CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Oak Knoll Health Care Center **Provider** **vs.** **Blue Cross Blue Shield Association/ National Government Services** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Endings: December 31, 1995 and December 31, 1999** **Review of:** **PRRB Dec. No. 2008-D33** **Dated: August 12, 2008**

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 §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). CMS' Center for Medicare Management (CMM) commented requesting that the Administrator affirm the Board's decision on Issue No. 1 and reverse the Board's decision on Issue No. 2. Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were also received from the Provider requesting that the Administrator affirm the Board's decision on Issue No. 2, or in the alternative, reverse Issue No. 1. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUES AND BOARD'S DECISION

Issue No. 1 was whether the Provider is entitled to a "new provider" exemption from the skilled nursing facility (SNF) routine cost limitation (RCL) under 42 C.F.R. § 413.30(e) for the fiscal year ending (FYE) December 31, 1995.

With respect to Issue No. 1, for FYE 1995, the Board agreed with CMS that the Provider was not eligible to be exempt from the application of the SNF RCL as a "new provider." The Board found that the Provider was a replacement facility for

Heritage and Colonial. Both Heritage and Colonial had existed previously and those facilities had provided SNF-type services for more than three years. Therefore, the Provider was not eligible for a SNF new provider exemption.

Issue No. 2 was whether the Intermediary's denial of the Provider's request to be reimbursed the transitional period rate for SNFs under 42 C.F.R. § 413.340(e) for the cost reporting year ended December 31, 1999, was proper.

With respect Issue No. 2, the Board held that the Provider was entitled to a transition period payment rate under 42 CFR. 413.340(e). The Provider argued that a SNF is an institution, which is an establishment or place, and is not to be limited to a provider with a particular provider number. The Board agreed and found that the Provider had received payment from Medicare (under a different provider number) prior to the October 1, 1995 eligibility date, and also continued to be controlled by the same party. Therefore, it qualified for the transition payment. The Board found that §2834A of the Provider Reimbursement Manual (PRM), which defines a SNF by its provider number, went beyond the clear meaning of the controlling law by requiring the Provider, under its particular provider number, to have received payment by the October 1, 1995 date to be eligible for the transition rate. This was an additional criterion outside the statute, which restricted entitlement to a transition period payment. Accordingly, the Board held that the fact that CMS assigned a new provider number to the Provider, under which it did not receive payment until after the October 1, 1995 date, was not a sufficient basis upon which to disqualify the Provider for a transition period rate.

SUMMARY OF COMMENTS

CMM commented with respect to Issue No. 2, requesting that the Administrator review and reverse the Board's decision that the Provider was entitled to a transition period payment rate under 42 C.F.R. § 413.340(e). CMM argued that § 1888(e) of the Act applied to long term care facilities that were currently certified to participate in the Medicare program as a SNF, not to institutions that were not certified to participate in the Medicare program.

CMM noted that to be a SNF under the Medicare program, an institution must have a provider agreement with the Secretary under §1866(a) of the Act and meet the requirements found in §1819 of the Act. Only thereafter is the certified SNF eligible to provide covered services that are reimbursable under the program. Absent this process, the institution is not covered by Title 18 of the Act. CMM stated that Title 18 of the Act, applied to entities that have entered into an agreement with the Secretary to participate in the Medicare program.

In this case, CMM noted that the Provider entered into an agreement with the Secretary to participate in the Medicare program as a SNF that was effective on November 20, 1995, 51 days after the October 1, 1995 date. Therefore, CMM stated that the Provider is a "new provider" under the SNF PPS provision found in §1888(e)(2)(ii) of the Act. CMM further stated that the Provider's acceptance or rejection of a provider agreement under a change of ownership (CHOW) affected the provider agreement. Specifically, where a CHOW has occurred, CMS automatically assigns the provider agreement to the new owner. However, if the new provider decides not to accept the provider agreement, CMS will recognize the refusal to accept the provider agreement as a voluntary termination of the seller's provider agreement. In such a case, the Medicare provider ceases to exist and the seller's facility's Medicare provider agreement is terminated along with the CMS certification number (CCN) that tracks the agreement. The new owner must now apply to participate in the Medicare program and is treated and processed as an initial application for Medicare participation.

When a new owner does not assume the previous owner's Medicare provider agreement, CMM contended that the new owner is not held responsible for past liabilities under the previous provider agreement. As such, the new owner is not able to retain the benefits established under the previous Medicare provider agreement. CMM noted that this policy conformed to longstanding reimbursement policy and payment principles as applied under the former reasonable cost payment system. Furthermore, the policy is consistent with Congress' intent to exclude newly-certified SNFs from receiving payment, other than at the Federal rate under the SNF PPS.

The Provider submitted comments requesting that the Administrator affirm the Board's determination allowing the Provider to receive transition rate reimbursement. The Provider argued that Heritage and the Provider are the same institution. Therefore, since Heritage was certified for participation in the Medicare program beginning on July 1, 1990 and received payment prior to October 1, 1995, the Provider is entitled to the transition rate reimbursement for the year ending December 31, 1999. The Provider argued that the issue is not whether a SNF entered into a provider agreement with Medicare after October 1, 1995, but whether the SNF had a Medicare contract and received payment prior to October 1, 1995. The Provider argued that nothing in the statute, or the regulation, required the Provider to retain the same Medicare agreement that was in existence prior to October 1, 1995, in order to receive transition rate reimbursement. If Congress had intended transition rate reimbursement to depend upon whether a replacement facility accepted or rejected, an existing Medicare agreement, it could have and would have drafted the statute differently.

The Provider disagreed with CMS' position that when a CHOW occurs and the new owner does not assume the previous owner's Medicare agreement, the new owner is not able to retain the benefits established under the previous agreement. To support this position, the Provider argued that this is not a CHOW, since the Provider and the predecessor SNFs are controlled by the same person. Furthermore, it's a benefit conferred under the statute, based on the original date of payment, not a benefit established under the previous Medicare provider agreement. The purpose of the statute was to allow older SNFs a transition period to move from the prior reimbursement method to the new SNF PPS even if they were out of the program for a period of time.

Finally, the Provider argued, if the Administrator determines that the Provider is not entitled to transition rate reimbursement for 1999, then the Provider should be granted an exemption from the RCL for the 1995 year. CMS cannot both, (i) preclude the Provider from receiving an exemption from the CLS on the ground that the Provider is the same provider as Heritage and, (ii) preclude the Provider from receiving transition rate payments on the ground that it has a different provider than Heritage.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Issue No. 1

Since its inception in 1966, Medicare's reimbursement of health care providers was governed by §1861(v)(1)(A), which provides that the:

> 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….

The Secretary's regulation at 42 C.F.R. §413.30 sets forth the general rules under which CMS may establish payment limits on the reasonable costs of providers. The Secretary also 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.[1] The Secretary implemented regulations that further established exemptions, from and exceptions to, limits on cost reimbursement in order to address the special needs of certain situations and certain providers. Relevant to this case, the regulation allows for an exemption from the RCL for new providers. This exemption is set forth in the regulation at 42 C.F.R. § 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.)

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.[2] 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, exclusive of specific provider numbers, names, etc. since these are subject to change, in order to determine if the institution provided skilled nursing or rehabilitative services.

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

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

[2] 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).

> institution has been furnishing hospital health care services for two full years prior to its certification it shall only be considered a "new provider" in its third full year of operation, which is its first full year of participation in the program.
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> ….
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> Although a complete change in the operation of the institution …shall affect whether and how long a provider shall be considered a "new provider", changes of institution ownership or geographic location do not itself alter the type of health care furnished and shall not be considered in the determination of the length of operation.

The Administrator notes that Transmittal No. 400, dated September 1997, removed §2604.1. The Transmittal stated that new §2533.1.A of the PRM set forth, *inter alia*, longstanding Medicare policy. 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 (and hence prior to any Medicare payment), it will not be considered a new provider.

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." Paragraph E.1 explains the transaction types which are considered to involve a CHOW for this purposes (although not necessary a CHOW for reimbursement purposes). The specific examples include, at paragraph E.1.b, 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)[[3]] that has or is rendering skilled nursing or rehabilitative services to establish (in whole or part) a long term care facility or to enlarge an existing long term care…. [4]

The longstanding policy set forth at PRM at §1500 gives several examples of CHOW transactions and explains that:

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[4] 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.

> 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 asset or the continuation of the provider agreement.[5] (Emphasis added.)

Notably, §1500.7 of the PRM describe 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.

Consequently, a change of ownership under the new provider exemption policy, will trigger a "look back" at how the prior owner of the transferred assets "operated." This event is not related to a change of ownership that affects the historical costs of an asset and does not examine whether there is a continuation of the provider agreement or consequently whether the provider has been paid under Medicare for such services. CMS does not focus on the provider agreement(s) and any payments an entity may have received for services from Medicare as a result of that agreement under prior ownership.

CMS focuses on the type of services provided by the prior owner of the assets, including the owner of assets that affect licensure or certification such as the certificate/determination of need or right to operate. Where there is only a transfer of the right to operate, the Secretary has reasonably concluded that, as the bed rights are essential to the ability to operate the facility, there has been a change of ownership which triggers an examination of the prior owner's operation. Under the circumstances where the previous owner provided similar services for three years, there is no additional benefit gained in the overall delivery of health services when beds are merely shifted from one provider to another. In a State that imposes a moratorium on the operation of beds, a provider that has purchased or received the right to operate beds from an existing facility in the same geographic area is not likely to face underutilization when proving the same or equivalent type of services. The new provider exemption is intended to allow a provider to recoup the higher costs normally resulting from low occupancy rates during the time it takes to build its patient population.[6] It is not intended to compensate for higher start-up capital costs.

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[5] Rev. 332 (1985).

[6] See 44 Fed. R. 15745, March 15, 1979 (Proposed Rule) and 44 Fed. R. 31802, June 1, 1979 (Final Rule).

In this case, Oak Knoll Health Care Center is a SNF which received the assets of Heritage Long Term Health Care Center (SNF/NF) and Colonial House Nursing Home (NF) and in particular, assets relating to the State certification of the Provider in the form of the determination of need. Prior to the transfer of the assets, Heritage was owned by the FMR II Corporation. Heritage entered into provider agreements to participate in the Medicaid program, as well as the Medicare program. Heritage voluntarily withdrew all of its 40 beds from participation in the Medicare Program effective October 13, 1995. Heritage stated its intent to apply as a new provider for certification in the Medicare program once it moved into a new facility. CMS terminated Heritage's Medicare provider agreement on October 13, 1995. Heritage continued to operate beds in the Medicaid program.

Colonial House Nursing Home, owned by the FMR I Corporation, likewise, had a provider agreement to participate in the Medicaid program. Colonial House terminated its Medicaid provider agreement and closed on September 29, 1994.

FMR II Corporation (owner of Heritage) submitted an application for Determination of Need on September 1, 1987, to the State of Massachusetts proposing new construction of a 123-bed facility to replace two existing nursing homes (Colonial and Heritage) and a 24-slot Adult Day Care Program. The application was approved by the State of Massachusetts on July 31, 1989, and is identified as DON Project No. 4-1154.

Subsequently, Arbetter Corporation d/b/a Oak Knoll Long Term Health Care Center requested that the DON Project No. 4-1154 be transferred to the Arbetter Corporation, a new corporation created specifically for the purpose of holding the DON and being the licensee of the State. FMR Corporations I and II were to remain in existence only until they satisfied business obligations and wound up their respective affairs. All of these corporations, FMR I, FMR II, and Arbetter, are owned by Dr. Alfred Arcidi. The State approved the transfer of ownership of DON Project No. 4-1154.

On November 6, 1995, Oak Knoll Long Term Health Care Center opened under its new name, Oak Knoll Skilled Nursing Facility. Heritage's existing Medicaid provider agreement was transferred to Oak Knoll Long Term Health Care Center the same day. At the same time, Oak Knoll Long Term Health Care Center entered into a provider agreement to participate in the Medicare program as a SNF and was assigned Provider Number 22-5682 and it was certified to participate in the Medicare program as a SNF.

The Administrator finds that the record shows that the Provider received assets (including the building site), and in particular, the transferred rights and license of the DONs, through a change of ownership. The prior owners of the assets were a NF and

SNF that had provided SNF-type services for more than three years prior to the transfer.[7] Thus, the Administrator affirms CMS' denial that the Provider is not eligible to be exempt from the application of the SNF RCL as a "new provider." The Administrator affirms the Board's determination with respect to Issue No. 1.

Issue No. 2

Under §1866 of the Act, a provider of services shall qualify to participate under Medicare and be eligible for Medicare payment if the provider meets certain conditions and files an agreement with the Secretary. Section §1866 specifically provides that: "[a]ny provider of services ….shall be qualified to participate under this title and shall be eligible for *payments* under this title if it files, with the Secretary, an agreement....." Section 1819 of Act defines a "skilled nursing facility" and the requirements for a skilled nursing facility under Tile 18. Consistent with the statute, the regulations at 42 C.F.R. § 400.202 defines a Medicare SNF as, inter alia, "a… SNF… that has in effect an agreement to participate in Medicare." Thus, to be eligible for payment, a SNF must, among other things, have a provider agreement filed with the Secretary. This provider agreement allows a provider to receive payment and is tracked through the assignment of an individual provider number.

Consistent with §1866 of the Act and the Secretary's authority under §1871, the Secretary promulgated the regulations at 42 CFR 418.18. The regulation explains the effect of a change of ownership on a provider agreement and sets forth that, when there is a change of ownership, the existing provider agreement will automatically be assigned to the new owner. Subsection (d) of that regulation further provides that an assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued.[8] However, the new owner may decline to accept the existing provider agreement and voluntarily terminate the existing provider agreement along with the CMS certification number (or provider number) that tracks the agreement.[9] In such case, the new owner must apply and meet the conditions of participation outlined in §1819 of the Act and the implementing regulations at 42 CFR 483.100, et seq. along with entering into a new provider agreement and receiving a new separate and distinct provider number.

Prior to 1998, skilled nursing facility services provided under Part A of the Medicare program were paid under a retrospective reasonable cost-based system. Under the Medicare payment principles set forth in §1861 of the Act and Part 413 of the Code

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[7] See, e.g., Intermediary Exhibit I-3; CMS dated February 14, 1996 pp 2-3, regarding the type of services provided by the NF and SNF.
[8] 42 CFR 489.18(d).
[9] 42 CFR 489.52.

of Federal Regulations, SNFs receive payment for three major categories of costs: routine costs, ancillary costs, and capital-related costs. Routine costs (i.e., services included by the provider in a daily service charge) are paid on a reasonable cost basis subject to per diem limits. The reasonable costs of ancillary services (specialized services such as therapy and drugs and laboratory services that are directly identified to individual patients) and capital-related costs (the cost such as land, building, interest) are paid in full. In addition, §1861(v)(1) of the Act and §1888 of the Act authorize the Secretary to set limits on the allowable routine costs incurred by a SNF.

Section 4432 of the Balance Budget Act of 1997, enacted on August 5, 1997, amended §1888 of the Act by adding subsection (e).[10] This subsection requires the implementation of a Medicare SNF prospective payment system (PPS) for cost reporting periods beginning on or after July 1, 1998.[11] Under the PPS, SNFs are paid through a per diem prospective case-mix adjusted payment rate applicable to all covered services. Section 1888(e)(2) of the Act, consistent with the definition of a SNF at §1819, defines "skilled nursing facility services." Section 1888(e)(4) of the Act provides for the establishment of the per diem Federal payment rates applicable under the PPS and sets forth a formula for establishing the Federal rates as well as the data on which they are based.[12]

Beginning with certain SNFs' first cost reporting periods beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During the transition phrase, SNFs receive a rate comprised of a blend between the Federal rate and a facility specific-rate based on each provider's fiscal year 1995 cost report.[13] After the transition period, and continuing thereafter, payment is determined entirely on the Federal rate.[14] In defining the SNFs that are not eligible for the transition payment, §1888(e)(2)(E)(ii) states that:

> TREATMENT OF NEW SKILLED NURSING FACILITIES.- In the case of a skilled nursing facility that first received payment for services

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[10] Pub. Law No. 105-33 §4432, 111 Stat. 251 (codified as amended at 42 U.S.C. § 1395yy *et seq*. 42 CFR 413.330, *et seq*., implemented § 1888(e) of the Act.

[11] Section 1888(e) of the Act.

[12] Section 1888(e)(3) of the Act.

[13] 42 C.F.R. § 413.340(a) (1999). "For the first cost reporting period beginning on or after July 1, 1998, payment is based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. For the subsequent cost reporting period, the rate is comprised of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the final cost reporting period, for the transition, the rate is comprised of 25 percent of the facility-specific rate and 75 percent of the Federal rate.

[14] *Id*.

> under this title on or after October 1, 1995, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

Conversely, §1888(e)(3) of the Act explains that "the Secretary shall determine a facility-specific per diem rate for each [SNF] not described in paragraph 2(E)(ii)." (Emphasis added.)

Likewise, the implementing regulation at 42 CFR 413.340(e) states that:

> *SNFs excluded from the transition period.* SNFs that received their first payment from Medicare, under present or previous ownership, on or after October 1, 1995, are excluded from the transition period, and payment is made according to the Federal rates only.

The Provider Reimbursement Manual or PRM also provides guidance implementing CMS regulations and interpretative policy. Section 2834 of the PRM explains "Calculating Payment Under SNF PPS" and states:

> *SNFs Receiving the Federal Rate.*—SNFs who first received payment from Medicare (i.e., based on when the payment was issued by the intermediary), under its current provider number, on or after October 1, 1995 are paid based on the Federal rate only. For example, an institution that was assigned a Medicare provider number prior to October 1, 1995, but did not receive its first payment from Medicare until after October 1, 1995, would receive the Federal rate. Where a merger or a consolidation has occurred, a determination is made based on the payment history of the surviving entity as indicated by the surviving SNF provider number.
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> *SNFs Receiving the Transition Period Rate.*—SNFs who first received payment from Medicare (i.e., based on when the payment was issued by the intermediary), under its current provider number, prior to October 1, 1995 are paid based on the transition rate only and excluded from receiving the Federal rate. For example, an institution that was assigned a Medicare provider number prior to October 1, 1995, and received its first payment from Medicare on or before September 30, 1995, would receive the transition rate. Where a merger or a consolidation has occurred, a determination is made based on the payment history of the surviving entity as indicated by the surviving SNF provider number.

Thus, for cost reporting periods beginning on or after July 1, 1998, a SNF that receives its first payment from Medicare under its existing provider number, prior to October 1, 1995, is eligible for the transition payments. If the SNF received its first payment from Medicare under its existing provider number on or after October 1, 1995, it is excluded from receiving the transition period rate, and payment is made according to the Federal rate only.

In this case, the Provider argued that the statute defines a SNF as an institution that is primarily engaged in providing skilled nursing care to its residents. The Provider argued, and the Board agreed, that an institution is an establishment or place, not limited to a provider with a particular number. The Board found that the Provider had received Medicare payments before October 1, 1995, even though it was under a different provider number, and, thus, it qualified for a transition period payment rate for FYE 1999.In addition, the Board found significant that the same party involved with the prior SNF and NF controlled the Provider after the transfer of the DON to the Provider.

Applying the relevant law and program policy to the foregoing facts, the Administrator does not agree with the Board's determination that the Provider was entitled to a transition period payment rate under 42 CFR 413.340(e) for cost reporting period 1999. The Secretary specifically spoke on the issue of the effect of a change of ownership on eligibility for the PPS transition in the final rule published at 64 Fed. Reg. 41644, 41654 (July 30, 1999). In response to comments, the Secretary stated that:

> We received a number of comments regarding our policy on changes of ownership and mergers as they relate to a provider's eligibility for the PPS transition.
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> *Response*: As discussed earlier in this section, SNFs that first received payment from Medicare on or after October 1, 1995 receive payment based on the Federal rate only, while SNFs that first received payment from Medicare prior to October 1, 1995 are paid according to the transition rate and are precluded from receiving payment solely based on the Federal rate. In addition, our policy, as stated broadly in transmittal 405 of the Provider Reimbursement Manual, requires that, for purposes of determining a provider's eligibility for the transition, Medicare makes its determination based on the date of first Medicare payment (interim or otherwise) under the present provider number.
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> For example, when an SNF undergoes a change in ownership, such as a merger or a consolidation, <u>the payment is determined by the payment</u>

> history of the surviving entity as indicated by the surviving SNF's provider number. This conforms with longstanding reimbursement policy and payment principles as applied under the former reasonable cost payment system and provides administrative simplicity in addressing complex transactions among SNFs, hospitals, and other entities. (Emphasis added.) [15]

The Administrator finds that this interpretation is consistent with the Medicare statute, which requires that for an entity to participate in the Medicare program as a SNF and receive payment for services under section 1866, the entity must enter into a provider agreement and in doing so is assigned a provider number (now referred to as the CMS certification number) which tracks the SNF's payment history. The provider number is the evidence of that individual SNF's entitlement to receive payment under Medicare. Consequently, the provider number must be used to identify the individual SNF and when it first received payment under Medicare for purposes of the transition eligibility criteria.

The Administrator finds that the criteria under §1888(e)(2)(E)(ii) of the Act, for determining eligibility for the SNF PPS transition rate is not the same as that set forth under 42 CFR 413.30, for a "new provider" exemption. While the language of 42 CFR 413.30(e) and 413.340(e) both contain the phrase "under present or previous ownership", the RCL exemption criteria focuses on whether the provider has "operated" as the type of provider "under previous or present ownership", while the transition eligibility criteria focuses on when "the SNF" received its first "payment" "under present or previous ownership." These differences in the language, applied within the context of the specific Medicare policies and to the distinct facts in this case, are the reason for the different results reached in Issue No. 1 and 2.

When there is a change of ownership, under 42 CFR 413.30, CMS looks back at the operation of the entity under past ownership regardless of specific provider numbers or Medicare payment to determine if the past owner provided skilled nursing or rehabilitative services. In contrast, the SNF PPS payments provision found at §1888(e)(2)(ii) of the Act, is focused upon when "the SNF" first received a Medicare "payment" for services. Notably, the Provider's "payment" and right to receive payment is inseparable from the assignment of an individual and unique provider number.

In this case, the record shows that the Provider, as identified by its provider number, entered into an agreement with the Secretary to participate in the Medicare program as a SNF that was effective on November 20, 1995, 51 days after the October 1, 1995

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[15] Id. at 41654.

statutory date. Thus, the record reflects that the Provider first received payment for services as a SNF after October 1, 1995 and therefore is not entitled to payment under the transition rate.

The Provider also alleges that the provider number is not relevant as the same individual continues to control the various assets through various corporations both before and after the assets (including the determination of need) were transferred from Heritage and Colonel and eventually to the Provider (Oak Knoll). However, for purposes of Medicare payment, a provider is always no more than the entity that entered into the provider agreement. As the Court recognized in Baptist Health v. Thompson, 458 F. 3d 768 (8th Circuit 2006): "In short the Medicare reimbursement system is based on the costs incurred by individual provider hospital without regard to the underlying ownership structure." Therefore, the fact that the same individual has retained control of the assets throughout the transformation of provider numbers, is not relevant to defining the SNF for purposes of determining when the first payment under Medicare was received. The relevant inquiry is when the SNF, as identified by its unique provider number, has received its first payment under Medicare as the contract holder with Medicare.

Consistent with the statute at section 1866 and the definition of a SNF under the Act, the Secretary has promulgated the regulation at 42 CFR 489.18. The regulation provides for the automatic assignment of a provider agreement and, hence, the transfer of the provider number when there is a change of ownership. When there is a change of ownership for licensing purposes and the entity agrees to accepted assignment of the provider agreement, that entity is obligated for any liabilities or civil money penalties, existing plans of correction of the seller. However, a provider may decide not to accept automatic assignment of the provider agreement and that provider number. When that occurs the provider is not obligated for the past owner's liabilities, but also does not get the benefit of the past history of the facility.

The Courts directly addressed this issue concerning the effect of automatic assignment of the provider agreement in U.S. v. Vernon Home Health, 21 F.3d 693 (5th Cir.1994). Where the provider accepted automatic assignment of the provider agreement, the Court stated that:

> Vernon II could have chosen not to accept the automatic assignment of the provider agreement. Indeed, the government acknowledges that the case would be different if Vernon II had not assumed Vernon I's provider number. In that case, Vernon II would have had to apply as a new applicant to participate in the Medicare program. But Vernon II accepted the automatic assignment because it did not want a break in service while it awaited approval. Provider No. 45-7124 was

> automatically assigned to Vernon II pursuant to 42 U.S.C. § 1399cc. By accepting that assignment, Vernon II agreed (albeit unknowingly) to accept the terms and conditions of the regulatory scheme. Thus, it is liable for the overpayments."[16]

Further, the Court in Deerbrook Pavilion v. Shalala, 235 F. 3d 1100 (8th Cir. 2000), explained that:

> As several commentators have pointed out, since 1994 HCFA has taken the view that there is successor liability in an effort to curb fraud and sham transactions in the nursing home industry. See Paul R. De Muro & Esther R. Scherb, *Steering Around Successor Liability in Health Care Transactions*, 1129 PLI/Corp 23, 30 (June 1999); Greg Radinsky, *How Health Care Attorneys Can Discern Vernon, Successor Liability and Settlement Issues*, 44 St. Louis U.L.J. 113, 123-124 (2000). Specifically, the agency put forth a memorandum in 1994 that emphasized successor liability regarding plans of correction and CMPs. See HCFA Memorandum on Commerce Clearinghouse Report of Court Ruling Regarding Transfer of Provider Agreement, Anthony J. Tirone to Spencer K. Ericson (Dec. 29, 1994). An agency's interpretation of its own regulations is entitled to great deference. See Baker v. Heckler, 730 F.2d 1147, 1149 (8th Cir. 1984); Abbott-Northwestern Hosp., Inc. v. Schweiker, 698 F.2d 336, 340 (8th Cir. 1983).[17]

Such a policy is not only consistent with the statute, but prudent for the administration of the Medicare program and the need to ensure the integrity of the Medicare Trust fund. CMS allows a provider to make the choice of whether to accept assignment and balance, for itself, the advantages and disadvantage of accepting assignment of the provider agreement. In doing so, the policy eliminates questionable changes of ownership for monetary gain that do not also provide benefits to the program. The policy presents a measured balance of advantages and disadvantages that does not favor any particularly situated provider.[18] Consistent

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[16] An example of the effects of a change of ownership and the automatic assignment, or non-acceptance of assignment, of the provider agreement under 42 CFR 489.18 is at 71 Fed. Reg. 47870, 48070 (August 18, 2006)(regarding prohibition of the use of wage data under 42 CFR 412.230 of existing hospital facility, where the existing provider agreement is not assigned pursuant to a change of ownership.).

[17] Deerbrook Pavilion v. Shalala, 235 F. 3d 1100 (8th Circuit 2000).

[18] With respect to this PPS SNF transition payment provision, certain providers initially found that they would receive a higher payment under the Federal rate only.

with this policy, therefore, the Secretary's implementation of the SNF PPS provision requires a provider to have received its first payment under its present provider number prior to October 1, 1995, in order to receive the transition rate payment.

In addition, the cost data upon which the Provider proposes to base its facility-specific rate,[19] is also inconsistent with both the statute and regulation. The Provider seeks either to have the costs incurred by the prior owner of the assets (Heritage) combined with the Provider's cost, or to use the Provider's alone, to determine the facility-specific rate. There is no support in established general Medicare policy for a provider to use another separate and distinct provider's costs (with a separate provider number) to determine a *facility*-specific base year costs. The regulation at 42 CFR 413.340(b) further supports the contention that an individual SNF's cost report is to be used to determine these costs. The regulation states that: "The facility–specific rate is computed based on the SNF's Medicare allowable costs from its fiscal year 1995 cost report plus an estimate of the amount payable under Part B for covered SNF services." (Emphasis added.) Thus, such language does not suggest that multiple cost reports from more than one SNF, maybe used to develop the facility specific rate. Alternatively, the structure of the statute implicitly suggests, in setting forth an October 1, 1995 date for first payment, that Congress had an expectation that the 1995 base year costs would be derived from costs incurred over a minimum period of time, which would exceed that incurred by a provider that did not enter the program until November 1995. Use of the Provider's November 6, 1995 through December 31, 1995 cost report to develop a facility specific rate would appear inconsistent with the statute. Thus, the Provider's cost data supports the conclusion that Provider is not entitled to receive the transition payment rate.

Accordingly, the Administrator finds with respect to Issue No. 2, under §1888(e)(2)(E)(ii) of the Act, the Provider did not meet the requirements to be reimbursed the transition period rate for SNF PPS. For the Provider's cost reporting

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CMS instructed providers that they would have to voluntarily decertify as a SNF along with its provider number in order to receive a new provider number on or after October 1, 1995 and therefore be eligible for the Federal rate only. See also 64 Fed. Reg. 41644. Congress subsequently enacted section 102 of the Balanced Budget Refinement Act (Pub. Law 106-13), to prospectively allow SNFs to immediately transition to the Federal rate on or after December 15, 1999, for cost reporting periods beginning on or after January 1, 2000.

[19] Provider Exhibit P-0.

period ending December 31, 1999, payment is to be made according to the Federal rate.

DECISION

Issue No. 1

The decision of the Board with respect to Issue No. 1 is affirmed in accordance with the foregoing opinion.

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Issue No.2

The decision of the Board with respect to Issue No. 2 is reversed in accordance with the foregoing opinion.

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

Date: **__10/14/08_______** **_/s/________________________________**

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