PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D98

PROVIDER -Mono General Hospital
Mono County, California

Provider No. 05-0450

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of California

DATE OF HEARING-
August 13, 1998

Cost Reporting Period Ended -
June 30, 1987

CASE NO. 89-1753

INDEX

ISSUE:

Was the Provider's request for additional payment due to volume decrease, properly made within 180 days from the date of the revised Notice of Program Reimbursement (NPR)?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mono General Hospital ("Provider") is a small short term acute rural hospital with 25 licensed beds. In the fiscal year ended June 30, 1987 the Provider had 25 available beds. Blue Cross of California ("Intermediary") audited the Provider's cost report and issued a Revised Notice Of Program Reimbursement (NPR) in February 24, 1989, in final settlement of the audit.

The Provider disagreed with the Revised NPR and on June 13, 1989, filed an appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement affect is approximately $25,074.

The Provider was represented by Withbert Payne of Starcare International and the Intermediary was represented by Bernard M. Talbert Esq. of Blue Cross and Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The Provider contends that the filing of the request for Sole Community Hospital Payment adjustment was timely. The Provider argues that it filed a timely request based on the date of the revised NPR. The Provider cites the following PRRB decision concerning timeliness for filing an appeal. Care Unit Hospital of Dallas v. Mutual of Omaha, Dec. No. 95-D26, March 8, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,222, rem'd HCFA Adm. Dec., Medicare and Medicaid Guide (CCH) ¶ 43,510.

The Provider contends that it should receive additional reimbursement of $25,074 for the fiscal year 1987, because it experienced a twenty six percent (26.40%) decrease in its total discharges of inpatients in that year as compared to its immediately preceding cost report period. The total discharges were 197 in fiscal year 1986 and 145 in fiscal year 1987. The Provider points out that its following exhibits support its contentions:

1. Analysis of relevant data relating to the Provider's 1986 and 1987 fiscal years

2. Payroll data- the total full time employees (FTES) are analyzed based on the:

    (a) Natural Classification, such as Management & Supervision Staff, Registered Nursing Staff etc. and

(b) Hospital Services, such as Daily Hospital Service Staff, Ancillary Service staff etc., for the fiscal years 1986 and 1987.

3. Analysis of fixed and variable costs as follows:

Fiscal Year	Fixed Costs	Variable Costs	Total Costs
1985	$1,249,023	$188,219	$1,437,242
1986	$1,101,317	$150,867	$1,252,184
1987	$1,023,397	$161,185	$1,184,582.

4. Map of Bridgeport Valley and the surrounding National Forests, National Parks and National Monuments.[1]

5. Audited worksheet S-1 for fiscal years 1986 and 1987 and relevant pages of the Office of Statewide Health Planning and Development (OSHPD) report for the 1986 and 1987 fiscal years.[2]

6. Analysis of the Provider's Net Income/Net Loss from Service to patients during the fiscal years 1985 through 1987.[3]

7. Job descriptions of the staff personnel at the hospital as reported in the official document in hospital administrative manual.[4]

8. Resolution 92-91[5] of December 15, 1992 made certain findings with regard to the layoff of hospital employees. This Resolution states that it was unanimously decided, and the Board has determined, that the hospital has run at substantial deficits. The county cannot afford to operate the current facility at projected deficit levels and still provide reasonable levels of other governmental services.

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1 Exhibit p-5.

2 Exhibit p-6.

3 Exhibit p-7.

4 Exhibit p-8.

5 Exhibit p-9.

> Also resolution 92-91 states making changes in the type and level of medical services offered at the facility, must be contingent upon compliance with the law. The lack of population in the Bridgeport Valley and surrounding area, and the availability of medical services elsewhere, among other reasons, have resulted in continuing substantial operational deficits at the hospital. The County Administrative officer and the hospital Administrator, together with two members of this Board, have spent a considerable period of time looking into alternative means for providing medical services. Based upon the above, the Board decided that the facility located at Mono General Hospital shall be changed to one operated by the physicians' group under contract with the board of supervisors which provides urgent care clinical services.
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> Minute order 93-43 relates to the establishment of a 24 hour referral service which can give eligible people immediate information as to the available services or access to them and to recommend and respond to complaints from people eligible for services under Chapter 2.5 of Division 2 of the Health and Safety code.

The Provider argues that it provided essential health services to those living in Bridgeport Valley, and to the many travelers on Highway 395. It also provided services to the tourists visiting the various state parks and points of interest.

The Provider points out that due to the lack of population in the Bridgeport Valley and surrounding areas, the availability of medical services elsewhere and the substantial deficits incurred over the years, the Provider's Administrator spent a considerable amount of time looking into alternative means for providing medical services, such as opening a skilled nursing facility in the FY 1988.

The Provider contends that it has provided adequate documentation and evidence to support its request to receive the additional reimbursement of $25,074 for the fiscal year 1987. This is in compliance with the Medicare regulation 42 C.F.R. § 412.92(e) on additional payments to Sole Community Hospitals experiencing a significant volume decrease.

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that in order for a hospital to be automatically classified as a Sole Community Hospital under 42 C.F.R. § 412.92(b)(5), the Provider has to be granted an exemption from the hospital cost limits as an SCH before October 1, 1983; or the Provider's exemption request be received by the appropriate intermediary before October 1, 1983, and subsequently approved as an SCH under the Prospective Payment System (PPS), unless there is a change in the circumstances under which the classification was approved.

The Intermediary points out that according to its records, the Provider became effective as a Sole Community Hospital in July 1, 1990. Based on this information, the Intermediary asserts that the

Provider has no basis to request additional payments as a Sole Community Hospital for the referenced fiscal year.

The Intermediary also points out that HCFA Pub. 15-1 §2810.1 addresses the situation where a hospital is classified as a 'sole community hospital and experiences circumstances beyond its control, it may receive a payment adjustment if there is a decrease of more than 5 percent in its total number of discharges compared to the immediately preceding cost report period. This payment adjustment provision applies to cost reporting periods beginning on or after October 1, 1983, and before October 1, 1990.

The Intermediary contends that the proposed adjustment was in accordance with Medicare regulations and HCFA instructions. The Provider did not comply with the criteria for classification as a Sole Community Hospital for the fiscal year in question, as is specified in 42 C.F.R. § 412.92. Based on the above information, the Intermediary believes that the Provider has no basis to request a payment adjustment for the fiscal year 1987.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

1395x(v)(1)(A)	-	Reasonable Cost

2. Regulations:

§ 412.92 et seq.	-	Special Treatment: Sole Community Hospital

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

§ 2810.1	-	Additional Payments to SCHs That Experiences a Decrease In Discharges

4. Cases:

Care Unit Hospital of Dallas v. Mutual of Omaha Insurance Company, PRRB Dec. No. 95-D26, March 8, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,222, rem'd HCFA Adm. Dec., Medicare and Medicaid Guide (CCH) ¶ 43,510.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after consideration of the controlling laws, regulations and program instructions, the facts in the case, the parties' contentions and evidence in the record, finds and concludes that the Provider is not entitled to additional payments as a Sole Community Hospital.

The Board finds that there is no evidence in the record that the Provider was an approved Sole Community Hospital. In order for a hospital to be classified as a Sole Community Hospital under 42 C.F.R. § 412.92(b)(5), the hospital has to be granted an exception from the hospital cost limits as an Sole Community Hospital and subsequently approved by HCFA. The record indicates that the Provider became an approved Sole Community Hospital on July 1, 1990. Therefore, the Provider was not an approved Sole community Hospital prior to that date.

The Board concludes that the Intermediary's adjustment was proper. The provider did not comply with the criteria for classification as a Sole Community Hospital for the fiscal year ended June 30, 1987.

DECISION AND ORDER:

The Intermediary's denial of the provider's request for Sole Community Hospital status was proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: September 17, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman