PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D29

PROVIDER –
Standish Community Hospital
Standish, Michigan

Provider No. 23-0205

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
United Government Services

DATE OF HEARING -
October 8, 2002

Cost Reporting Period Ended -
September 30, 1993

CASE NO. 01-1866

INDEX

ISSUE:

Was the Intermediary's adjustment to DRG[1] payments proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The issue before the Provider Reimbursement Review Board (Board) concerns the treatment of a provider as a Medicare Dependent Hospital (MDH). The regulation at 42 C.F.R. § 412.108(d) allows MDH hospitals that experience a significant volume decrease, i.e., a more than 5% decrease in its patient discharges as compared to its immediately preceding cost reporting period, certain favorable reimbursement treatment; i.e., a Low Volume Adjustment. The regulation requires the Provider to demonstrate that the decrease was due to circumstances beyond its control.

It is undisputed that Standish Community Hospital (Provider) is a Medicare Dependent Hospital and that it had greater than a 5% inpatient admission volume decline in 1993. The Provider's dispute with the Intermediary falls under 42 C.F.R. § 412.108(d) in that it believes that it has demonstrated that the reason for the inpatient admission volume reduction in 1993 from 1992 meets the regulatory test of circumstances beyond the hospital's control. The parties have stipulated that the amount in controversy is approximately $263,000 in Medicare reimbursement. The Provider appealed the Intermediary's determination to the Board. The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented Ronald K. Rybar of the Rybar Group. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the facts in this case do not support the Intermediary's conclusion that the Provider did not meet the regulatory requirements of 42 C.F.R. §412.108(d) that its volume decline was due to "circumstances beyond the hospital's control. The Intermediary utilized the inability to recruit essential physicians test in HCFA Pub. 15-1 § 2810 (1)(A)(1) for denial of the payment adjustment request and concluded that the decline in admissions was due to a shift from inpatient to outpatient services. In addition, the Intermediary cited a pending involuntary termination of the Medicare Certification which it asserted likely affected admissions.

The Provider contends that in a previous Medicare Dependent Hospital adjustment case, Boone County Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 2002-D 29, August 2, 2002, Medicare and Medicaid Guide (CCH) ¶ 80,888, (Boone County) the Board found that HCFA Pub. 15-1 § 2810 does not apply to Medicare

[1] Diagnostic Related Group (DRG) - - Payments made to providers on a prospective payment basis based on categories of patient conditions and needs.

Dependent Hospitals. As such, the test required by the Intermediary exceeds the test in the regulation. However, the Provider asserts that it clearly meets both 42 C.F.R. § 412.108(d) and the HCFA Pub. 15-1 § 2810 tests. The reduction in inpatient admissions was due to two major issues:

a. **Loss of Essential Physician Services of Dr. Page and Dr. Runyan**.[2] This change, which reduced their hours in the Emergency Room and consequently reduced admissions, constitutes roughly 77% of the admission decline for the 1993 year. These two had admission declines of approximately 25% in 1993 over 1992. Thirty-seven of the full-year admission count drop out of 45 occurred in the last four months of 1993. The net effective loss was approximately .5 FTE physicians from the entire medical staff.

b. **Inability to Recruit Essential Physician Staff**. There was a total admission drop of 53 in 1993 [3] and a drop of 80 in emergency room (ER) admissions. ER admissions fell from 74.9% of the total for the Provider in 1992 to 70.2% in 1993. This is a significant reduction to a small rural hospital that is heavily dependent upon ER admission activity.

The Provider contends that the volume growth of non-admitted ER and clinic patients caused physician staffing problems in that the same physician that treated the ER patients also treated the new clinic patients. To provide more ER coverage, the Provider contracted with a regional staffing firm and hired some part-time ER physicians. They did not have admitting privileges and therefore sent patients out of the Provider's ER. Physicians wearing multiple hats could not keep up with the workload. Even if there were physicians to admit the patients, there was a limited availability of primary care physicians to care for them. For this reason, the Provider attempted to recruit primary care physicians as well.

The Provider observes that HCFA[4] and the Intermediary recognized the difficulty that the Provider had in the recruiting process. HCFA gave the Provider a three-year grant in 1993 to assist it in recruiting one FTE emergency room physician and partial FTE physicians in other specialties.[5]

The Provider notes that the Intermediary's original internal analysis also recognized that the Provider had trouble recruiting physicians for several years.[6] The Intermediary nevertheless denied the Providers request, noting that the same core physicians were on staff in both years. The Provider counters that HCFA Pub. 15-1

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[2] See Provider Exhibit P-8.
[3] See Provider Exhibit P-5.
[4] Now Centers for Medicare and Medicaid Services (CMS).
[5] Transcript (Tr.) at 74-76.
[6] See Intermediary Exhibit I-4.

§ 2810.1A1 only requires an inability to recruit essential physician staff. There is no requirement related to core physicians.

The Provider cites three other factors that it claims contributed to the Provider's volume decline:

1. An admitting cardiologist that used to admit to the Provider began admitting patients to Tollfree Memorial Hospital.
2. Physician radiology coverage was lost on some weekends.
3. The entire county market was down 4.8% - clearly outside the control of the Provider.

The Provider further observes that the Intermediary provided no documentation, nor did it address at the hearing, any information related to the Medicare certification issue. Provider Exhibit P-12 shows that most major statistical indicators, except acute admissions, increased from 1992 to 1993 in the last eight months of the year, thus indicating that the certification problems did not deter use of the hospital.

Finally, the Provider observed that the U.S. Congress has made numerous attempts over time to support fragile rural hospitals. The Provider is clearly one of those hospitals. Provider Exhibit P-10 shows a hospital whose liquidity is declining. Its current ratio in 1993 was below one; its current liabilities exceeded current assets. Provider Exhibit P-10A shows a trend line of falling days cash on hand with an average below 30 days and a low point of 19 days by 1995.

INTERMEDIARY'S CONTENTIONS:

The Intermediary determined that the reason for the decline in discharges was not due to problems of recruiting core physician staff, but rather was due to a shift to outpatient services. It argues that the documentation provided by the Provider did not refute nor address this determination, but in fact clearly established that the essential core physician staff situation remained constant during this time. Therefore, the Provider had simply failed to carry the burden of proof to show that it met the requirements of the regulation or the criteria set forth at A(1) or A(2) of HCFA Pub. 15-1 § 2810.1. The Intermediary believes it is significant that the Provider had been notified by HCFA of a pending involuntary termination of its Medicare certification in January, 1993. This notice was published in a community newspaper, and the Intermediary reasons, likely precipitated the decline. Since the need for the notice was not a circumstance or occurrence beyond the control of the hospital and in fact was due to the hospital's prior actions or inaction, the decline in discharges did not meet the criteria for a Low Volume Adjustment payment.

The Intermediary contends that the Provider is improperly asking the Board to interpret "circumstances beyond the hospital's control" in 42 C.F.R. § 412.108 very broadly. The

Provider believes that as long as the decline in discharges cannot be affirmatively blamed on the Provider due to a lack of proper reaction or adjustment, the hospital is entitled to the low volume adjustment payment.[7] The Intermediary counters that the regulation's intent is to cover fixed costs and to maintain a core staff, particularly when an unusual event is externally imposed on a hospital and a decline in volume results. Thus, what is critical is an event beyond the Provider's control.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, Program instructions, parties' contentions and evidence submitted, finds and concludes that the Provider has met the regulatory requirement of 42 C.F.R. § 412.108(d) and that circumstances beyond its control resulted in a greater than 5% reduction in patient admissions in 1993.

The following facts are undisputed:

(1) 70% of inpatient admissions come from the emergency room.
(2) HCFA gave the Provider a $50,000 grant in 1993 to help it recruit one emergency room physician.
(3) Radiology services were not available on a full time basis, especially on weekends.
(4) The loss of two physicians who had admitting privileges in 1993 resulted in reduced inpatient admissions.
(5) There were complaints by various physicians regarding the lack of radiology services in the emergency room.[8]
(6) The Provider is in an under-served area and meets the regulatory definition of a Medicare Dependent Hospital.
(7) The Provider had in excess of a 5% decline in inpatient admissions from 1992 to 1993.

The Board finds that the exception criterion in regulation 42 C.F.R. § 412.108(d), i.e., establishing circumstances beyond the provider's control, is the only controlling criterion to be applied to the factual situation of a provider. HCFA Pub. 15-1 §2810.1 used by the Intermediary to support its reasons for denying the Provider's exemption does not apply to Medicare Dependent Hospitals. That section applies only to sole community hospitals. Moreover, the Manual-based arguments used by the Intermediary to deny the Medicare Dependent Hospital exception are excessively restrictive and conflict with the plain language of the Medicare MDH statute and regulation. The Boone County, supra, decision, which the CMS Administrator declined to review, supports this conclusion.

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[7] Tr. at 15.

[8] See Board of Director Minutes – Provider Exhibit P-6.

The Board observes that there is no dispute that there is a trend by this Provider to use outpatient services to a greater degree than inpatient services from 1992 to 1993.[9] This trend, however, does not negate the MDH statutory purpose of maintaining the availability of inpatient services and covering the fixed inpatient costs related thereto. The Board further finds that the shift from inpatient admissions to outpatient services is not within the control of the Provider. The decision on where treatment is offered and given is a physician decision and is essentially based on the physical condition of patients.

The Board rejects the Intermediary's arguments regarding recruitment. Sufficient information is in the record to demonstrate that the loss of emergency room physicians significantly reduced inpatient admissions.[10] Moreover, physicians who filled in for the emergency room physicians who left the Provider could not admit patients to the hospital because they were temporary physicians who did not have admitting privileges. Further, HCFA recognized the recruitment problems which the Provider had and gave the Provider a $50,000 grant in 1993 to help with the recruiting process. This program allowed a recruitment specialist to provide training and guidance to the Provider's recruitment and retention committee.[11]

The Board concludes that the Provider experienced a shift of services from inpatient to outpatient and had physician recruitment problems. Both were beyond its control as defined in 42 C.F.R. § 412.108.

DECISION AND ORDER:

The Provider meets the requirements of 42 C.F.R. § 412.108 regarding circumstances beyond its control and is allowed a Low Volume Adjustment due to its reduced inpatient admission volume. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esq.
Henry C. Wessman, Esq. (Concurring)
Dr. Gary B. Blodgett

Date : May 14, 2003

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9 Tr. at 100-103, 121-122.

10 See Provider's Position paper Attachment A, at 11.

11 Tr. at 75-76.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Concurring Opinion – Henry C. Wessman

I file this short concurring opinion to identify my rationale for changing my opinion from the recently issued Boone County Hospital Decision (PRRB Decision 2002-D29, August 2, 2002) in which I wrote a concurring Dissent.

I am not at all convinced that the decline in admissions evidenced at Standish Community Hospital was due to circumstances beyond the hospital's control, as required by 42 C.F.R. § 412.108(d). Further, I do not believe that the Decision squares with the most basic of Medicare payment principles: Reasonable Cost (42 U.S.C. § 1395x(v)(1)(A)). There is nothing reasonable, for instance, about assisting in the opening of an urgent care clinic to compete with your own ER, and then ask the Medicare Trust Fund to supplement the hospital's decline in ER-based admissions; or to hire ER locum tenens, but provide no avenue for those hired to be able to admit directly to Standish from it's own ER. I believe that the Intermediary had this case pegged correctly.

In my opinion, this decision, as the decision in Boone County, throws good money after bad. But I follow the sage advice of song writer Don Schlitz, as sung by Kenny Rogers: "You gotta know when to hold 'em, know when to fold 'em, know when to walk away; know when to run". When the highest staked player at the table, the CMS Administrator, folds 'em and runs, and does not feel compelled to question the propriety of the award, as occurred in Boone County, (Boone County Hospital, PRRB Decision 2002-D29, CMS Administrator's Decision, declined review, 9/20/02) there's little incentive to stand and fight.

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Henry C. Wessman
Senior Board Member