds licensed to PHM. This transfer of assets constituted a transfer of ownership of PHM to the SSH.

The Intermediary states HCFA Pub. 15-1 § 1500.7 describes an event that is a common form of CHOW as follows-- "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."

Testimony at the hearing indicated that the DON rights were virtually the only assets that PHM had at the time of sale to the SSH. Further, the letter from the Commonwealth of Massachusetts, Department of Public Health, Determination of Need Program, dated March 22, 1994,[61] approved the transfer of ownership of PHM and the 40-beds to the site of the Provider. That letter stated "[t]he primary reason given for the transfer of site is that the Division of Health Care Quality approved transfer of ownership of Prospect Hill Manor to South Shore Hospital, assuming relocation of the long-term care facility to the campus of South Shore Hospital."

The Intermediary states the Provider failed to meet the second aspect of the NPE definition because, under prior ownership, PHM provided skilled nursing care for several years going back at least until 1990.

The Intermediary maintains that HCFA determined that the Provider, under prior ownership via PHM, had engaged in providing residents skilled nursing care and related services for residents who required medical or nursing care, or rehabilitation services for the rehabilitation of the injured and disabled, or sick persons as identified in 42 C.F.R. § 409.33 (b) and (c); and PHM had not primarily rendered care and treated residents with mental diseases. This statutory definition of a SNF is also stated in section 1819(a)(1) of the Social Security Act. PHM had been providing skilled nursing care for a number of years.

The Omnibus Reconciliation Act of 1987 (OBRA '87) included the Nursing Home Reform provisions[62] that regulate the certification of long-term care ("LTC") facilities under the Medicare and Medicaid programs. The effect of these provisions was that both Medicare SNFs and Medicaid NFs were required to provide, directly or under arrangements, the same basic range of services described in section 1819 (b)(4) and 1919(b)(4) of the Social Security Act. The range of services included those nursing services and specialized rehabilitative

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61 Intermediary Exh. I-10.

62 Effective for services rendered on or after October 1, 1990.

services needed to attain or maintain each resident's highest practicable level of physical, mental, and psychological well being.

42 C.F.R. § 409.33 describes services considered skilled nursing or skilled rehabilitation including intravenous, intramuscular, or subcutaneous injections; feeding tubes; tracheotomy aspiration; catheters; application of dressings; involving prescription medications; treatment of skin disorder; heat treatment; oxygen, respiratory therapy and other rehabilitative nursing procedures, and physical, occupational, speech therapy. The Intermediary maintains that PHM was providing these types of services even though such services may have been provided at a low volume.

The Intermediary asserts the Provider, under prior ownership, was providing skilled and rehabilitative services. The Intermediary refers to the "On-line Survey and Certification Report" ("OSCAR") as evidence of skilled nursing services performed at PHM in the years prior to Medicare certification of TCC at SSH. The OSCAR report for PHM indicates that between 1989 and 1993, skilled nursing and rehabilitative services were provided including: treatment of skin pressure sores; special care, ostomy-I injections; and rehabilitative services.[63] Those services are considered skilled pursuant to 42 CFR § 409.33. In 1992, three years prior to SSHs certification of the TCC as a Medicare provider, PHM was operating as the same type of provider. The Intermediary states PHM may not have provided skilled nursing services as frequently as a SNF; however, the regulation at 42 C.F.R. § 413.30(e) makes no allowance for institutions providing a low volume of skilled nursing services prior to SNF certification.[64] The Intermediary asserts it is the rendering of skilled nursing services, regardless of volume, that is determinative as to whether or not the exemption is available. Therefore, TCC is not entitled to a new provider exemption.

The Intermediary claims the Provider failed to meet the NPE definition because the regulation § 413.30(e), requires a look back of three years from the date the Provider was certified under the Medicare program (February 1995) to determine if the provider was providing the same type of services for which it is certified under Medicare. The Intermediary states since there was a CHOW, the regulation requires that the three-year look-back include the services rendered by PHM under prior ownership.

The Intermediary asserts since the Provider was certified as a SNF in February of 1995, that looking back more than three years to 1990, the Provider, under prior ownership (via PHM), was providing skilled and rehabilitative services as discussed in II above. As stated above, the OSCAR evidences that skilled nursing services were performed at PHM in the years prior to Medicare certification of TCC at SSH. The OSCAR report for PHM indicates that between 1989 and 1993, skilled nursing and rehabilitative services were provided including: treatment

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63 Tr. at pp. 160-164.

64 Tr. at p. 166.

of skin pressure sores; special care, ostomy-I injections; and rehabilitative services. Those services are considered skilled pursuant to 42 C.F.R. § 409.33. Thus, in 1992, three years prior to TCCs certification as a Medicare provider, it was operating as the same type of provider, under prior ownership, even though such services may have been at a lower volume.

The Provider Reimbursement Manual, § 2604.1 provides that NPE is not available where the relocation did not result in a substantial change in the population served at the new location, and the inpatient days at the new location were not substantially less than at the old location during a comparable period.

The Intermediary argues that the provider is not entitled to an exemption based on § 2604.1 because: i) the relocation of beds from PHM to SSH did not result in a substantial change in the population served at the new location, and ii) the inpatient days at the new location were not substantially less than at the old location during a comparable period.[65] SSH was located in the same HSA as PHM; thus, the admissions to PHM and SSHs TCC were from the same HSA. The testimony showed that a review of admissions confirmed 73 % of admissions to TCC were from the same HSA served by PHM.[66] As a result, the Intermediary determined that SSH's TCC was not entitled to an exemption under §2604. 1.

Recent Cases:

The Intermediary also cites two recent comparable PRRB decisions on the same issue; namely, Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40, April 14,1998, and in Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/Administar Federal, PRRB Dec. No. 98-D64, June 16, 1998. Both cases represent similar fact situations, and the Board affirmed HCFA's application of 42 CFR 413.30(e) in determining that a NPE was not appropriate.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Laws

42 U.S.C.:

§ 1395x(v)(1)(A) - Reasonable Cost

65 Tr. at pp. 172-174.

66 Tr. at p. 173.

Title XVIII of the Social Security Act:

§ 1819 et seq.	-	Requirements for, and Assuring Quality of Care in, Skilled Nursing Facilities
§ 1919 et seq.	-	Requirements for Nursing Facilities

2. Regulations - 42 C.F.R.:

§ 405.1800 et seq.	-	Provider Reimbursement Determinations and Appeals
§ 409.33	-	Examples of Skilled Nursing and Rehabilitation Services
§ 413.30(e)	-	Limitations on Reimbursable Costs-Exemptions

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 1500 et seq.	-	Change of Ownership
§ 2604.1	-	Definitions. New Provider

4. Case Law:

Bowen vs. Georgetown University Hospital, 488 U.S. 204 (1988).

Milwaukee Subacute and Rehabilitation Center v. United Government Services, PRRB Dec. No. 98-D40 (April 14,1998).

Mercy St. Teresa Center v. Blue Cross and Blue Shield Association/Administar Federal, PRRB Dec. No. 98-D64, June 16, 1998.

5. Federal Register

Vol. 44, No. 52, p. 15746.

Vol. 63, No. 91, p. 26284.

6. Other:

Omnibus Reconciliation Act of 1987
HCFA Form 672

FINDINGS OF FACT, AND CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, evidence, testimony presented at hearing, and post hearing briefs, finds and concludes that HCFA properly denied the provider's request for an exemption to the routine cost limits as a new provider. The Provider does not qualify as a new provider under either 42 C.F.R. § 413.30(e) or HCFA Pub. 15-1 § 2604.1.

The Board majority finds that the controlling regulation for granting a new provider exemption ("NPE") from the routine cost limits ("RCL") is 42 C.F.R. § 413.30(e). This regulation defines a new provider as:

> [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.

42 C.F.R. § 413.30(e) (emphasis added).

Based on the substantial evidence in this case, the Board majority finds that:

1. South Shore Hospital ("SSH") purchased the DON rights for 40 operational beds from Prospect Hill Manor ("PHM") in early 1994 which was a purchase of assets constituting a change of ownership ("CHOW") under HCFA Pub. 15-1 § 1500.7.

2. The letter from the Department of Public Health clearly stated there was both a change of ownership and a relocation involved in the purchase transaction of the DON rights. The March 22, 1994 letter from the Department of Public Health, Commonwealth of Massachusetts, concerning the Determination of Need ("DON") program, stated "... [t]he primary reason given for the transfer of site is that the Division of Health Care Quality approved the transfer of ownership of Prospect Hill Manor to South Shore

Hospital, assuming relocation of the long-term care facility to the campus of South Shore Hospital."[67]

3. The Provider, Transitional Care Center ("TCC"), was created about a year later through the transfer of DON rights for 40 beds at the new location of SSH. The Board majority acknowledges the only relationship between PHM and TCC was the purchase of the DON rights. TCC was created out of new cloth because none of PHMs operations, staff, patients, referral sources, etc. were transferred. Moreover, the type of patients treated at the two facilities were completely different, i.e, from largely custodial to medically complex. The physical plant aspects were completely different. However, these aspects do not alter the Department of Public Health's determination that there was a CHOW and a relocation to SSH which supports the Board's finding.

4. In view of the CHOW, it was proper to consider the previous operations of PHM in determining whether TCC meets the requirement of 413.30(e) for a NPE.

5. There is evidence that during the three year look back period, PHM had been "operating as" a SNF since some skilled nursing services had been provided to its patients. The Board majority acknowledges that PHM did not render skilled nursing services as frequently or at the level generally found in Medicare SNFs. Moreover, these services were at an extremely low level, and the reporting forms showing these services may have had some imperfections. However, the regulation cited above makes no allowance for a low volume of services prior to TCC's certification as a SNF.

6. Since PHM was a Medicaid nursing facility ("NF"), it was required under section 1819(b)(4) of the Social Security Act, to be capable of providing, either directly or under arrangements, a basic range of services. Thus, both Medicare SNFs and Medicaid NFs were required to provide the basic range of skilled nursing services stated in sections 1819(b)(4) and 1919(b)(x)(4) of the Social Security Act. This range of services included those nursing services and specialized rehabilitative services required to attain or maintain each resident's highest practicable level of physical, mental, and psychological well-being.

7. The Provider was certified as a SNF in February 1995; and neither SSH or TCC had provided SNF type services. However, TCC failed to meet the requirements of § 413.30(e) since the operations and services rendered by PHM must be considered in determining whether TCC meets the regulatory requirements because there was a CHOW. And, as stated in ¶ 5 and ¶ 6 above, PHM had been providing skilled nursing services and was required to be capable of rendering such services. Therefore, PHM's

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67 Intermediary Ex I-10.

provision of some skilled nursing services are imputed to TCC under the concept of prior ownership causing TCC to fail the requirements of § 413.30(e).

8. The Provider does not qualify for a NPE under the avenue permitted by the provision of HCFA Pub. 15-1 § 2604.1 where there has been a relocation of operations to a different site. This manual provision allows a NPE "where the normal inpatient population can no longer be expected to be served at the new location." The Board majority finds that the Provider did not demonstrate with convincing evidence that a substantially different inpatient population was being served by TCC. A review of admissions confirms that 73 % of admissions to TCC were from the same health service area ("HSA") served by PHM.[68] Thus, the provider continued to serve the same HSA before and after the relocation. Additionally, the state regulatory authorities premised the transfer of the licensed beds on the fact that TCC would continue to serve the same HSA.[69]

In view of the foregoing findings, the Board majority concludes that the Provider is not entitled to an exemption as a new provider under 42 CFR 413.30(e) because through PHM it had operated under previous ownership as the same type of provider for which it became certified within the past three years . Further, the Provider is not entitled to an exemption as a new provider under the provisions of HCFA Pub. 15-1 § 2604.1. This provision permits a NPE where there has been a relocation of operations. However, TCC does not serve a substantially different inpatient population since many of its patients come from the same HSA served by PHM.

The Board majority notes that this decision is compatible with its recent decisions in Mercy St. Teresa Center and Milwaukee Subacute and Rehabilitation Center involving the same issue.

DECISION AND ORDER:

The Provider is not entitled to a new provider exemption to the routine service cost limits as stated in 42 C.F.R. § 413.30(e) or HCFA Pub. 15-1 § 2604.1. HCFA's denial of the Provider's request for a new provider exemption is affirmed.

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68 Tr. at p. 173.

69 Intermediary Ex I-10.

Board Members Participating:

Irvin W. Kues
James G. Sleep (dissenting opinion)
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

Date of Decision: April 21, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of James Sleep

After consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and post-hearing briefs, this Board member disagrees with the determination of my colleagues. I find and conclude contrary to the Board majority that the Provider [TCC] is entitled to an exemption from the routine cost limits as a "new provider."

I find the Provider meets the requirements of a new provider as stated in the controlling regulation:

> New Provider. The provider of inpatient services has operated as the type of provider (or equivalent) for which it is certified for Medicare, under present and previous ownership, for less than three full years.

42 C.F.R. § 413.30(e).

I also find that the Provider did not "operate as the type of provider for which it is certified" under present or past ownership. Based on the evidence, HCFA's denial was incorrect. HCFA's denial hinged on the erroneous determination that there was a change of ownership ("CHOW") when SSH purchased the intangible DON rights to 40 beds from a defunct medicaid facility as discussed below.

Based upon the evidence in this case, I find that:

. Neither SSH or TCC ever provided SNF type services prior to TCC's SNF certification in February 1995.

. HCFA improperly determined that there was a CHOW by the Provider's purchase of the intangible DON rights to all of the beds of a defunct medicaid facility [40 beds]; and then improperly concluded that the defunct facility had provided SNF services within the 3-year regulatory "look-back" period which HCFA then imputed to TCC because of the CHOW.

. The Medicaid facility, PHM, was a closed defunct entity that was in receivership when the owner abandoned the facility because certification was lost due to extensive physical plant deficiencies.

. The DON rights to 40 beds was at best an intangible asset because it only evidenced the "right to create and operate nursing beds." The DON rights had some residual value only because the State had instituted a cap on the number of beds that could be licensed within the state.

. Although SSH purchased the DON rights to 40 beds licensed to PHM, this transaction did not constitute a CHOW with PHM within the meaning of HCFA Pub 15-1 § 1500.7 as relied upon by HCFA in its denial.

That manual provision states:

> 1500.7 Other Disposition of Assets.--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 <u>if the disposition affects licensure or certification of the provider entity.</u>

HCFA Pub. 15-1 § 1500.7 (emphasis added).

PHM was closed in December 1993 and was already defunct, when the purchase of the intangible DON rights occurred. The manual provision contemplates that the enumerated types of dispositions would adversely "affect [the] licensure or certification of the provider entity." In this case, PHM's certification was lost due to the inability to meet physical plant requirements. The entity was like a "totaled vehicle" with some parts being sold from the carcass. Thus, the receiver was merely selling available assets to generate funds to pay creditors. Hence, the sale of the intangible DON rights in 1994 did not affect the licensure or certification of PHM within the meaning of section 1500.7 since licensure and certification was lost due to other reasons.

Although a license may have value, it is only evidence of the right to do or to own something. It certainly can not form the basis for a CHOW in this case. The dictionary defines the term "license" as:

> 1. a. "Official or legal permission to do or own a specified thing. b. Proof of permission granted, as in the form of a document.

Webster's II New Riverside University Dictionary (1984).

PHM had ceased operations. Therefore, SSH did not purchase those operations. In fact, SSH did not purchase PHM's corporate entity or stock, the facility itself [land or building], or any other assets. Likewise, there was no transfer of patients, employees, referral sources etc. Thus, there was no CHOW under any circumstance within the meaning of the manual section 1500 et seq., nor a transfer or relocation of PHM's operations.

The typical situation of a CHOW occurs when:

i. a facility relocates its operations to a new and/or different physical setting for a wide variety of reasons; or ii. the existing facility is purchased by new owners.

. The March 22, 1994 letter from the Department of Public Health, Commonwealth of Massachusetts, concerning the determination of need ("DON") program did not support the conclusion that a CHOW had taken place based upon the specific language in the letter. The letter stated:

> "... [t]he primary reason given for the transfer of site is that the Division of Health Care Quality approved the transfer of ownership of Prospect Hill Manor to South Shore Hospital, assuming relocation of the long-term care facility to the campus of South Shore Hospital."

The "assumption" of a relocation of that facility was not supported by the facts because PHM was defunct and nothing else was purchased. There certainly was no relocation of a long-term care facility or relocation of operations since the operations had been closed for more than a year. The language of the letter appears to be "boiler-plate" and simply did not fit the facts in this case. What in reality was approved was a transfer of ownership of the license for 40 beds rather than a transfer of ownership of PHM because that simply did not happen.

. Without the lynch pin of a CHOW, all of the other aspects of the definition of a new provider become moot because it is inappropriate to impute the operations of PHM to TCC.

Therefore, the other erroneous aspects of the HCFA determination are not relevant.

For example, there is no need to examine and rebut those aspects relative to HCFA's erroneous determination that PHM was providing skilled nursing services, etc. It was clear from the evidence and the expert testimony of the Provider's witness that genuine skilled nursing services were not in fact rendered.

PHM provided custodial type care to its residents who were predominately ambulatory with physiatric and mental disorders [31 of 36 residents] with limited episodic and intermittent provision of some nursing services.

It is clear that PHM never operated like a SNF within the context of the Medicare statute. When comparing the statutory requirements of a SNF in § 1819 of the Social Security Act, PHM can not begin to qualify. For example:

- Section 1819(a)(1) provides a SNF is primarily engaged in providing skilled and rehabilitative services to residents who are injured, disabled, or sick, and is not engaged primarily for the care and treatment of mental conditions. PHM did not meet that requirement.

- There was no evidence of any compliance with § 1819(b)(1) concerning "Quality Assessment and Assurance" which entails:

    - A quality assessment and assurance committee.

    - Quality assessment by a written plan of care for each patient which includes:

        [i] A quarterly review of this care plan by a team consisting of the director or nursing, a physician, and 3 other staff members; or
        [ii] Identification of medical problems and assessment by appropriate health professionals;
        [iii] nor any certification by health professionals of the assessment;
        [iv] reports of an assessment of each resident's functional capacity, etc., etc.

    - A professional nurse being assigned the responsibility for a particular resident.

There are other examples which would only underscore PHM's inability to comply with Medicare SNF type requirements. For example, there was evidence of some questionable occasions of intermittent nursing services. However, despite being questionable, it is noted that these particular isolated nursing services are no longer considered skilled services by Medicare. The uncontroverted testimony of the expert

witness showed that PHM did not and could not provide skilled nursing services within the meaning of the Medicare regulations.

. HCFA's stated purpose in the preamble to the new provider exemption regulation was to recognize the costs associated with the initial periods of developing the ability to provide skilled nursing facility services.

Thus, the definition of a "new provider" emphasized that where a provider has in the past "operated as" the "type of provider" or the equivalent, then it will not be incurring the costs associated with the initial periods of development of the ability to provide the inpatient services and the "new provider" exception would not be appropriate.

In this case, TCC has never operated as a SNF; and PHM did not operate as a SNF in reality. PHM did not incur any significant start-up costs relative to training or developing a staff to provide the requisite skilled nursing and rehabilitative services.

The "new provider" exemption was intended to address the precise circumstances of TCC, i.e., the start-up of a new operation where the Provider is incurring for the first time the costs for clinical and administrative staff training, development, and education; developing a patient referral base; and problems of achieving a high level of occupancy of the beds of a newly constructed facility in the start-up phase.

Start-up costs are not being incurred twice to provide the same skilled services because the PHM's personnel never had the training, education, and experience in nursing; and in providing rehabilitation therapy services, necessary to provide the type of Medicare certified skilled nursing services on an ongoing and continuous basis [like TCC].

. HCFA's relocation argument is also moot since that is merely another avenue to obtain a new provider exemption. It is noted, however, that HCFA's determination on this element was flawed because the defunct operations of PHM were never relocated at TCC. True, the DON rights to 40 beds were purchased and transferred to TCC; but this is not a relocation of operations. There are other differences:

- TCC served a substantially different inpatient population than served by PHM.

  PHM's admissions were from state psychiatric hospitals, or from the private psychiatric units of hospitals rather than from medical/surgical beds. TCC's patients were predominately from SSH's medical/surgical units and some from other local hospitals.

  PHM's patients were long term custodial residents. TCC's patients were short term and discharged after receiving intensive therapeutic skilled nursing and rehabilitative services, and none were custodial psychiatric

patients.

- TCC's service area was the southeastern part of HSA IV, Greater Boston, and the northern part of HSA V, Southeastern Massachusetts. 35-40% of its admissions were from HSA V. PHM's served only a small area in HSA IV around Summerville, Massachusetts.

Accordingly, I would reverse HCFA's denial of the new provider exemption request because it was incorrect for the above stated reasons.

This case is completely distinguishable on the facts from the Board's prior decisions in Mercy St. Teresa and Milwaukee Subacute and Rehabilitation Center, and this dissent is not inconsistent with those decisions which I support.

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James G. Sleep
Board Member