PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D15

PROVIDER -
Mayo Regional Hospital
Dover-Foxcroft, ME

Provider No. 20-0066

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Associated Hospital Services of Maine

DATE OF HEARING-
March 1, 2001

Cost Reporting Period Ended -
September 30, 1994

CASE NO. 97-1432

INDEX

ISSUES:

1. Was the Intermediary's denial of the Provider's request for a sole community hospital (SCH) decreased volume adjustment proper?

2. Does the Board have jurisdictional authority to allow the Intermediary to adjust Provider's Medicare reimbursement for fiscal year (FY) 1994 to include an allowance for Medicare/Medicaid crossover bad debt?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mayo Regional Hospital (Provider) is a 60 bed short-term, acute care, not-for-profit hospital located in Dover-Foxcroft, Maine. The 60 beds include 48 adult and pediatric beds, four intensive care beds, and eight nursery beds. The Provider qualified and has been reimbursed as an SCH since 1991. Associated Hospital Services of Maine (Intermediary) issued a Notice of Program Reimbursement (NPR) denying the Provider's SCH decreased volume adjustment. The Intermediary also challenges the Provider's jurisdictional authority to be reimbursed for Medicare/Medicaid crossover bad debts. The Provider appealed the Intermediary determinations to the Provider Reimbursement Review Board (Board). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by Charles F. Dingman, Esquire, of Preti, Flaherty, Beliveau, Pachios & Haley, LLC. The Intermediary was represented by Eileen Bradley, Esquire, Associate Counsel, of Blue Cross and Blue Shield Association.

Issue No. 1 -- Decreased Volume Adjustment

FACTS:

In September of 1996, the Intermediary issued an NPR for the fiscal year ended September 30, 1994. A Notice of Correction-Program Reimbursement (Revised NPR) was issued on December 11, l996.[1] On March 5, 1997, the Provider requested an additional payment of $345,000 in the form of a volume adjustment that is available to sole community hospitals that experience a large decrease in volume, pursuant to the regulations at 42 C.F.R. § 412.92(e). Subsequently, the parties agreed that the amount in contention was incorrectly computed and should have been $318,722.[2] Also on March 5, 1997, the Provider filed a timely appeal of the Intermediary's NPR, accompanied by a List of Issues (LOI), seeking an adjustment to the SCH reimbursement, a claim

[1] See Intermediary Exhibit I-7.

[2] See Intermediary Exhibit I-19.

intended to reserve the Provider's rights with respect to such decision as the Intermediary would ultimately make on the SCH volume adjustment request.

On August 28, 1997, 176 days after the Provider's request was filed, the Intermediary requested additional supporting information for the proposed SCH adjustment.[3] On February 25, 1999, the Provider submitted additional information to the Intermediary in response to this request.[4] On April 5, 1999, the Intermediary denied the request.[5] The Provider requested reconsideration on April 13, 1999, and the Intermediary denied the reconsideration request on April 27, 1999.[6] On May 27, 1999, the Provider filed a timely appeal of the Intermediary's determination with the Board.

PROVIDER'S CONTENTIONS:

The Provider contends that it has met the requirements of the regulations and the Provider Reimbursement Manual in that it incurred a decrease in discharges of 7.86%, from 1,794 discharges in FY 1993 to 1,653 discharges in FY 94.[7] Since the decrease in discharges was beyond its control, the Provider believes it is entitled to the additional payment as an SCH experiencing a decline in volume. Specifically, these volume decreases, culminating in the FY 94 decline for which the Provider is requesting an adjustment, were triggered during the FY 91 and 92 periods when three essential physicians terminated their relationships with the Provider. These physicians accounted for approximately 40% of the Provider's discharges at that time. Two primary care physicians, accounting for 281 discharges left in June, 1992; two more responsible for 300 discharges, in the first half of 1993; and two more family practitioners with large practices left

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[3] See Intermediary Exhibit I-11.

[4] See Intermediary Exhibit I-14.

[5] See Intermediary Exhibit I-15.

[6] See Intermediary Exhibits I-16 and I-17.

[7] See Provider Exhibit P-11, internal Exhibit I.

before FYE September 30, 1994.[8]

[8] See Provider Exhibit P-24; Tr. at 89-90, 110-111, 187, 218-219.

The Provider notes that as the Provider encountered difficulty in recruiting replacement physicians to the area, it initially obtained the services of *locum tenens* (temporary) physicians to fill the gap. However, due to the prohibitive cost and significant patient dissatisfaction, area residents turned to providers outside of the Provider's primary and secondary service areas. The Provider contends that it aggressively sought to recruit physicians to meet community needs throughout the relevant time frame. It used a series of contract physician recruiters and actively involved its board of trustees and community in its efforts. Nevertheless, it was unable to attract physicians to the community until it implemented an alternative strategy by creating its own physician practice corporation to operate several clinics in areas eventually designated as health professional shortage areas, medically underserved areas, or medically underserved populations.[9] This served to address the inherent and uncontrollable obstacles to physician recruitment in this rural and economically challenged area.[10] The Provider also points out that the difficulties of rural physician recruitment and their significance were recognized as a basis for approving the Provider's formation of a group practice affiliate by the Maine Health Care Finance Commission.[11]

The Provider observes that equally beyond the Provider's control was a significant economic recession in the community. The town of Dover-Foxcroft and surrounding area suffered from sharp increases in unemployment, greater than those experienced in other areas of the state or in the United States as a whole.[12] The state economist commented a few years later on the dramatic decline in the economic-well-being of this part of the state during the 1980's and 1990's.[13]

The Provider contends that the above-described causative factors are among those specifically listed as circumstances qualifying for the adjustment under Provider Reimbursement Manual (HCFA Pub. 15-1) § 2810.1.A, which refers to "inability to recruit essential physician staff, ... serious and prolonged economic recessions,.., or similar occurrences with substantial cost effects." Id.

The Provider also contends that the Intermediary denied the requested adjustment without ever considering the merits or the substance of Provider's filings. The Intermediary's decision was based entirely on its opinion that too much time had elapsed between the Intermediary's request for additional information and the Provider's delivery of that information. The Intermediary's subsequently advanced objections to the adjustment request amount to criticisms of certain details of the factual submission, none of which detract from the Provider's entitlement to relief under the criteria set forth in the volume adjustment regulation and Provider Reimbursement Manual provisions. In material respects the Provider's situation parallels another SCH volume adjustment

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[9] Tr. at 68.

[10] Tr. at 64-75; 216-223.

[11] See Provider Exhibit P-27.

[12] See Provider Exhibit P-21, P-22.

[13] See Provider Exhibit P-23.

case recently considered by the Board, Rumford Community Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D90, Sept. 28, 2000, Medicare and Medicaid Guide (CCH) ¶ 80,575. As in that case, the Provider contends that it made all reasonable efforts to improve the availability of physician services, took such measures as were possible to reduce its staff and related costs, and was entitled to relief for the revenue shortfall resulting from the sudden decline in volume.
The Provider notes that the applicable portion of HCFA Pub. 15-1 §2810.l.D contemplates that the Intermediary will request any additional information deemed necessary as it reviews an SCH volume adjustment request. However, the Intermediary responded in this instance by denying the adjustment completely after judging the Provider's response to its earlier inquiry to be insufficient and untimely. The Provider contends that this action by the Intermediary was arbitrary, irrational, and contrary to the requirement of the Provider Reimbursement Manual.

The Provider further contends that its requested adjustment was correctly computed in accordance with the methodology prescribed by HCFA Pub. 15-1 §§ 2810.1.C. 6 and 2810.1.D which provide for an analysis of an applicant's "core staffing" requirements, using the Hospital Administrative Services (HAS) Monitrend Data Bank accumulated by the American Hospital Association. If the actual full time equivalents (FTEs) in the year of the volume decline are greater than the HAS Monitrend peer data, the staffing in excess of peer group FTEs must be subtracted from costs in the relevant cost centers. Once excess salary costs are eliminated, the cost report is rerun, generating a new Program inpatient operating cost that is the basis for the payment adjustment. The HAS Monitrend peer data was not available to the Provider for years subsequent to 1988. Therefore, the Provider employed its own peer group analysis, based on other hospitals in the State of Maine. Substitution of HAS Monitrend peer data for 1988, the most recent period available, would not cause any change in the total amount of the adjustment as determined in accordance with HCFA's guidelines. The Provider's original application corresponded to Example A in HCFA Pub. 15-1 §2810.1.C.6, and its re-analysis of the SCH adjustment calculation using Monitrend data, wherein it used the same cost centers (Adult and Pediatric and ICU), calculated core staffing (using 1988 HAS data), and determined a cost reduction based on an excess of adult and pediatric FTEs above the HAS Monitrend level, results in determinations that correspond to Example B in HCFA Pub. 15-1 § 2810.1.C.6. The cost report was then rerun to calculate the requested adjustment. Applying the upper limit on the adjustment pursuant to HCFA Pub. 15-1 § 2810.1.D reduced both the originally requested amount of $345,000 and the revised calculation to the mutually agreed upon contested amount of $318,722.

The Provider contends that the Intermediary's various after-the-fact arguments against granting the adjustment, all developed after the Provider's application was incorrectly rejected on timeliness grounds, failed to provide a sound reason for rejecting the calculated amount of the adjustment as prepared by the Provider and adjusted to the agreed upon amount in controversy. The Intermediary argues that the Provider's hiring of temporary contract physicians establishes that it was not unable to recruit and consequently had not shown that the volume adjustment was due to factors beyond its control. The Provider counters that ample testimony from its chief financial officer and the chairman of its board of directors at the time demonstrate that all possible efforts were made to recruit physicians, but that the volume decline continued nevertheless because temporary contract physicians did not attract a sufficient number of local patients and recruitment

of permanent replacement physicians could not be accomplished despite all reasonable efforts for an extended period of time. Additional time was required for the community to develop confidence in newly established physician practices and return to obtaining medical care locally rather than traveling to the city of Bangor to obtain health services.

The Provider observes that the Intermediary's criticism of its use of 1995 economic data fails to establish a reason for denying the adjustment. This information was readily available at the time its application was prepared, and it is corroborated by various employment and other economic statistics for 1994 and other years pertinent to the fiscal period. The Provider also emphasizes the findings of the State of Maine's economist with respect to the economic decline in its service area.

The Provider rejects the Intermediary's argument that its decline in volume resulted from a shift from inpatient to outpatient service. The Intermediary's calculation of such a shift depends on its belief that outpatient costs increased by 10.2% from FY 93 to FY 94. This calculation, however, ignores the fact that the information used by the Intermediary from Provider's cost reports incorrectly omitted the Provider's gross receipts tax expenses from FY 93 but included them in FY 94. When these figures are adjusted to provide comparable treatment of the hospital tax, there is actually a small decrease in outpatient costs from FY 93 to FY 94.[14] Finally, the Intermediary's evidence with respect to Provider's positive operating margins is irrelevant because the SCH volume adjustment regulations and Provider Reimbursement Manual provisions do not require a showing of adverse economic results or financial harm, a point to which Intermediary's witness agreed at the hearing.[15] The Provider's positive operating margins in the face of serious decline in volume resulted from rate increases that were viewed as unavoidable and were undertaken in consultation with local industry.[16]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the absence of a deadline in regulations or the Provider Reimbursement Manual (PRM) does not give rise to any assumption that a provider has an indefinite time to present the documentation necessary to support its application for an SCH volume adjustment. Indeed, the PRM exhorts interested providers to make their applications early so that the intermediary can make any on-site verification that might be required. The lapse

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[14] See Provider Exhibits P-41 and P-40; Tr. at 272-274.

[15] Tr. at 398.

[16] Tr. at 154-159, 188-191.

of time between the Intermediary's letter of August 1997 to the Provider and the Provider's next communication with the Intermediary on February 25, 1999, certainly frustrated the PRM's premise that contemporaneous verification was important.

The Intermediary contends that it was perfectly reasonable for it to interpret the thunderous silence from the Provider during the interim as an abandonment of its request. The Intermediary's use of the term "untimely" in its denial was an alternative way of saying that the unreasonable time that had elapsed amounted to a constructive abandonment of the application. On point with this posture is a decision by the Centers For Medicare and Medicaid Services (CMS) Administrator in University of California Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of California, CMS Admstr. Dec., Nov. 29, 1996 Medicare and Medicaid Guide (CCH) ¶ 45,031. As in this case, the provider there submitted its original request for an ESRD exception for 1989 on a timely basis. This issue arose before the later rule adopted by the Administrator that all documentation had to be submitted — a complete application — within 180 days of the open window. The PRM instructions in effect at the time did not limit a facility from submitting additional documentation after its timely filed exception request. The Provider's ESRD applications were deficient. A few years later, the Provider submitted additional documentation which the intermediary rejected as untimely with the Administrator's later sanction: "Even assuming ... that the Provider was not precluded from submitting additional information after the close of the exception windows, it does not follow that the provider had an unlimited amount of time to submit revised requests. Such a proposition would be contrary to an agency's orderly administration of its programs."[17]

The Intermediary observes that in addition to the Provider's failure to comply with the requirements of the Manual as to the documentation that is specifically required to support an SCH adjustment request, the substance of its submission complemented by the testimony of the Provider's witnesses does not support the grant of its exception request. The major issues are as follows:

Doctor Shortage: The Intermediary does not dispute the difficulty that rural areas face in attracting physicians to their communities which is one reason accounting for the additional compensation that accompanies classification as an SCH. However, the record here is equivocal about whether the Provider did face such problems. First, physicians were interested in coming to the hospital in salaried positions, but the Provider would not or could not take on physicians as employees. Thus, this deterred doctors from mainstay affiliation with the hospital. Second, the reasons the doctors left varied considerably; they were not all going to greener pastures or warmer climes. Indeed, the former Provider board chairman and its current treasurer alluded as much when he

[17] CMS Admstr. Dec. at 2. See Intermediary Exhibit I-44.

described it as "a Peyton Place type of operation."[18]

[18] Tr. at 229-30.

The Intermediary observes that the Provider's physician discharge statistics belie the Provider's assertions that the quick departure of the physicians had an adverse impact on discharges, and also that temporary physician arrangements also contributed to this picture. An analysis of the data at Intermediary Exhibit I-21 shows that the decrease in discharges is partly attributable to the physicians who remained on staff--not to the departure of the temporary physicians. A decrease in discharges was occurring by those the hospital was retaining and working hard to do so. The record certainly does not make clear the real, if any, distinctions that existed between the "temporary" doctors who had staff privileges at the hospital and other physicians who were not employees of the hospital but also had staff privileges. In effect temporary physicians had the same standing as all other doctors.[19] Indeed, the Provider's chief financial officer conceded that inability to hire on a salaried basis was a major factor in recruitment.[20]

Peer Group Comparison: The PRM contemplates that any peer group would be comprised of hospitals of the same size, geography (census division) and period of time. The Intermediary observes that the peer group submitted by the Provider did not satisfy any of these criteria. Therefore, it is reasonable to describe it as contrived. Only one of the four hospitals was an SCH; the other three were urban hospitals. Of the three urban hospitals, one was competing in the same local job market as Boston. The fiscal years varied with only Northern Maine Medical Center's coinciding with that of the Provider's. The bed capacities of the institutions were not comparable. They were all clients of the firm which also served as a consultant to the Provider. Even those hospitals who were the firm's clients and resembled the Provider were not made part of the peer group. Indeed, there is no discernible rationale for the peer group that the Provider proposed to support its case.

Credibility of Provider Data: The Intermediary observes that the record is replete with inconsistent, sometimes contradictory, and often inexplicable information. A few examples include the use of the wrong PPS update factors, questions of how many beds the Provider has at any particular point in time, asserting to the State of Maine that it was not an SCH when it was, using average length of stay as some meaningful determinant of dietary and laundry costs, use of Monitrend data for one purpose, but not for another.[21] Thus, the materials from the Provider cannot be relied upon to ascertain whether it deserves an SCH adjustment payment.

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[19] Tr. at 93-94,104.

[20] Tr. at 86, 103-04.

[21] Tr. at 128, 278, 346, 351, 412-13.

Audited Financial Statements: The Intermediary notes that all of the Providers audited financial statements in the record show that it was a healthy thriving enterprise, with patient revenues rising every year.[22] Though the Provider attributed this in part to the fact that the hospital was forced to increase its rates, the Provider also conceded that it had been one of the lowest rate and lowest charge hospitals in the state and not near the ceiling imposed by the Maine Healthcare Commission.[23] But the Provider also stated that the rate increases had no effect on either discharges or admissions.[24]

Economic Conditions: The Intermediary observes that though clearly not affluent, community economic conditions were picking up and at a rate that even exceeded the state's growth.[25]

Issue No. 2 - - Board Jurisdiction Over Medicare/Medicaid Cross-over Bad Debts

FACTS:

In response to the List of Issues, the Intermediary on May 30, 1997, disputed the Board's jurisdiction over the Provider's crossover bad debt claim because it had not specifically been presented to and decided by the Intermediary. On March 16, 1998, the Board requested briefs on this issue. The Provider filed its Jurisdictional Brief on May 15, 1998. On September 14, 2000, the Board reviewed the jurisdictional arguments and concluded that it had jurisdiction over all issues in this appeal. At the hearing held on March 1, 2001, the Intermediary asked the Board to reconsider and rescind its conclusion with respect to jurisdiction over the Medicare/Medicaid cross-over bad debt issue. The Provider and the Intermediary filed Reply Briefs on jurisdiction with the permission of the Board.

PROVIDER'S CONTENTIONS:

The Provider contends that the Board's prior decision that it had jurisdiction to hear Provider's claim for an adjustment to include reimbursement for Medicare/Medicaid cross-over bad debt costs was correct. Its decision is supported by the United States Court of Appeals in Maine General Medical Center v. Shalala, 205 Fed. 3d. 493 (1st Cir. 2000). The Board has the power to hear an appeal with respect to any matter regarding a fiscal intermediary's final determination of reimbursement for a period covered by a cost report with which Provider is "dissatisfied" within the meaning of 42 U.S.C. §1395oo. The First Circuit decision cited above specifically addressed Medicare cross-over bad debt costs that a hospital had inadvertently omitted from its cost report

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[22] See Intermediary Exhibits I-29 and I-35.

[23] Tr. at 156-58.

[24] Tr. at 158.

[25] See Intermediary Exhibits I-36 and I-40.

and subsequently appealed to the Board. The Court held that the Board had jurisdiction to hear and decide the issue, although it may decline to do so as a matter of discretion.

The Provider also argues that the Board should not decline to hear the matter in the exercise of its discretion because the Intermediary had an affirmative obligation to audit the cost report and identify any Medicare cross-over bad debt expense. Further, a decision to hear this matter will correct an inadequacy in reimbursement with which Provider is dissatisfied without disrupting the proper scope of the Board's review of the activities and decisions of fiscal intermediaries.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Medicare bad debt issue fails to meet the jurisdictional requirement for a Board hearing. This issue was introduced for the first time in the Provider's List of Issues presented to the Intermediary on March 5, 1997.[26] This issue was not the subject of any Intermediary determination. The issue thus concerns a "self-disallowed" cost, i.e., the Provider made no claim for cross-over Medicare bad debts on its as-filed cost report for the reporting period ending September 30, 1994. The Intermediary's determination was based on what the Provider claimed in its report. The Intermediary deals with the objective presentation which in this case did not include cross-over bad debts and is therefore not the subject of any "Intermediary Determination" as required by the law and regulation. See, Section 1878(a)(1)(A) of the Social Security Act, 42 U.S.C. § 1395oo(a)(1)(A). See, also, 42 C.F.R. §§ 405.1801, 405.1803, and 405.1835.

The Intermediary observes that the Provider admits in its LOI that the Intermediary made no adjustment related to that unclaimed or "self-disallowed" item. In Miles Memorial Hospital, case number 97-0724, Board jurisdictional decision dated February 6, 1998, Kennebec Valley Medical Center, case number 97-1825, Board jurisdictional decision dated February 6, 1998, Kennebec Valley Medical Center, case number 97-0822, Board jurisdictional decision, dated February 6,1998, and Mid-Maine Medical Center, case number 97-0821, Board jurisdictional decision, dated December 17, 1997, the Board refused to hear the appeal of a self-disallowance issue when no legal bar existed to prevent the Provider from making the claim. In these cases the Board denied jurisdiction on the identical bad debt issue, stating that the costs are not a matter covered by the cost report as required by 42 U.S.C. § 1395oo(a), and the Board does not have jurisdiction. The Board, therefore, dismisses the issue from the appeal.[27] The Intermediary is requesting the

[26] See Intermediary Exhibit I-1.

[27] See Intermediary Exhibit I-2.

Board to reconsider its September 14, 2000 determination and deny jurisdiction on the cross-over bad debt issue. The Provider made claims for other kinds of debts, which the Intermediary adjudicated.

The Intermediary notes that because the Provider's failure to make a claim is being characterized as a "self-disallowance" as opposed to an omission, the judicially-created exception to the statutory "Intermediary Determination" rule must be considered. In Bethesda Hospital Association v. Bowen, 485 U.S. 399, 108 S.Ct. 1255 (1988) and Somerset Rehabilitation. P.C. v. Blue Cross and Blue Shield Association, CMS Admstr. Dec. Aug. 16, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,661, the Court and the Administrator held that a provider may press an appeal to the Board even in the absence of an intermediary determination if two requirements are met: (1) the claim must be one that would have been futile for the Provider to make on its cost report because of a specific regulation or manual instruction requiring intermediary disallowance; and (2) the claim must be filed "timely," that is, within 180 days of the initial intermediary determination. The bad debt cross-over claims issue fails completely to meet the first prong of the two-part test. There is no futility attached to any Provider cost report claim for cross-over Medicare bad debts. No regulation or manual instruction prevented the Intermediary from exercising discretion in this area. Indeed, the Provider now believes its claim would have been allowed based upon its current understanding of Medicaid cross-over claims. The second requirement, the 180 day requirement, does not need to be considered because the Provider failed to satisfy the first prong of the test.

The Intermediary asserts that the CMS Administrator Decision, January 27, 1997, Westchester General Hospital v. Blue Cross and Blue Shield Association/ Blue Cross of Florida, Medicare and Medicaid Guide (CCH) ¶ 45,181, supports its claim that, for a provider to be dissatisfied with the reimbursement reflected on the NPR, it must have requested reimbursement for all costs to which it is entitled under the applicable rules.[28] Thus, a provider who fails to claim a cost on the cost report, not because of binding law or policy, but because of error, does not meet the dissatisfaction requirement necessary for Board jurisdiction.

The Intermediary recognizes that the Federal District Court in Maine has issued a recent decision, based on an earlier decision handed down from the United States Court of Appeals for the First Circuit, suggesting that the Board is not absolutely foreclosed from considering such matters. The Board has discretion to entertain such appeals and provide relief – it may or may not do so. The Provider resides in the First Circuit. Because the Board is not so compelled, we urge it to refrain from exercising that discretion. First, it has established no substantive or procedural standards nor published any guidelines by which providers in the First Circuit can know that their particular problem is eligible for redress. Second, it diminishes the role of the Board as an appellate body to oversee and act on claims that have not been presented in the ordinary course of business; namely, the filing of the cost report. Third, exercising discretion to entertain such *de novo* claims acts as an incentive for Providers to be less careful in their filings with the Intermediary because of the fail-safe that the Board now serves. Certainly exigencies may occur that might warrant Board

[28] See Intermediary Exhibit I-3.

intervention akin to the "good cause" concepts. But to routinely take such matters under consideration and decide them undermines the cost reporting system and drastically changes the role of the Board.

CITATION OF LAW. REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.

§ 1395oo et seq. (§ 1878(a)(1)(A) of the Social Security Act)	-	Provider Reimbursement Review Board

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

§ 405.1801	-	Introduction
§ 405.1803	-	Intermediary Determination and Notice of Amount of Program Reimbursment
§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.92(e) et seq.	-	Special Treatment-Sole Community Hospital

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

§ 2810.1	-	Additional Payments to SCHs that Experience a Decrease in Discharges
§ 2810.1.A et seq.	-	Criteria for Determining Eligibility for Additional Payments
§ 2810.1.C. et seq.	-	Requesting Additional Payments
§ 2810.l.D.	-	Determination on Requests

4. Cases:

Rumford Community Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2000-D90, September 28, 2000. Medicare and Medicaid Guide (CCH) ¶ 80,575.

University of California Medical Center v. Blue Cross and Blue Shield Association/Blue

Cross and Blue Shield of California, CMS Admstr. Dec. Nov. 29, 1996, Medicare and Medicaid Guide (CCH) ¶ 45,031.

Maine General Medical Center v. Shalala, 205 Fed. 3d 493 (1st Cir. 2000).

Miles Memorial Hospital, case number 97-0724, Board jurisdictional decision dated February 6, 1998.

Kennebec Valley Medical Center, case number 97-1825, Board jurisdictional decision dated February 6, 1998.

Kennebec Valley Medical Center, case number 97-0822, Board jurisdictional decision, dated February 6, 1998.

Mid-Maine Medical Center, case number 97-0821, PRRB jurisdictional decision dated December 17, 1997.

Bethesda Hospital Association v. Bowen, 485 U.S. 399, 108 S.Ct. 1255 (1988).

Somerset Rehabilitation P.C. v. Blue Cross and Blue Shield Associaition, CMS Admstr. Dec., Aug. 16,1990 Medicare and Medicaid Guide (CCH) ¶ 38,661.

Westchester General Hospital v. Blue Cross and Blue Shield Association/Blue Cross of Florida, CMS Admstr. Dec., January 27, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,181.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties' contentions, evidence submitted and post-hearing briefs finds and concludes as follows:

Issue No. 1 -- Decreased Volume Adjustment

The Board finds that the Provider's factual situation allows it to qualify for additional reimbursement due to its decrease in discharges from FY 93 to FY 94. It meets the requirements of 42 C.F.R. § 412.92(e) in that its discharges of inpatients exceeded the five percent threshold required by the regulation. In addition, the Provider has also demonstrated that the decrease was due to circumstances beyond its control as required by 42 C.F.R. § 412.92(e)(2)(ii). The Provider clearly demonstrated that its loss of physicians in prior years caused the reduction in discharges and such activity was beyond its control. A total of seven physicians left this sole community provider between FY 91 and FY 94, which accounted for a loss of approximately 581 discharges. This was a major reduction in discharges. It is noted that the Provider did attempt to bolster its physician population with temporary physicians but had no success. It then established physician groups to improve its capacity to attract patients. Thus, the Board believes that the Provider

efficiently attempted to deal with this problem in this difficult circumstance.

The Board further finds that specific evidence submitted to the Board supports the regulatory requirement of circumstances beyond its control. Provider Exhibit P-28 documents that the area in which the Provider operated was a low income - underserved population which resulted in difficulty in retaining and recruiting physicians. This document consisted of a letter from the State of Maine, Department of Human Services. Essentially, it is an independent verification of the Provider's contention that it had difficulty in retaining physicians. Provider Exhibit P-21 presents historical data for the Provider's service area which was developed by the State of Maine's Department of Labor. It shows that the Provider's unemployment rate of 9.3% was inordinately high relative to the United State's average of 6.1%.
Finally, the Board finds that HCFA Pub. 15-1 § 2810.1 applies to the Provider's situation. That section deals with the special treatment of sole community hospitals under the CMS' Prospective Payment System. Essentially, HCFA Pub. 15-1 § 2810.1.A.1 and 2810.1.A.2 are the same as 42 C.F.R. § 412.92 (e). However, HCFA Pub. 15-1 § 2810.1.A.1 offers examples of circumstances beyond a provider's control. One of the examples cited was "... inability to recruit essential physician staff." Id. As addressed above, the Provider has met this requirement. HCFA Pub. 15-1 § 2810.1.A.2 requires the SCH to experience a decrease in discharges of more than five percent. The decrease in discharges at the Provider was 7.86%. Further, the Provider has essentially met the determination requests requirement of HCFA Pub. 15-1 § 2810.1.D. That section requires the Intermediary to seek information that it deems missing or necessary. There is no time requirement for the Provider to submit the requested information. It is true that the Provider took an inordinate amount of time to reply to the Intermediary's initial request for additional information. However, the manual section sets no time limit for such submission. Further, the Intermediary could have made a follow-up request for the information. It chose not to do so. The only requirement of this PRM section is that the Intermediary must notify a provider of its decision within 180 days of the date it has received all required information.

Regarding the primary Intermediary arguments, the Board finds them to be non-compelling. Regarding the lack of documentation, the Board finds that the Provider has sufficiently documented the problems that it had retaining physicians due to its remote location and poor economic conditions. Regarding the Intermediary's contention that the Provider's peer group comparison was inadequate, the Board finds that although the peer group was far from perfect, it adequately provided sufficient information to establish an FTE staffing in the Adults and Pediatrics and Intensive Care Unit cost centers. Although HAS Monitrend Data Books were unavailable in FY 94, the Provider did take prior HAS data into consideration when comparing its costs with its peer group. It found no significant variances from this analysis. Finally, regarding the Intermediary's contention that the Provider's financial statements showed that the Provider was a thriving institution, the Board finds this irrelevant to whether the Provider should be permitted additional reimbursement due to a decrease in discharge volume. The regulations and Manual section clearly provide the parameters for allowing such payment. A provider's financial condition is not one of those parameters.

Issue No. 2 - - Board Jurisdiction Over Medicare/Medicaid Cross-over Bad Debts

The issue before the Board is whether it has jurisdiction over cross-over bad debts, alleged by the Provider to have been claimed on Worksheet G, line 2 of the Medicare cost report as part of contractual allowances. The Board finds that it has jurisdiction over the cross-over bad debts issue under 42 U.S.C. § 1395oo(a) because it is a matter covered by the above cost report.

The Board notes that the Provider did claim some Medicare bad debts on its cost report. In addition, the Board accepts the Provider's assertion that it claimed the cross-over bad debts on Worksheet G. The Board believes that, from an accounting standpoint, contractual allowances include bad debts and would be reported on the cost report on Schedule G. The Board further believes that a contractual allowance loss could lead to cross-subsidization of payors. The Court in Maine General v. Shalala, 205 F.3d 493 (1st. Cir. 2000)(Maine General) held that the Board has the power to decide this bad debt issue even if it was not first raised before the Intermediary, but the power to do so is discretionary. Id. at 497. In this case, where the Provider has claimed the cost on its cost report, the Board is electing to review the issue. The fact that the Provider claimed the cost on its cost report distinguishes this case from the facts in Maine General where the Provider failed to claim the costs on its cost report, and the Board found that it lacked jurisdiction over that appeal.

DECISION AND ORDER

Issue No. 1 -- Decreased Volume Adjustment -- The Provider is entitled to compensation as a result of its decreased volume. The Intermediary's adjustment is reversed.

Issue No. 2 -- Board Jurisdiction Over Medicare/Medicaid Cross-over Bad Debts

The Board reaffirms its prior decision that it has jurisdiction over the Medicare/Medicaid cross-over bad debts. The Intermediary's request for reconsideration is denied.

Board Members Participating

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett

Date of Decision: March 27, 2002

FOR THE BOARD

Irvin W. Kues
Chairman