PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2008-D1

PROVIDER –
Marion General Hospital
Marion, IN

Provider No.: 15-0011

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services - Indiana

DATE OF HEARING -
August 9, 2007

Cost Reporting Period Ended -
June 30, 2005

CASE NO.: 05-0686

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ISSUE:

Whether the recission of the hospital's previously approved request for Sole Community Hospital (SCH) status was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). See, 42 U.S.C. § 1395ww(d). PPS provides Medicare payment for hospital inpatient operating and capital-related costs at predetermined, specific rates for each hospital discharge. The rates are average standardized amounts that are divided into a labor-related component and a non-labor related component. CMS adjusts the labor-related component by the wage index applicable to the urban or rural geographic area where the hospital is located. 42 CFR §412.64. The wage index measures the ratio of the average hourly wage (AHW) of hospitals in a given geographic area with the nationally calculated AHW and adjusts PPS rates to reflect local variations in labor costs. The wage index is usually greater for hospitals located in an urban county. PPS also allows special treatment for facilities who qualify as "Sole Community Hospitals" (SCHs). 42 C.F.R. §412.92 sets forth the special treatment for SCHs and establishes the criteria that must be met in order for a hospital to be classified as a SCH. CMS adjusts the PPS rates for SCHs to accommodate their special operating circumstances (e.g., isolated location, weather/travel conditions,

unavailability of other hospitals). The issue in this case involves the continued recognition of the hospital as a SCH.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Marion General Hospital (Provider) is an acute care, not-for-profit hospital located in Marion, Indiana. The Provider applied for SCH status as a rural hospital on February 4, 2004. National Government Services (Intermediary), formerly AdminaStar Federal, sent the Provider's request along with a positive recommendation to CMS which, in turn, approved the Provider's request on June 16, 2004. The Provider's SCH status became effective 30 days after CMS' approval. Subsequent to the approval, the Intermediary discovered that the Provider had been reclassified as an urban facility on January 15, 2003, for its standardized amount through September 30, 2004. As an urban facility, the Provider did not qualify for SCH status[1] and, consequently, CMS rescinded the Provider's SCH status on August 6, 2004. The Provider made an immediate request to CMS for reclassification from urban to rural status in a letter dated August 16, 2004. The Provider's letter also included a request that its original SCH application be reconsidered. CMS granted the Provider's reclassification request on October 6, 2004 and made the effective date of the reclassification August 17, 2004. However, CMS denied the Provider's request for SCH status because the request had not been filed with the Intermediary as required by 42 C.F.R. §412.92(b). On October 12, 2004, the Provider formally filed a request for SCH status with the Intermediary, and CMS approved the request on January 5, 2005. The effective date of the Provider's SCH status was February 4, 2005. The Provider subsequently appealed CMS' withdrawal of its original approval for SCH status.

The Provider appealed the denial to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835 - 405.1841. The Provider was represented by Keith D. Barber, Esq., of Hall, Render, Killian, Heath & Lyman, P.C. The Intermediary was represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that CMS' rescission of its SCH status was based upon an improper application of the urban/rural standards at 42 U.S.C. §1395ww(d)(2). The Provider argues that classifications of rural vs. urban were no longer applicable with the implementation of the uniform standardized amount mandated by Public Law 108-173.[2] The Public Law was signed on December 8, 2003, and covered all discharges beginning with fiscal year 2004. As codified at 42 U.S.C.§1395ww(d)(3)(A), its provisions effectively superseded the standardized rate process described in 42 U.S.C. §1395ww(d)(2) that formed the basis for the different urban/rural standardized rates. The

[1] " . . . To the extent that a hospital's status as an . . . SCH . . . is dependent upon its being located in a rural area, it will lose its special status if it qualifies for reclassification to an urban area for its standard amount." See, 56 Fed. Reg. 25482 (June 4, 1991).

[2] P.L. 108-173 is titled "Medicare Prescription Drug, Improvement, and Modernization Act of 2003."

Provider contends that CMS addressed the application of the reclassification standards in its commentary on the impact of P.L. 108-173:

> Section 401 of Pub.L. 108-173 established that all hospitals will be paid on the basis of the large urban standardized amount, beginning with 2004. Consequently, all hospitals are paid on the basis of the same standardized amount, which made such reclassifications moot.[3]

The Provider contends that the Intermediary's application of a process as decisive that CMS had already determined to be "moot" is both improper and inconsistent with the Public Law.

Alternatively, the Provider argues that the Intermediary unreasonably delayed processing its subsequent reconsideration request for SCH status. The Intermediary took no action on the August 16, 2004 request because it was filed with CMS rather than with the Intermediary as required by 42 C.F.R. §412.92(b)(1)(i). The Provider argues that the regulation references only SCH requests for SCH status, and that since its request had already been approved, all of its subsequent correspondence with CMS constituted a request for reconsideration of the rescission of its status.

The Intermediary contends that the Provider knew that its original SCH request was flawed. Despite the fact that the Provider had been notified that it had been classified as urban on January 15, 2003, the Provider nevertheless filed its request for SCH status on February 2, 2004. Consequently, the Intermediary contends that the Provider did not meet SCH requirements until October 12, 2004. On that date, the Provider submitted its first request to the Intermediary while it was actually classified rural, and it was the Provider's first full compliance with 42 C.F.R. §412.92(b)(1)(i).

The Intermediary further contends that the regulations at 42 C.F.R. §412.92(b)(2)(i) sets out the procedure for approval of requests for SCH status. The procedure requires that CMS must review and approve a provider's request for classification as a SCH and that SCH status will become effective 30 days after the date of CMS' written notification. The Provider's request in this case was processed in accordance with Medicare regulations, and SCH status was effective February 4, 2005, 30 days after the date of CMS's written notification of approval dated January 5, 2005.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented in the record and the parties' contentions and stipulations, the Board finds and concludes as follows:

It is undisputed that the Provider is geographically located in a rural area as defined by the Office of Management and Budget (OMB). The Provider was reclassified from rural to urban on January 15, 2003 for standardized amount purposes for the fiscal period from

[3] 70 Fed. Reg. 47379 (August 12, 2005).

10/01/03 to 9/30/04. The link between the reclassification from urban to rural and SCH status was explained by CMS in the June 5, 1991 Federal Register. It states " . . . to the extent that a hospital's status as an . . . SCH . . . is dependent upon its being located in a rural area, it will lose its special status if it qualifies for reclassification to an urban area for its standard amount." See, 56 Fed. Reg. 25482 (June 4, 1991).

After being notified that it would be reclassified, but before the effective date of the reclassification, a new statute, Public Law (P.L.) 108-173, went into effect mandating a uniform standardized rate. CMS has interpreted the P.L.'s mandate for a uniform standardized rate as rendering "moot" the prior distinction between urban and rural standardized rates. Fed. Reg. 47379 (August 12, 2005). Despite the change in legislation, the regulations were not changed.

The Provider's February 4, 2004, request for SCH status as if it were a rural provider was therefore justified because the basis on which it had been reclassified to urban had been removed by statute. It is undisputed that the Provider met the requirements of 42 C.F.R. §412.92(b)(1)(i) but for the Intermediary's subsequent imposition of the urban/rural distinction that had been removed by the statute. Accordingly, the Board concludes that the imposition of that distinction was improper and that the Provider qualified for SCH status beginning July 16, 2004 – 30 days after CMS' original approval letter dated June 16, 2004.

DECISION AND ORDER:

CMS' rescission of the Provider's SCH status for the period from August 6, 2004 until February 4, 2005 is reversed.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

DATE: October 10, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson