Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
Mira Vista, Inc.	Date: May 23, 2007
Petitioner,	
	DAB Docket No. A-06-114
	Before Leslie A. Sussan
- v. -	
Centers for Medicare & Medicaid Services.	

DECISION

This dispute arose over the proper Medicare payment rate to be paid for services provided in a skilled nursing facility (SNF) created when an existing SNF relocated part of its bed capacity to a different location. From December 1998 to December 1999, Mira Vista, Inc., a Washington corporation, operated a 30-bed Medicare-certified SNF in building space leased from United General Hospital (UGH), an acute care hospital located in Sedro-Woolley, Washington. Mira Vista opened this SNF, known as Mira Vista Rehabilitation Center – UGH Campus (MV-UGH), after securing the State of Washington's permission to relocate 30 beds from its 94-bed SNF in Mount Vernon, Washington (Mira Vista Care Center or MVCC) to the grounds of UGH. I detail below the complicated procedural history of the dispute, but at this stage of the proceedings I am charged only with resolving the merits of Mira Vista's contention that MV-UGH was entitled to the Medicare payment rate applicable to facilities receiving their first Medicare payment before October 1, 1995 instead of the lower payment rate applicable to facilities receiving their first Medicare payment on or after October 1, 1995.

The principal issue before me in resolving this dispute on the merits is whether, for Medicare program purposes, the Centers for Medicare & Medicaid Services (CMS) properly refused to designate MV-UGH as a "provider-based" component of MVCC. I conclude that CMS's refusal to do so was neither legally erroneous nor an abuse of discretion. I also reject Mira Vista's contention that MVCC and MV-UGH constituted a single "composite distinct part" SNF under the Medicare program. Finally, I find that MV-UGH was a new facility which received its first Medicare payment after October 1, 1995. Consequently, the Medicare payment rate applicable to services furnished at MV-UGH was the federal prospective payment system rate, not the "transition period" payment rate applicable to services furnished at MVCC, which had received Medicare payments before October 1, 1995.

A. Legal Background

The Medicare program, established under Title XVIII of the Social Security Act (Act),[1] provides medical insurance to the elderly and disabled. See Act §§ 1811-1812, 1831-1832. In most instances, the program pays medical institutions and practitioners directly for the care they provide to program beneficiaries. Id. §§ 1815, 1833; 42 C.F.R. § 424.51.

Among other things, Medicare covers "extended care services" furnished to an inpatient of a "skilled nursing facility." Act §§ 1812(a)(2)(A), 1861(h). The Act defines a "skilled nursing facility" in part as an "institution (or a *distinct part* of an institution)" that is primarily engaged in providing "skilled nursing care" or "rehabilitation services." Act § 1819(a) (italics added). Before it can receive Medicare payment for extended care services, a SNF must undergo an onsite survey that certifies its compliance with requirements — known as "participation requirements" — relating to quality of care, residents' rights, health and safety, and administration. See Act §§ 1819(a)-(d), 1866; 42 C.F.R. § 424.5(a)(2); 42 C.F.R. § 483.330.

As the Act indicates, a SNF may participate in Medicare as the "distinct part" of some other institution. A "distinct part" is

---

[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

the part of an institution or institutional complex (a hospital, for example) that is certified to provide skilled nursing or rehabilitation services to Medicare beneficiaries. See 42 C.F.R. § 483.5(b). To be eligible for participation in Medicare as the distinct part of a larger institution, a SNF must meet various criteria, one of which is that it must be operated under "common ownership and control . . . by the institution of which it is a distinct part[.]" 42 C.F.R. § 483.5(b)(2).

In 1997, Congress enacted the Balanced Budget Act of 1997 (BBA), Pub. L. 105-33, 111 Stat. 251, which changed the method by which Medicare pays for covered SNF services. Prior to the BBA, SNFs were paid under a retrospective, reasonable cost-based system. See *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, Interim Final Rule with Comment Period*, 63 Fed. Reg. 26,252, 26,253 (May 12, 1998). Section 4432 of the BBA, codified in section 1888(e) of the Act, required CMS to replace the reasonable cost system with a prospective payment system (PPS). Pub. L. 105-33, 111 Stat. 414. Under the SNF PPS, a SNF is paid on the basis of pre-determined per diem rates for each Medicare-covered day that a beneficiary spends in the SNF. 63 Fed. Reg. at 26,254. The BBA provided that the SNF PPS would apply immediately to all SNFs that received their first Medicare payment on or after October 1, 1995. Act § 1888(e)(1), (e)(2)(E). For SNFs that received their first Medicare payment before that date, a three-year transition period (starting July 1, 1998) was established. Id. During that transition period, Medicare was required to pay for covered services at a rate that was a blend of the new per diem PPS rate and a "facility-specific rate based on historical costs." 63 Fed. Reg. at 26,254; see also Act § 1888(e)(1)(A).

For purposes of Medicare cost reimbursement, CMS has long distinguished between "provider-based" and "freestanding" health care facilities. See 63 Fed. Reg. 47,552, 47,587 (Sept. 8, 1998). A "provider of services" is defined in section 1861(u) of the Act to include hospitals, SNFs, home health agencies, and other institutions or organizations. Medicare recognizes that some providers, known as "main providers," have owned and operated other types of facilities, some located on the main provider's campus and others off campus. Id. Often in these situations, the main provider and subordinate facility share overhead costs and use of revenue-producing assets, such as buildings, equipment, and personnel. Id. When there is sufficient evidence of financial and operational integration, Medicare has recognized the subordinate facility as a provider-based component of the main provider. Id. Such recognition permits the main provider to achieve economies of scale and

allocate shared overhead or other costs to the subordinate facility. Id. In some areas, the designation of a facility as provider-based has resulted in Medicare payments for covered services that exceed what Medicare would have paid for those services had the facility been classified as freestanding. Id. at 47,588. A provider-based designation may also increase the coinsurance liability of Medicare beneficiaries who receive covered services from the provider-based facility.[2] Id.

As the discussion below will make apparent, CMS's criteria for designating an entity as provider-based are, to a large degree, similar to the criteria for classifying a SNF as a distinct part. In general, each set of criteria requires substantial legal, operational, and financial integration of the main provider or primary institution and the subordinate or distinct part entity. See infra pages 21-23, 28 n.25.

B. Case Background

This case has a long history. It began in December 7, 1999, when Mira Vista requested a hearing before an administrative law judge (ALJ) at the Departmental Appeals Board (DAB).[3] The hearing request alleged that CMS (then known as the Health Care Financing Administration) had improperly denied a request to assign provider-based status to MV-UGH.

In June 2001, ALJ Marion Silva dismissed Mira Vista's December 1999 hearing request, finding that she had no authority to decide the matter. Mira Vista Care Center, Inc., DAB CR777 (2001). Mira Vista appealed the ALJ's decision to the Board itself, which affirmed the dismissal. Mira Vista Care Center, Inc., DAB No. 1789 (2001).

---

[2] Because the result can be an increase in costs supported by Medicare "with no commensurate benefit to Medicare and its beneficiaries," CMS made clear that "it is critical that CMS designate only those entities that are unquestionably qualified as provider-based." Ex. H at 305 (CMS Program Memorandum A-96-7 (as reissued in May 1998)).

[3] We use herein the acronym "DAB" to refer to the Departmental Appeals Board as an institutional entity, which includes a corps of ALJs supported by the Civil Remedies Division of the DAB. We use the term "Board" to refer to the five-member Departmental Appeals Board itself, supported by the Appellate Division of the DAB.

While litigating CMS's denial of provider-based status before the DAB, Mira Vista pursued a related case before the Provider Reimbursement Review Board (PRRB). During the PRRB proceeding, Mira Vista raised the issue of whether MV-UGH should have been classified by CMS as provider-based.

In December 2003, the PRRB dismissed Mira Vista's parallel case for lack of jurisdiction. Mira Vista then filed suit in United States District Court against the Secretary of Health and Human Services (and others), asking the court to remand the case to the PRRB for a hearing on the merits.

The parties ultimately entered a settlement agreement resolving the court litigation. In June 2005, the district court approved the settlement and dismissed Mira Vista's suit with prejudice. The settlement agreement states that, although the DAB had previously found that it lacked jurisdiction to adjudicate Mira Vista's December 1999 hearing request, the DAB could decide the dispute under the Secretary's general authority to provide an administrative hearing process. The settlement agreement further provides that the defendants have waived any jurisdictional barrier to the DAB providing a full administrative adjudication and that the DAB "shall render a decision on the merits of the matter using the procedures detailed in 42 C.F.R. Part 498, Subparts D and E."

Pursuant to the settlement agreement, the parties returned to the DAB, which assigned the matterto ALJ Richard Smith. On June 14, 2006, Judge Smith dismissed the case on the grounds that the DAB's September 2001 decision was final and binding on the parties pursuant to sections 205(g) and 205(h) of the Social Security Act, and that the Secretary's authority had not been lawfully exercised in the execution of the settlement. Mira Vista Care Center, Inc., DAB CR1459 (2006).

On August 10, 2006, the Board vacated Judge Smith's decision and determined that it would, in compliance with the settlement agreement, provide a forum to resolve the parties' dispute on the merits. The parties agreed that the case should be assigned to a Member of the Board, rather than remanded to an ALJ for the hearing, while preserving an opportunity for the adversely-affected party to appeal to the Board itself. Accordingly, the Board assigned the matter to me to (1) conduct an evidentiary hearing in accordance with 42 C.F.R. Part 498, subpart D, and (2) render a de novo decision on the merits of the dispute.

During an October 25, 2006 telephone conference, the parties agreed that the main issue to be decided in this proceeding is properly framed as follows:

> Did CMS improperly deny Mira Vista's request for provider-based status for the 30 skilled nursing beds that were relocated from Mira Vista's main campus in Mount Vernon to the United General Hospital satellite location during the period December 1998 through December 1999?

The parties also agreed that an in-person hearing was unnecessary, and that I may issue a decision based solely on their briefs, documentary evidence, and other written material in the record before me.

As agreed at the October 25, 2006 conference, the parties designated those parts of the records of prior DAB, PRRB, and court proceedings that they wanted to be part of the record of this proceeding. Without objection, I have admitted all the designated material into the record of this proceeding, even though some of the items in the designated parts of the records duplicate each other. In addition to designating material from prior proceedings, Mira Vista submitted new material. Without objection, I have admitted all of the new material proffered as exhibits by Mira Vista. I have indexed the parties' designated and new material as Exhibits A through L. I have also prepared a chronological index of post-settlement correspondence, briefs, and other case-related material. The material referenced in these indices constitute the record and sole basis for my decision.

I note that, in Exhibits A through I, the documents have stamped numbers at the bottom of each page, a remnant of prior litigation. I have used these numbers to help identify the portions of the record to which I cite in this decision.

Three briefs were submitted in this proceeding: Mira Vista's opening brief (MV Br.), CMS's response brief (CMS Br.), and Mira Vista's reply brief (MV Reply Br.).

C. Findings of Fact

Based on the documentary evidence and briefs submitted by the parties, I make the following findings of fact:

1. Mira Vista, Inc. is a Washington corporation. Ex. H at 272.

2. At the start of 1998, Mira Vista owned and operated a 94-bed Medicare-certified SNF in Mt. Vernon, Washington, known as Mira Vista Care Center. Ex. A at 89, 95-96. Mira Vista operated MVCC pursuant to a Certificate of Need (CON) issued by the Washington Department of Health (WDOH). Ex. F at 77; Ex. G at 159-163. The CON precluded MVCC from adding new beds or relocating existing beds without WDOH's prior approval. See Ex. G at 159-63.[4] MVCC's Medicare provider number is 505315. Ex. A at 127.

3. UGH is an acute care hospital located approximately 10 miles from MVCC in Sedro-Woolley, Washington.[5] Ex. F at 77.

4. In April 1998, Mira Vista and UGH entered into an agreement which allowed Mira Vista to lease building space at UGH in order to operate a 30-bed "skilled nursing transitional care unit" at that location.[6] Ex. A at 89, 91-94, 100; Ex. J. To implement the agreement, Mira Vista asked WDOH's permission to relocate 30 of MVCC's 94 nursing home beds to the UGH space and to operate the relocated beds under the existing CON. Ex. A at 86-94.

5. On July 23, 1998, the WDOH approved Mira Vista's bed relocation plan. Ex. A at 102-03; Ex. G at 162. The WDOH

---

[4] See Wash. Rev. Code §§ 70.38.105, 70.38.115.; Wash. Admin. Code § 246-310-044.

[5] MVCC's address is 300 South 18th Street, Mount Vernon, WA 98274. Ex. A at 104. The address for MV-UGH is 1971 Highway 20, Sedro-Woolley, WA 98284. Id. Google Maps, an internet mapping website (http://maps.google. com), shows that the driving distance between the two facilities is 9.7 miles. Mira Vista also describes the distance as "less than ten miles." MV Br. at 10.

[6] Mira Vista asserts that its willingness to "consider UGH's request" that it operate 30 beds on UGH's campus was conditioned on Mira Vista's ability to operate as a single provider from two locations. MV Br. at 2. I make no findings about this assertion. Any agreement between Mira Vista and UGH cannot bind the federal government to accept Mira Vista's characterization of the UGH-based facility as part of a single provider operating at two locations because federal law governs the status of Medicare providers. Any private agreement between Mira Vista and UGH could only be enforceable, if at all, between those private parties.

did not require Mira Vista to apply for a new CON because it determined that the relocation constituted a "replacement of existing nursing home beds" under the applicable state regulations. Id.; see also Wash. Admin. Code § 246-310-044.

6. Although the WDOH did not require a new CON, another state agency, the Washington Department of Social and Health Services (WDSHS), which performs Medicare certification surveys on behalf of CMS,[7] required Mira Vista to obtain a new license to operate its UGH-based skilled nursing unit. Ex. I; Ex. H at 273; MV Br. at 11. Mira Vista's license application indicated that the UGH-based facility would be operated under the name "Mira Vista Rehabilitation Center – UGH Campus." Ex. I.

7. During July 1998, Mira Vista discussed its plans for MV-UGH with a CMS employee named Judy Ramberg. Ex. H at 215. On July 29, 1998, Ms. Ramberg sent Mira Vista a Medicare enrollment application form (form HCFA-855) as well as a memorandum (Ramberg Memo) that states in relevant part:

> Based on the information we discussed today, we believe your new facility will be an initial Medicare and Medicaid certification, even though the CON is allowing you to take 30 beds from your current facility. We do not allow satellite long term care facilities and do not consider your new facility a replacement facility for Medicare certification purposes. For Medicare's purposes, a replacement facility, keeping the same provider number, would only occur if all 94 beds were moved to the new facility and the old facility went out of business.
>
> Your new facility will be issued a separate Medicare provider number based on an initial survey where the state agency establishes the facility's compliance with the long term care requirements.

Id.; Ex. A at 107.

8. In August 1998, Mira Vista was advised by its Medicare fiscal intermediary that Medicare would pay for covered SNF services provided at MV-UGH at the federal PPS rate, rather

---

[7] See Wash. Admin. Code § 388-97.

than at the transition period rate applicable to SNFs that received their first Medicare payment before October 1, 1995. Ex. A at 109.

9. In November 1998, Mira Vista submitted a Medicare enrollment application for MV-UGH. Ex. H at 216. The application stated that it was for an "initial enrollment" rather than an "enrollment of additional location(s)." Id. The application also indicated that MV-UGH was not an "off site clinic," a "distinct part unit," a "branch," or a "provider based facility." Id. at 219.

10. In December 1998, an initial certification survey performed by WDSHS found that MV-UGH was in substantial compliance with Medicare participation and state licensing requirements. Ex. H at 258, 259.

11. On January 19, 1999, CMS informed the administrator of MV-UGH that its application for participation in the Medicare program had been accepted effective December 8, 1998. Ex. H at 266, 268, 270. CMS assigned MV-UGH its own provider number, 505506. Id. at 270.

12. Through early 1999, Mira Vista accepted interim Medicare PPS payments for services provided at MV-UGH. Ex. F at 80.

13. On July 5, 1999, the CMS Regional Office received by facsimile transmission an unsigned letter asking for a "determination that [MV-UGH] is not a new Medicare provider pursuant to existing regulations and HCFA policies." Ex. H at 271. The letter identified the author as Mira Vista's President, Daniel Humphrey, but Mr. Humphrey had not signed it. The letter stated that Mira Vista owned and operated both MVCC and MV-UGH, that these facilities were not "separate providers" but "part of one institution," that MV-UGH did not meet the definition of a "new provider" under 42 C.F.R. § 413.30(e), and that MV-UGH met CMS requirements for designation as a provider-based component of MVCC. Id. at 271-72. Citing provisions of program manuals that discuss certification of distinct part SNFs, Mira Vista also claimed that CMS was authorized to treat its Mount Vernon and UGH-based "campuses" as a "single facility." Id. at 275-76.

14. On July 22, 1999, Mr. Dan Dolan, a branch chief in the CMS Regional Office, responded to a July 1, 1999 letter from Senator Slade Gordon on behalf of Mira Vista seeking to have CMS rescind MV-UGH's Medicare certification and to include

MV-UGH under MVCC's provider number.[8] Ex. A at 121; Ex. H at 295. Mr. Dolan referenced the Ramberg Memo's advice to Mr. Humphrey in July 1998 that MV-UGH required its own Medicare provider number based on a certification survey and that MV-UGH could not be considered as a satellite facility of MVCC or a replacement facility for Medicare purposes. Id.

15. On September 10, 1999, Mira Vista reiterated its request that MV-UGH be designated as a provider-based entity. Ex. H at 287. In addition, Mira Vista asked for permission to "submit an amended application for Medicare certification under our existing provider number at our Mount Vernon campus." Id.

16. On October 1, 1999, Thomas Hoyer, a CMS headquarters employee, responded to Mira Vista's request that MVCC and MV-MGH "be merged and treated as a single provider under the Medicare program." Ex. H at 292. Mr. Hoyer wrote:

> At this time, Mira Vista Care Center and Mira Vista at United General Hospital operate as two independent freestanding facilities that participate separately in the Medicare program . . . . In terms of certification and management, these two institutions do not operate as a single entity, nor does it appear that they could operate as a single entity. A freestanding facility cannot operate at more than one physical location, unlike a hospital-based facility which is able to operate at various locations within the confines of its physical plant which comprise the institutional complex. Therefore, in this instance, Mira Vista Care Center and Mira Vista at United General Hospital were correctly established as separate providers. Furthermore, Mira Vista at

---

[8] Mira Vista complains that no denial of its July 5, 1999 request was sent to it directly, but admits that, on July 19, 1999, it received a copy of the CMS letter to Senator Gordon. MV Br. at 7. Furthermore, Mira Vista acknowledges that Mr. Hoyer met with Mr. Humphrey during the summer of 1999, as Mr. Hoyer stated in his October 1, 1999 letter discussed below. MV Br. at 5 n.1. Mira Vista admits that, at that meeting, Mr. Hoyer explained that MV-UGH "could not meet the requirements to be considered provider-based for purposes of Medicare reimbursement . . . ." Id.

> United General Hospital could not meet the requirements to be considered provider-based for purposes of Medicare reimbursement, which it would need to do in order to be based to Mira Vista Care Center. The provider based requirements relate to those entities that seek to be part of a hospital complex, not to freestanding entities.

Id.

17. On October 21, 1999, Dan Dolan informed Mira Vista that CMS did not permit SNFs to have "satellite locations" and that "to assure the health and safety of patients, each SNF location must be separately surveyed and certified for Medicare." Ex. H at 295.

18. On November 1, 1999, David Haffie, a CMS associate regional commissioner, informed Mira Vista that because MV-UGH had been certified to participate in Medicare after October 1, 1995, MV-UGH was appropriately paid at the federal PPS rate (rather than at the transition period rate). Ex. H at 298. Mr. Haffie further stated that MVCC and MV-UGH were "separate facilities" and could not be treated as a single provider under the Medicare program. Id.

19. In December 1999, Mira Vista closed MV-UGH and obtained the State of Washington's permission to relocate those beds to MVCC. Ex. H at 299-303.

D. Discussion

Mira Vista now contends that CMS wrongfully denied its request to designate MV-UGH as a provider-based component of MVCC. MV Br. at 8-12. Mira Vista also contends that CMS should have treated MVCC and MV-UGH as a "composite distinct part," a designation that, according to Mira Vista, authorizes an organization to provide skilled nursing care at more than one physical location under a single provider agreement and provider number. Id. at 12-17.

In addition, Mira Vista asserts that "at no time did [it] own two skilled nursing facilities, nor did [it] ever relocate 30 beds to a 'new facility.'" MV Reply Br. at 2. Mira Vista contends that "[a]t all relevant times, [it] has been the owner and operator of a 94-bed skilled nursing facility in Washington State," and that it merely operated this facility at two locations, one in Mount Vernon and the second at a "satellite campus" ten miles away. Id.

Underlying these contentions is Mira Vista's ongoing complaint about the Medicare payment it received for covered services provided at MV-UGH. As indicated, Medicare paid for services provided at MV-UGH at the federal PPS rate while paying for services at MVCC at a higher "transition period" rate. Mira Vista complains that MV-UGH was deemed a "new provider," and was hence disqualified from receiving payment at the transition period rate, because of CMS's improper refusal to accord MV-UGH provider-based status and its failure to recognize MVCC and MV-UGH as a composite distinct part. MV Br. at 18-20. Mira Vista represents that the difference between the two rates in payment amounts to MV-UGH, and hence the amount in controversy here, is $480,385. MV Br. at 18, n.3; see also Ex. A at 61, 136. Mira Vista asserts that its "decision to move some of its beds to another location and operate both locations as a single provider should not determine whether or not the transitional rate applies." MV Br. at 19.

1. CMS properly granted MV-UGH's application to be certified as a free-standing SNF.

Before addressing the specific issues relating to "provider-based" and "composite distinct part" status, I reject the proposition, implicit throughout Mira Vista's argument, that CMS acted improperly in certifying MV-UGH as a freestanding "skilled nursing facility" under the Medicare program. The important context here is that Mira Vista seeks to belatedly and retroactively have MV-UGH recertified as a different kind of facility than Mira Vista represented MV-UGH to be in Mira Vista's own original application to CMS for MV-UGH to participate in Medicare. Mira Vista ignores this simple fact – that it chose to submit an application seeking freestanding SNF status.[9] Nowhere

[9] Mira Vista attempts to obfuscate this reality by pointing to a document which Mira Vista asserts that WDOH sent to the Medicare fiscal intermediary. MV Br. at 3; Ex. G, at 164. The form reports that WDOH is considering a request to transfer 30 beds from Mira Vista's existing facility to a facility licensed to be run by Mira Vista on the campus of UGH. Ex. G at 164. On the form is the question "Is new entity provider-based?" and the box for "Yes" is checked. Id. This form does not constitute a request to the fiscal intermediary or Medicare to classify the "new entity" as provider-based. Rather, the form is an "advance notification of a potential Medicare Change of Ownership (CHOW)" by the State. Id. It further warns that WDOH has "not completed

(continued...)

in the application did Mira Vista suggest that certification was sought for any other status; on the contrary, the boxes asking if MV-UGH was a "Provider Based Facility" or a "Distinct Part Unit" were checked "No." Ex. H at 216. Mira Vista's original application is consistent with the advice given in the Ramberg Memo.[10] If Mira Vista disagreed with that advice, it could have

---

[9](...continued)
processing of the CHOW" and promises that, if the State does approve the CHOW, the fiscal intermediary "will receive official notice of the change." Id. The relevance of whether the proposed change involves a provider-based entity is that, where the main and provider-based entities are served by different fiscal intermediaries, the State is expected to send this "early alert" to both intermediaries. Id. I conclude that this form cannot be read as either a request by Mira Vista to consider MV-UGH as provider-based (especially in the face of the express representation to the contrary in MV-UGH's provider application) or as an evaluation by WDOH of the merits of any such Mira Vista request, much less a basis for Mira Vista to assume that CMS would approve that status. A July 23, 1998 letter from WDOH to Mira Vista announces that the replacement beds have been authorized for two years, but says nothing about the new site being treated as "provider-based." Ex. G at 162. This argument is one example among many in which Mira Vista mistakes questions of compliance with state requirements, such as obtaining certificates of need, for compliance with federal requirements for Medicare certification. Even if WDOH had purported to treat MV-UGH as provider-based, that conclusion could not bind CMS to accept such a determination where federal law does not authorize that treatment.

[10] Mira Vista suggests that the Ramberg Memo evidenced that the CMS Regional Office "was completely unsure how to process Mira Vista's request for provider-based status" and that CMS thus "ultimately deferred to the State's expertise," by telling Mira Vista to "keep in close contact" with WDSHS staff who "can guide you through the process of state licensure and Medicare-Medicaid certification." MV Br. at 4, quoting Ex. H at 1. Mira Vista's suggestion is not supported by the text of the memorandum. The text of the Ramberg Memo is clear that CMS does not permit satellite SNFs and would not allow use of the same MVCC provider number for MV-UGH under the circumstances, but that Mira Vista must file a new Medicare participation application for MV-UGH. Mira Vista is referred to the appropriate State agency for guidance in the process of applying (such as completing a HCFA-
(continued...)

applied for another status and sought to press its position through the application and certification process. Mira Vista instead represented itself as a new freestanding SNF and now complains that CMS accepted that representation.

A SNF is defined in section 1819(a) of the Act as an "institution" that (1) is primarily engaged in providing "skilled nursing care" or "rehabilitation services," (2) has a transfer agreement with a Medicare participating hospital, and (3) meets Medicare participation requirements. The term "institution" is not defined in the statute, but its common or ordinary meaning is a "building," "organization," or "place" devoted to a specific purpose or mission, including the care of disabled or ill persons. *The American Heritage Dictionary of the English Language* (4th ed. 2006).

MV-UGH clearly met, or was capable of meeting, the statutory definition of a SNF. First and foremost, MV-UGH was an institution – an organization or place – primarily engaged in providing skilled nursing care or rehabilitation services. The fact that MV-UGH was owned and operated by a corporation that provided SNF services at another location did not place MV-UGH outside that part of the statutory definition. Mira Vista identifies no other part of the statutory definition that precluded CMS from treating MV-UGH as a SNF as Mira Vista requested. Although Mira Vista now claims that it was a single, unified organization providing covered services in multiple locations, that characterization of its business is irrelevant in determining whether MV-UGH was properly enrolled as a distinct SNF under the Medicare program. In this area, the Medicare statute and regulations do not recognize a corporate or other business organization as the program participant. Instead, the statute and regulations recognize the participation of each qualified skilled nursing "facility," a term that itself connotes a discrete or geographically separate place, rather than a group of separate buildings at different locations, however interrelated they may be. Act §§ 1814-1815 (setting out conditions for payments to "providers of services"), 1866 (setting out eligibility criteria for participation in Medicare by "providers of services"), and 1861(u) (defining a "provider of services" as including a "skilled nursing facility"). "For Medicare . . . purposes (including eligibility, coverage,

---

[10](...continued)
855 form), not in order for Mira Vista to obtain a different opinion from state "experts," on the need for a new provider agreement and provider number.

certification, and payment), the 'facility' is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of, a larger institution." 42 C.F.R. § 483.5(a) (emphasis added). As a federal court has recently noted, the fact that a SNF "must obtain its own unique provider number" and that a SNF must have its own Medicare participation agreement as a provider of services implies that it is "certainly reasonable to conclude that a SNF is a separate provider under the Medicare program." Community Care, L.L.C. v. Leavitt, 477 F.Supp.2d 751, 758 (E.D. La. 2007)

In addition, CMS has identified a valid programmatic reason, which Mira Vista did not dispute, for enrolling MV-UGH as a separate or distinct SNF: the need for MV-UGH to *independently* satisfy Medicare participation requirements, which include minimum standards for residents' physical environment and for the quality of care provided at the facility.[11] See Ex. H at 295 (rejecting Mira Vista's request that MV-UGH be treated as a "satellite" of MVCC on the ground that "each SNF location must be separately surveyed and certified for Medicare"). That reason is consistent with CMS's own program instructions. The CMS State Operations Manual (SOM)[12] indicates that if an organization provides skilled nursing care in two geographically separate or noncontiguous locations, each location must be certified as meeting Medicare participation requirements in order to receive

---

[11] Mira Vista argues that the result of denying provider-based status is itself "irrational," claiming that the residents who moved from MVCC to MV-UGH received "the exact same services pursuant to the exact same care plan," at the "exact same costs" incurred by the "exact same operator," but yet the operator was reimbursed for those services at a lower rate. MV Br. at 6. It may well be that those residents brought with them existing care plans (although no evidence of that is present in this record) but the services after transfer were provided in a different facility, and I see no basis in the record to conclude that the costs of operating MV-UGH in leased space at UGH were identical to the per-resident costs of operating MVCC in its existing location.

[12] I cite to the paper-based version of the SOM that was in use during 1998 and 1999 (CMS Pub. 7). In 2004, CMS issued an electronic version of the SOM that supplants the paper-based version. See CMS Manual System, Pub. 100-07, Transmittal No. 1, dated May 21, 2004 (available on CMS's internet website at http://www.cms.hhs.gov/transmittals/downloads/R1SOM.pdf).

Medicare payment for services provided at the location.[13] SOM § 3324 (indicating that the Medicare statute inherently requires that each "branch, satellite or extension" location of a provider be found to meet applicable requirements for participation in the Medicare program, and noting that "there is no basis for a provider to bill Medicare for services provided by a site which has not been determined to meet applicable requirements for participation").

Mira Vista argues that CMS improperly treated MV-UGH as a "new provider" in granting it a different provider number than MVCC's. MV Br. at 18. Mira Vista argues that MV-UGH should not have been required to obtain a new provider number, and even if it did receive a new provider number, it should have been considered as part of a "single provider" having been in operation from the time that its licensee, Mira Vista, was first certified. MV. Br. at 18-19. I discuss below the origin of the term "new provider," in relation to Mira Vista's assertions that it should have received the transitional rate because it did not qualify as a "new provider" for purposes of applying the PPS rates to it. For purposes of this discussion, I merely point out that Mira Vista itself requested that CMS treat it as a new provider and assign a new provider number. Ex. H at 216. The provisions which Mira Vista now cites for the proposition that it did not "qualify" as a "new provider" are entirely irrelevant, having to do with allowances made for higher costs in the early days of a new entrant into a market. In any case, failing to qualify as a "new provider" certainly would not mean MV-UGH was qualified as a provider-based facility or a part of some single two-location SNF provider.

---

[13] A regulatory exception exists for home health agencies. Medicare treats the "branch office" of a home health agency as part of the home health agency because it is "located sufficiently close to share administration, supervision, and services *in a manner that renders it unnecessary for the branch independently to meet the conditions of participation*." 42 C.F.R. § 484.2 (italics added). The regulations governing SNFs contain no analog to a HHA's "branch office." See 42 C.F.R. Part 483. Since CMS obviously knew how to explicitly provide for treating separate locations as a single provider in the case where such treatment was consistent with the program purposes, I find it even more clear that CMS's silence on any such option for SNFs means that no option was available to Mira Vista in the circumstances here.

In short, Mira Vista may have wished from the beginning to obtain provider-based status for MV-UGH and to have the transitional rates being paid to MVCC at the time extend to MV-UGH, but Mira Vista was advised that CMS would not approve such a request long before Mira Vista submitted an application. Rather than pressing for its wish in its actual application for Medicare participation for MV-UGH, however, Mira Vista chose to indicate that MV-UGH was not provider-based. It appears that Mira Vista continued to hope that MV-UGH would still qualify for the transitional rate, but it is not clear on what basis.[14]

I conclude that CMS acted properly in granting Mira Vista's application for MV-UGH to be certified as a freestanding SNF. I turn next to Mira Vista's request to change MV-UGH's provider status retroactively.

2. CMS properly denied Mira Vista's request that MV-UGH be redesignated as provider-based.

After being certified to participate in Medicare effective December 8, 1998, MV-UGH received Medicare payments for SNF services provided at that location at the SNF PPS rate for some months. On July 5, 1999, Mira Vista first filed a "request for determination that" MV-UGH is not "a new Medicare provider pursuant to existing regulations and [CMS] policies." Ex. A at 112; Ex. H at 271.[15] In its request, Mira Vista argued that MV-UGH and MVCC constituted a single provider, although acknowledging that they had separate nursing home licenses and different provider numbers. Ex. A at 114. Mira Vista also argued that MV-UGH qualified as a provider-based facility. Id. at 118-120.

---

[14] It is especially unclear why Mira Vista would profess to have been surprised that the issuance of a new provider number implied payment at the SNF PPS rate, since Mira Vista reported in briefing before the PRRB that its fiscal intermediary (FI) had informed Mira Vista that "if CMS issues a new Medicare provider number, then the FI will automatically use the federal Medicare PPS rates." Compare Ex. A. at 66 with MV Br. at 5-6.

[15] CMS suggests, without citing authority, that even if MV-UGH "had been entitled to provider-based status, it would not have been entitled to a retroactive application of that status," at least prior to July 1999 when this request was made. CMS Br. at 8. I need not address what the appropriate starting date would be for provider-based status to apply because I find that MV-UGH was never entitled to that status.

On July 22, 1999, the CMS Regional Office (responding to the Senator's letter of inquiry) reaffirmed that MV-UGH required its own Medicare provider number based on a certification survey and that MV-UGH could not be considered as a satellite facility of MVCC or a replacement facility for Medicare purposes. Ex. A at 121; Ex. H at 295.

On September 10, 1999, Mira Vista sought reconsideration of CMS's decision to treat MV-UGH "as a new Medicare provider for rate setting purposes." Ex. A at 123. (A parallel request was made to the fiscal intermediary on September 11, 1999. Ex. A at 127.) Mira Vista concluded that MV-UGH could meet the "appropriate criteria for provider-based classification," and that MV-UGH should be "allowed to submit a revised application" for a change in location instead of its new provider application. Ex. A at 128. In his October 21, 1999 letter, Mr. Dolan denied reconsideration as untimely and reiterated that "each SNF location must be separately surveyed and certified for Medicare." Ex. H at 295.

The term "provider-based" does not appear in the Medicare statute. In April 2000, CMS for the first time promulgated regulations containing criteria for determining whether a facility is provider-based. 65 Fed. Reg. 18,483, 18,504-22 (April 7, 2000). These regulations, codified at 42 C.F.R. § 413.65, became effective after CMS made the determination under appeal in this case.[16] Neither party indicates that the regulations were intended to have retroactive effect, and I have found no authority for that proposition. On the contrary, the preamble to the regulations makes clear that CMS intended to apply the criteria in the new regulations only prospectively in evaluating claims of provider-based status.[17] For that reason, I

---

[16] As initially promulgated, section 413.65 became effective in October 2000. 65 Fed. Reg. at 18,504; see also 42 C.F.R. § 413.65(b)(2). Later amendments were made but are not relevant here.

[17] Thus, the preamble explains as follows:

> In response to the comment about possible retroactive application of the new regulations, we note that they will apply only on or after their effective date of October 10, 2000. We will not apply the provider-based criteria in the new regulations to periods prior to that date; on the contrary, decisions for such periods will be reviewed only

(continued...)

do not base my decision on those regulations.[18] Behrooz Bassim, M.D., DAB No. 1333 (1992) (noting that retroactivity is not favored in the law, and that "[t]he authority to promulgate rules having a retroactive effect must be expressly granted to an agency by Congress" (citing Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 208-9 (1998)).

Prior to April 2000, CMS made provider-based status determinations based on criteria set out in various CMS program manuals and memoranda. 65 Fed. Reg. at 18,504. In 1996, CMS published Program Memorandum (PM) 96-7, which consolidated and clarified the criteria used by CMS to make provider-based status determinations. Id. PM 96-7 was re-issued without change in May 1998 (as PM 98-15) and May 1999 (as PM 99-24). Ex. G at 191-94; Ex. H at 305. The Ramberg Memo summarized the longstanding policy of CMS as not allowing satellite SNF facilities. Ex. H at 215. Indeed, Mira Vista did not identify a single instance in which a SNF was certified as a satellite facility or provider-based entity of another SNF. The policies which I discuss next thus appear to constitute a consistent and longstanding interpretation of Medicare participation requirements for SNFs.

PM 96-7 and its successors state that "[t]he main purpose of the provider or facility-based designation is to accommodate the appropriate accounting and allocation of costs where there is more than one type of provider activity taking place within the same facility/organization, e.g., a hospital based skilled nursing facility." Ex. H at 305 (emphasis added). It is clear from this sentence and others in PM 96-7 that a provider-based designation is appropriate only with respect to an organization that is engaged in providing more than one type or category of

---

[17](...continued)
under the criteria in effect at the time, as stated in Program Memoranda and the Provider Reimbursement Manual and State Operations Manual.

65 Fed. Reg. at 18,508.

[18] In any case, even if the provisions of 42 C.F.R. § 413.65 were applied here, they would not lead to a different result. If anything, section 413.65(a)(1)(ii)(D) appears to more clearly exclude SNFs from the kinds of providers that can have provider-based entities. Further, section 413.65(a)(2) specifies that a provider-based entity must be established "for the purpose of furnishing health care services of a different type from those of the main provider."

Medicare-covered service. Mira Vista was not that type of organization. From December 1998 to December 1999, Mira Visa was not engaged in "more than one type of provider activity." It was not, for example, operating both a SNF and outpatient rehabilitation facility.[19] Rather, Mira Vista was a corporation that furnished inpatient SNF services at two non-contiguous locations. Nothing in PM 96-7 suggests that CMS was obligated to recognize MV-MGH as a provider-based component of MVCC under these circumstances. Moreover, none of CMS's regulations, manuals, or program memoranda even allude to the possibility that a Medicare-certified SNF can be treated as the provider-based component of another, non-contiguous SNF, regardless of their business or operating relationship.[20] The relevant program manuals and memoranda refer only to "hospital-based" SNFs or to SNFs that are "distinct parts" of some other type of institution. See, e.g., CMS Skilled Nursing Facility Manual (Pub. 12) § 201 (available on CMS's website at http://www.cms.hhs.gov/Manuals/PBM/list.asp). Moreover, it is difficult to see how the purpose of CMS's policy — to allow a main provider to reflect economies of scale in the Medicare cost allocation and accounting process — would have been served by designating MV-MGH as provider-based.

---

[19] The term "provider of services" in the Medicare statute includes a "comprehensive outpatient rehabilitation facility." Act § 1861(u). The term "comprehensive outpatient rehabilitation facility" means "a facility which is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons[.]" Act § 1861(cc)(2). "Comprehensive outpatient rehabilitation facility services" are a separately defined category of covered Medicare service. Act § 1861(cc)(1).

[20] Mira Vista contends that no express authority underlies CMS's contention that a SNF cannot have a satellite location that participates as a provider-based SNF of the main SNF. Reply Br. at 4. I would generally defer to CMS's reasonable interpretation of its own regulations and manuals, unless the party adversely affected lacked timely and adequate notice of the interpretation. Even in the latter case, I would defer to CMS's interpretation unless the other party could show that it had actually relied on an alternative reasonable interpretation. In the present matter, Mira Vista had timely and adequate notice of CMS's interpretation of the provisions on provider-based status as excluding satellite SNF locations in its discussion and correspondence with the CMS Regional Office and its fiscal intermediary prior to filing its application.

Mira Vista's only apparent purpose in seeking provider-based status was to increase its Medicare payment for services provided at MV-MGH during the period that the transitional rate was in effect.

Even if I accepted Mira Vista's position that PM 96-7 did not categorically preclude a provider-based designation in these circumstances (which I do not), Mira Vista failed to show that most of the criteria for the designation were met. PM 96-7 states that it was CMS's "policy that the following applicable requirements must be met before an entity can be designated as part of a provider for payment purposes":

1. The entity is physically located in close proximity of the provider where it is based, and both facilities serve the same patient population (e.g. from the same service, or catchment area);

2. The entity is an integral and subordinate part of the provider where it is based, and as such, is operated with other departments of that provider under common licensure.

3. The entity is included under the accreditation of the provider where it is based (if the provider is accredited by a national accrediting body), and the accrediting body recognizes the entity as part of the provider.

4. The entity is operated under common ownership and control (i.e., common governance) by the provider where it is based, as evidenced by the following:

    - The entity is subject to common bylaws and operating decisions of the governing body of the provider where it is based;

    - The provider has final responsibility for administrative decisions, final approval for personnel actions, and final approval for medical staff appointments in the provider-based entity; and

    - The entity functions as a department of the provider where it is based with significant common resource usage of buildings, equipment and service personnel on a daily basis.

5. The entity director is under the direct day-to-day supervision of the provider where it is located, as evidenced by the following:

    - The entity director or individual responsible for day-to-day operations at the entity maintains a daily reporting relationship and is accountable to the Chief Executive Officer of the provider and reports through that individual to the governing body of the provider where the entity is based; and

    - Administrative functions of the entity, e.g., records billing, laundry, housekeeping and purchasing, are integrated with those of the provider where the entity is based.

6. Clinical services of the entity and the provider where it is located are integrated as evidenced by the following:

    - Professional staff of the provider-based entity have clinical privileges in the provider where it is based;

    - The medical director of the entity (if the entity has a medical director) maintains a day-to-day reporting relationship to the Chief Medical Officer or other similar official of the provider where it is based;

    - All medical staff committees or other professional committees at the provider where the entity is based are responsible for all medical activities in the provider-based entity;

    - Medical records for patients treated in the provider-based entity are integrated into the unified record system of the provider where the entity is based;

    - Patients treated at the provider-based entity are considered patients of the provider and have full access to all provider services; and

- Patient services provided in the entity are integrated into corresponding inpatient and/or outpatient services, as appropriate, by the provider where it is based.

7. The entity is held out to the public as part of the provider where it is based (e.g., patients know they are entering the provider and will be billed accordingly).

8. The entity and the provider where it is based are financially integrated as evidenced by the following:

   - The entity and the provider where it is based have an agreement for the sharing of income and expenses; and

   - The entity reports its cost in the cost report of the provider where it is based using the same accounting system for the same cost reporting period as the provider where it is based.

Ex. H at 306-07. Collectively, these criteria require that the main provider and the subordinate entity have a substantial amount of managerial, operational, and financial integration. Johns Hopkins Health Systems, DAB No. 1712 (1999) (noting that under PM 96-7, "the key issue is whether an entity is under common ownership and integrated operationally" with the main provider).

The record here is devoid of any persuasive evidence demonstrating that MVCC and MV-UGH could meet these criteria, even if two SNFs operated by a single corporation could legally have a provider-based relationship.[21] For example, Mira Vista

---

[21] In its reply brief, Mira Vista suggests that CMS conceded that MV-UGH satisfied four of the eight factors on the grounds that CMS did not specifically set out its contentions about why MV-UGH failed to meet those criteria individually. Reply Br. at 7. This suggestion overlooks CMS's explicit demand that Mira Vista be put to its proof as to all eight criteria, stating –

> Petitioner seems to assume that CMS concedes the existence of the required elements. It does not. Certainly Petitioner's statements are not sufficient to establish the requisite elements. Unless Petitioner is able to come forward with precise and definitive evidence establishing each of the elements, CMS's

(continued...)

submitted no evidence that MVCC (as the main provider) had "final responsibility" for operations at MV-UGH, no declarations or other evidence indicating that MVCC exercised "day-to-day" supervision of MV-UGH, and no business records confirming that the two facilities shared administrative, financial, and other resources. In most areas, Mira Vista offered, at best, broad assertions in its briefs with little concrete proof of their accuracy.

Mira Vista asserts that MVCC and MV-UGH were "operated under common ownership and control" (criterion 4) because MVCC "maintained final responsibility for administrative and personnel decisions." MV Br. at 11. Although it is clear that Mira Vista (the corporation) owned the assets of both MVCC and MV-UGH, the record contains no business records, such as written personnel and operating policies, verifying that MVCC employees possessed or exercised final responsibility for operational and personnel matters at MV-UGH or that MV-UGH was staffed by MVCC employees. In addition, Mira Vista has not alleged that other indicia of "common ownership and control" specified in PM 96-7 were present, such as "significant common resource usage of buildings, equipment and service personnel on a daily basis."

Mira Vista contends that Daniel Humphrey, Mira Vista's corporate president, "served as the President of both the Mount Vernon and the UGH campus," and that this is sufficient proof of MVCC's "control" of MV-UGH. MV Reply Br. at 9. There is, however, no evidence of <u>actual</u> participation by Mr. Humphrey in the management or operation of either facility, and no explanation of how he acted to coordinate the operation of the two facilities on a daily basis. Other evidence that Mira Vista cites for its claim of "common ownership and control" is similarly

---

[21](...continued)
decision to deny provider-based status should be upheld. CMS reserves the right to address any new evidence that may be introduced by the Petitioner in its reply brief.

Response Br. at 15. In light of that statement, the claim that CMS conceded four criteria is not plausible. Mira Vista was thus on notice that the facts underlying its claims to meet all eight criteria were contested, yet it chose not to proffer any additional evidence with its reply brief or otherwise seek any further opportunity to develop the record. I therefore draw a negative inference about whether any additional unproduced evidence would be supportive of Mira Vista's assertions.

unilluminating. For example, Mira Vista points to an affidavit submitted by Mr. Humphrey to state regulators in February 1998. MV Reply Br. at 9 (citing Ex. A at 89). The affidavit states that Mira Vista (the corporation) would "own and operate" MV-UGH but says nothing about how the operations of MVCC and MV-UGH would be integrated. Ex. A at 89. Mira Vista also cites a WDOH document ("Skilled Nursing Facility Replacement Authorization #20") as evidence that MVCC and MV-UGH were governed by a "common board," but that document indicates only that the names of certain corporate officers of MVCC would be listed on the state license application for MV-UGH. MV Reply Br. at 9 (citing Ex. A at 103).

Mira Vista asserts that MVCC and MV-UGH were "financially integrated" (criterion 8) because they "shared income and expenses" and because MVCC included MV-UGH's costs on its cost report. MV Br. at 11. The only evidence of record Mira Vista cites for the truth of that assertion was its request on MV-UGH's enrollment application to send Medicare payments to MVCC's address. MV Reply Br. at 10 (citing Ex. H at 219). Mira Vista also cites assertions in the July 5, 1999 letter to the effect that both "campuses shared the same accounting system and the same cost reporting period." MV Reply Br. at 9 (citing Ex. H at 280). But no evidence was submitted to support that assertion.

Mira Vista omits to mention — or allege the inapplicability of — certain key criteria, such as the existence of "direct day-to-day supervision" by the main provider (criterion 5) and the integration of clinical services (criterion 6). MV Br. at 9-12. As for the remaining criteria, Mira's evidence is either incomplete or unpersuasive. For example, regarding criterion 1 — which requires that the main provider and subordinate entity be "physically located in close proximity" and "serve the same patient population" — Mira Vista asserts that MV-UGH and MVCC served the same patient population "as demonstrated by the fact that patients residing at the provider were transferred to the UGH satellite location when the SNF beds were taken from the Mount Vernon campus to the UGH location." MV Br. at 10. Mira Vista produced no evidence of this patient transfer, however. Even accepting that the new facility was initially populated by transfers from MVCC, I would have insufficient basis to infer that MV-UGH would provide ongoing services to same patient population from which MVCC drew its residents. Indeed, some representations made in the July 5, 1999 letter seem to indicate the opposite. Mira Vista there asked for a decision on its request for provider-based status in order to avoid closing MV-UGH. Ex. H at 279. Mira Vista then explained that it "would prefer to continue to provide this vital service to the Medicare

beneficiaries in the Sedro Woolley community" and asserted that the MV-UGH "unit provides medically intensive care to beneficiaries who generally stay less than 20 days" and also provides "inpatient care to medically fragile beneficiaries undergoing treatment" at the UGH Oncology Center. Id. I see no evidence that MVCC served the same Sedro Woolley community or housed medically fragile beneficiaries during their cancer treatment at UGH. Furthermore, the notion that facilities almost 10 miles apart can be considered in "close proximity" seems doubtful at best.[22]

In claiming that it met criterion 2 — which requires the provider-based entity to be "an integral and subordinate part of the provider where it is based" and as such be "operated with other departments of that provider under common licensure" (emphasis added) — Mira Vista asserts that the State of Washington did not require a separate Certificate of Need for MV-UGH. MV Br. at 11. Yet Mira Vista simultaneously concedes that the State required MV-UGH to obtain its own nursing home license. Id.

Mira Vista asserts that various statements in the July 5, 1999 letter sent to CMS under Mr. Humphrey's name requesting provider-based status constitute additional evidence of operational integration. MV Br. at 9 (citing Ex. H at 279, 280). These statements are entitled to little weight because the document is unsigned and unsworn, and was created after-the-fact for the purpose of seeking redesignation as a provider-based facility. In any case, the statements are brief to the point of being

[22] In its briefing, Mira Vista suggests that the hospital, UGH, must serve the same population as MVCC because they are located "in the same county." MV Br. at 2. Mira Vista cites no authority for the presumption that all institutions in a single county serve the same patient population. I therefore decline to make that assumption.

conclusory[23] and are unaccompanied by documentary evidence to substantiate them.

Citing Johns Hopkins Health System, Mira Vista asserts that it is unnecessary that all eight criteria in PM 96-7 be satisfied in order to obtain provider-based status. The Board said in that decision that PM 96-7's criteria "are best viewed as evidentiary factors to be considered as a whole in making a determination about whether common ownership and operational integration in fact exist." DAB No. 1712, at 5. Here, the record fails to show that Mira Vista satisfied even a majority of the criteria in PM 96-7, including the ones requiring proof of actual financial and operational integration. While failure to meet any one criterion might not be fatal to a claim to be provider-based, a massive failure of proof as to most of the criteria would not support acceptance of that claim. Given the deficient quality and quantity of Mira Vista's evidence, I have no trouble concluding that MV-UGH failed to meet its burden. Even viewing the criteria as evidentiary factors, the collective weight of the evidence cuts against any finding that MVCC and MV-UGH had the type of connection required to treat MV-UGH as a provider-based facility of MVCC.

For all the reasons above, I conclude that CMS committed no error or abuse of discretion in denying provider-based status to MV-MGH.

---

[23] For example, paragraph four in its purported summary of evidence that MV-UGH qualifies as provider-based reads as follows:

> 4. Both campuses are under the direct supervision of the Executive Administrator reporting directly to the Board of Directors
>
> > Daily reporting by the Sedro Woolley campus administrator to the Executive Administrator located at the Mount Vernon campus.
> >
> > Integration of medical records, billings, laundry, housekeeping, accounting and purchasing between both campuses.

Ex. H at 278.

3. MV-UGH and MVCC did not constitute a composite distinct part.

I further find no merit to Mira Vista's assertion that MVCC and MV-MGH constituted a "composite distinct part" under 42 C.F.R. § 483.5.[24] As indicated, a SNF is defined in the Medicare statute as an institution – or the "distinct part" of an institution – that furnishes skilled nursing or rehabilitation services. Section 483.5(b)(1) states that a "distinct part SNF" is "physically distinguishable from the larger institution or institutional complex that houses it" and "may be comprised of one or more buildings or designated parts of buildings" that are:

> [i]n the same physical area immediately adjacent to the institution's main buildings; other areas and structures that are not strictly contiguous to the main buildings but are located within close proximity of the main buildings; and any other areas that CMS determines on an individual basis, to be part of the institution's campus.

42 C.F.R. § 483.5(b)(1).[25]

---

[24] Although these regulations were promulgated after 1999, I apply them here because Mira Vista affirmatively relies upon them and because they are, to a large degree, a codification of longstanding agency criteria. See 68 Fed. Reg. 26,757, 26,777-779 (May 16, 2003).

[25] Section 483.5(b)(1) further provides that, in order to be considered a distinct part of another institution, a SNF must meet: (a) the requirements of "this paragraph"; (b) the requirements in section 483.5(b)(2); and (c) the statutory requirements for SNFs in section 1819 of the Act. The requirements in section 483.5(b)(2) are similar in key respects to the criteria in PM 96-7. Some of those requirements are: (1) the distinct part SNF "must be operated under common ownership and control . . . by the institution of which it is a distinct part"; (2) the SNF's administrator must report to and be directly accountable to the management of the institution of which the SNF is a distinct part; (3) the SNF must have a designated medical director who is responsible for implementing care policies and coordinating medical care and who is directly accountable to the management of the institution of which the SNF is a distinct part; and (4) the SNF is financially integrated with the institution of which it is a distinct part. 42 C.F.R.

(continued...)

Section 483.5(b)(1) states that "[t]he term 'distinct part' also includes a composite distinct part" that meets the additional requirements of section 483.5(c). Section 483.5(c)(1) states that "[a] composite distinct part is a distinct part consisting of two or more noncontiguous components that are not located within the same campus[.]" Section 483.5(c)(2)(i) states that a SNF "that is a composite of more than one location will be treated as a single distinct part of the institution of which it is a distinct part" and as such "will have only one provider agreement and only one provider number."

In the proposed rule to establish section 483.5, CMS indicated that the composite distinct part definition was intended to cover situations like a merger of hospitals in which each hospital brings its own distinct part SNF, located on separate campuses, into the merger. 68 Fed. Reg. 26,757, 26,779 (May 16, 2003). In such a situation, the regulations recognize the individual distinct part SNFs as a unified composite distinct part of the merged hospital institution in which they are based. Id. CMS indicated that a composite distinct part "could also be created when a hospital that already has a distinct part SNF acquires an additional nursing home that is not co-located on the hospital's campus." Id. In this context, it is clear that the institution of which the SNF would be a distinct part is intended to be itself a provider of services under Medicare.

According to Mira Vista, MVCC and MV-UGH met the criteria for designation as a composite distinct part, being "two or more noncontinguous components that [were] not located on the same campus." MV Br. at 15-16. This assertion completely misses the mark. Two noncontiguous institutions are not a composite distinct part unless they constitute a distinct part of some *other* institution or institutional complex. 42 C.F.R. § 483.5(c)(1) (stating a "composite distinct part" must itself be a "distinct part"); 483.5(b)(1) (defining a distinct part as "physically distinguishable from the larger institution or institutional complex that houses it"); 68 Fed. Reg. at 26,778 (stating that "the concept of a distinct part is actually broader than that of a 'hospital-based' facility, in that the former can encompass situations in which a *SNF is a part of a larger institution* that is not a hospital (for example, a domiciliary or 'board and care' facility") (italics added)). MVCC and MV-UGH were not, either individually or collectively, parts of some other larger institution (itself a provider of services). They

---

[25](...continued)
§ 483.5(b)(2).

were merely two geographically separate SNFs with a common owner.

While the Board has not previously addressed the precise issue presented here, analogous Board cases and unappealed ALJ decisions support my reading. For example, in Heartland Manor at Carriage Town, DAB No. 1664 (1998) (Heartland), the Board dealt with a SNF which had been terminated from the Medicare program and then sought to reapply after a change of ownership, denying that it should be considered as a previously-terminated provider seeking reentry (a category of determinations made unappealable by regulation). The Board noted that the regulations define a SNF as a facility meeting the statutory requirements and stated that, "'[f]or Medicare purposes, the "facility" is always the entity which participates in the program, whether that entity is comprised of all of, or a distinct part of a larger institution." Heartland at 11 (citing 42 C.F.R. § 483.5). The Board then considered whether the "provider" remained the same even though the owner had changed, and concluded as follows:

> Implicit in these provisions, read together,[26] is the concept that the term "provider," as applied to skilled nursing facilities, is integrally tied to the physical plant of the institution (or distinct part) in which patients are placed.
>
> * * *

---

[26] In addition to 42 C.F.R. § 483.5, the referenced provisions included, among others: Section 1861(u) of the Act ("provider of services" means, inter alia, a SNF); Section 1819(a) of the Act (SNF means "an institution (or a distinct part of an institution) which is primarily engaged in providing to residents skilled nursing care and related services . . . ."); Section 1819(d)(2)-(4) of the Act (SNFs required to meet provisions of Life Safety Code (unless waived) or other State law "which adequately protects residents of and personnel in skilled nursing facilities," as well as other requirements related to physical environment; applicable Federal, State, and local laws "which apply to professionals providing services in such a facility;" and such other requirements the Secretary may find necessary, including requirements "relating to the physical facilities thereof"); 42 C.F.R. § 498.2 ("provider" means "a hospital . . . , skilled nursing facility, [etc.] . . . that has in effect an agreement to participate in Medicare"); and various SNF requirements in 42 C.F.R. Part 483 dealing with the building/physical plant in which patients receive care such as life safety, fire, emergency power, space and equipment, resident room design, call system, toilet and bathing facility, and ventilation criteria. Heartland at 10-11.

> Moreover, by directing that a skilled nursing facility be identified by looking to the participating entity, whether "comprised of all of, or a distinct part of a larger institution," section 483.5 of the regulations not only reinforces the conclusion that provider status should be tied to identification of an institution/facility (including the physical plant), but implicitly rejects the conclusion that provider status is linked to ownership. That is, the regulation appears to contemplate that a single institution comprised of several distinct parts or types of facilities may be owned by a single person or entity. In such a case, the regulation directs the Medicare program to look to the distinct physical part of the operation which furnishes skilled nursing facility services, not the owner, in order to identify the provider. Under the program, each type of facility is separately certified; a separate provider agreement would be executed by the owner for each facility. 42 C.F.R. § 489.3.

Heartland at 12. Reading the same legal provisions and others discussed above, I too conclude that the concept of a SNF that is a provider under Medicare inheres in a physical plant where the relevant services are provided to beneficiaries. That physical plant may be co-located within a larger institution, as with a SNF ward in a hospital, but in no sense does common corporate ownership convert two distant physical facilities into distinct parts of each other or of some overarching corporate entity which is not itself a provider of services. Mira Vista's arguments to the contrary would potentially convert every corporate chain owning multiple providers into an infinitely expandible set of provider-based facilities.

Also enlightening, though not authoritative, here is the ALJ summary decision in Triad Eye Medical Clinic and Cataract Institute, P.C., DAB CR844 (2001) (Triad). The corporate owner of an ambulatory surgical center (ASC) opened another ASC and argued that the newer facility should have been treated as a "distinct entity" of the shared corporate owner or of the sister ASC. Triad at 9. The ALJ held that the regulations do not "allow subsidiary or satellite ASCs to participate in Medicare using the provider numbers of a parent company," a conclusion I have also reached in relation to SNFs. Triad at 8. The ALJ too focuses on the importance given in the ASC context, as it is in the SNF context, to on-site certification surveys which imply that a newly-opened physical location is to be subject to

surveys, even if the same owner was certified to participate another facility elsewhere. Triad at 8-9, 12. Thus, the ALJ in Triad opined that --

> reading the regulations as a whole, including one of the requirements for certification (that an on-site survey be conducted) I conclude that the phrase 'distinct entity,' in the regulations means a single ASC facility, not a corporate entity that operates multiple ASCs.

Id. at 8-9.

I find that a thorough review of the regulations governing SNFs leads me to the analogous conclusion in the present case. MV-UGH is not a distinct part of MVCC, but is itself a freestanding SNF; MV-UGH and MVCC are not together a composite distinct part of Mira Vista but are themselves each freestanding SNF facilities.

4. CMS committed no error in paying for Medicare services provided at MV-UGH at the federal SNF PPS rate.

Finally, I reject the claim that CMS was required to extend the transitional rate at which MVCC was paid to services furnished at MV-UGH, even if MV-UGH was properly certified as a separate provider. I conclude that CMS committed no error in refusing Mira Vista's request that it do so.

The regulation that implements the BBA's requirement for a transition period payment rate, 42 C.F.R. § 413.340, provides in relevant part:

> (e) *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. [emphasis added]

It is undisputed that MV-UGH became a Medicare-certified SNF as of December 8, 1998. In early 1999, MV-UGH received its first (interim) payments from Medicare. Ex. F. at 80. Because it received its first payment from Medicare after October 1, 1995, MV-UGH was excluded from the transition period under the plain wording of section 413.340.[27] Furthermore, there is nothing in

[27] Applying a transition period payment rate to services (continued...)

section 413.340 that makes the applicability of the transition period dependent on whether a SNF is provider-based or a distinct part. Furthermore, as the earlier discussion makes clear, designating MV-UGH as provider-based or a distinct part would not have altered the fact that MV-UGH was a "SNF" – an "institution" engaged in providing "skilled nursing care" or "rehabilitation services" – that received its first payment from Medicare after October 1, 1995. Act § 1819(a); 42 C.F.R. § 483.5(a) (stating that for payment and other program purposes, the "facility" is always the entity that participates in Medicare, "whether that entity is comprised of all of, or a distinct part of, a larger institution").

Mira Vista contends that it is entitled to payment at the transition period rate for MV-UGH's services because MV-UGH could not qualify as a "new provider" as that term has been used or defined in Medicare's regulations. MV Br. at 18-19. The term "new provider" is wholly inapplicable here. It appears nowhere in the sections of the Medicare statute and regulations that establish or implement the BBA's payment rate changes. See Act § 1888(e); 42 C.F.R. § 413.340(e). Instead, the term relates to the limits imposed on the reimbursement of "routine costs" under the reasonable cost reimbursement methodology.[28] See 42 C.F.R.

---

[27](...continued)
provided at MV-UGH would be fundamentally inconsistent with how the transition period rate is supposed to be calculated. The transition period rate is a blend of the federal PPS rate and a "facility-specific" rate. 42 C.F.R. § 413.340(a). In turn, the facility-specific rate is derived from the facility's Medicare allowable costs from fiscal year 1995. 42 C.F.R. § 413.340(b). MV-UGH did not exist in 1995, of course, and thus there are no appropriate historical costs upon which to calculate a facility-specific rate for MV-UGH. Apparently, Mira Vista believes that CMS should have calculated and applied a transition period rate for MV-UGH based on MVCC-MV's historical "facility-specific" costs, but Mira Vista has provided no legal or practical justification for such a payment methodology.

[28] As indicated, prior to the advent of the SNF PPS, Medicare paid SNFs on the basis of their reasonable costs – that is, costs found necessary and related to patient care – up to specified limits. See Act §§ 1861(v)(1)(A), 1888(a). For a SNF, those reimbursement limits were imposed on its "routine costs" (such as general nursing, room and board, and administrative overhead). Act § 1888(a); 51 Fed. Reg. 11,234 (April 1, 1986);
(continued...)

§ 413.30(e). Whether or not MV-UGH could have qualified as a "new provider" if it had been eligible to be paid under the pre-BBA reasonable cost methodology is entirely irrelevant to whether SNF PPS rates applied to it as a SNF that received its first Medicare payment on or after October 1, 1995.

Finally, I reject Mira Vista's suggestion that it was treated unfairly with respect to the payment issue. Mira Vista asserts that it closed MV-UGH "due to financial pressures caused by Medicare's determination that the thirty relocated beds were 'new SNF' beds subject to the fully federal PPS rate." MV Br. at 7-8. Mira Vista contends that it "opened the UGH campus with the belief that the relocated beds would be considered part of the total ninety-four bed Mira Vista Care Center, and that all beds would be paid at the same rate." Id. In addition, Mira Vista claims that it asked CMS in July 1999 to alter MV-UGH's status after realizing that "the payment structure at the Mount Vernon and UGH locations was inconsistent with its understanding and expectation that both locations would be treated as a single provider entity and paid at the same Medicare rate." Id. at 6.

If Mira Vista believed that MV-UGH would be paid at the transition period rate when it opened in December 1998, that belief was unreasonable. Mira Vista was informed by CMS in July 1998 that MV-UGH would have to be enrolled in the program as a distinct or separate SNF, operating under its own provider number and provider agreement. Ex. H at 216. In August 1998, Mira Vista's attorney wrote to MVCC's administrator regarding the payment issue. Ex. A at 109. The letter indicated that Mira Vista had been advised by the Medicare fiscal intermediary (FI)

---

[28](...continued)
42 C.F.R. § 413.53(b). The regulations provided an exemption from routine cost limits for a "new provider" that had operated as a Medicare certified SNF under present or previous ownership for less than three full years. 42 C.F.R. § 413.30(e) (Oct. 1, 1998). This exemption, commonly known as the "new provider exemption," was created in order to mitigate business risks by allowing the new provider "to recoup the higher costs normally resulting from low occupancy rates and start-up costs during the time it [took] to build its patient population." Paragon Health Network, Inc. v. Thompson, 251 F.3d 1141, 1149 (7th Cir. 2001) (internal quotation marks omitted); see also St. Elizabeth's Medical Center of Boston, Inc. v. Thompson, 396 F.3d 1228, 1230 (D.C. Cir. 2005). The new provider exemption ceased to be meaningful when the SNF PPS system replaced the reasonable cost system.

that MV-UGH's beds would not be eligible for the transition period payment rate. Id. The letter also indicated that CMS concurred with the FI's judgment. Id. at 110. The attorney advised the administrator to discuss the issue further with the FI and that Mira Vista would have to file an appeal if the FI failed to change its position. Id. at 110. There is no evidence of any further discussion or interaction between Mira Vista and the FI (or between Mira Vista and CMS) on the payment issue prior to MV-UGH opening for business in December 1998. Given these circumstances, it is clear that Mira Vista opened MV-UGH with the knowledge that the payment issue had not been resolved in its favor — and might never be. In choosing to open MV-UGH with that knowledge, Mira Vista assumed the risk that Medicare might not alter its position on the payment issue and that PPS payments might be insufficient to support the operations at MV-UGH.

Conclusions of Law

In view of the findings of fact and analysis above, I make the following conclusions of law.

1. Mira Vista Rehabilitation Center-United General Hospital Campus was a Medicare-certified SNF that received its first Medicare payment after October 1, 1995.

2. CMS committed no error of law or abuse of discretion in refusing to designate Mira Vista Rehabilitation Center-United General Hospital Campus as a provider-based SNF.

3. Mira Vista Care Center and Mira Vista Rehabilitation Center-United General Hospital Campus did not constitute a composite distinct part SNF under 42 C.F.R. § 483.5.

4. Mira Vista Rehabilitation Center-United General Hospital Campus was ineligible for Medicare payment at the transition period payment rate described in section 1888(e)(1)(A) of the Act and in 42 C.F.R. § 413.340(a).

/s/
Leslie A. Sussan, Member
Departmental Appeals Board