PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D23

PROVIDER –
Mary Greeley Medical Center
Ames, IA

Provider No.: 16-0030

vs.

INTERMEDIARY –
Wisconsin Physicians Service/
Blue Cross and Blue Shield Association

DATE OF HEARING -
June 15, 2012

Cost Reporting Period Ended -
June 30, 2009

CASE NO.: 10-0224

INDEX

ISSUES:

1. Whether the intermediary and CMS Regional Office for Region VII ("CMS Regional Office") evaluated market share for the provider for the correct geographic area when they denied the provider's request for classification as a sole community hospital on the grounds that the provider failed to meet the market share criteria under 42 C.F.R. § 412.92(a)(1)(i).[1]

2. Whether the Regional Office used the correct denominator in its market share calculation.[2]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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 to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[3] determine payment amounts due the providers under Medicare law, regulations and under interpretive guidelines published by CMS.[4]

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant period and the portion of those costs to be allocated to the Medicare program.[5] The MAC reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[6] A provider dissatisfied with the MAC's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[7]

The operating and capital-related costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System ("IPPS").[8] IPPS provides Medicare payment for such costs at predetermined, specific rates for each hospital discharge. IPPS allows special treatment for facilities who qualify as "Sole Community Hospitals" ("SCHs"). The statutory definition of an SCH is as follows:

---

[1] Transcript ("Tr.") at 5-6; *see also* Stipulations of Fact at ¶1 (June 6, 2012) ("Stipulations").
[2] During the hearing, the parties recognized that this appeal involves this second legal issue. *See* Provider Post Hearing Brief at 2; Intermediary Post-Hearing Brief at 8; Tr. at 40-41, 57-59; 66; 75-82; 97-104; 109-111.
[3] FIs and MACs are hereinafter referred to as MACs.
[4] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[5] *See* 42 C.F.R. § 413.20.
[6] *See* 42 C.F.R. § 405.1803.
[7] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1839.
[8] *See* 42 U.S.C. § 1395ww(d).

> (iii) for purposes of this subchapter, the term "sole community hospital" means any hospital –
> (I) that the Secretary determines is located more than 35 road miles from another hospital,
> (II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standard promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in the geographic area who are entitled to benefits under part A of this subchapter, or
> (III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i-4(i)(1) of this title as in effect on September 20, 1997.[9]

42 C.F.R. § 412.92 (2009)[10] 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 IPPS rates for SCHs to accommodate their special operating circumstances (*e.g.*, isolated location, weather/travel conditions, unavailability of other hospitals). In particular, § 412.92(a)(1) establishes the following criteria that the Provider in this case must meet to obtain SCH status:

> (a) *Criteria for classification as a sole community hospital.* CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.64) and meets one of the following conditions:
> (1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:
> (i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;
> (ii) The hospital has fewer than 50 beds and the intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or

---

[9] 42 U.S.C. § 1395ww(d)(5)(D)(iii).
[10] All citations to the Code of Federal Regulations ("C.F.R.") are to the edition dated October 1, 2009 unless specified otherwise.

> (iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.[11]

Further, § 412.92(b) specifies the information that a provider applicant needs to submit to a MAC in order to determine whether the provider applicant meets this SCH criteria. The information required is as follows:

> (b) *Classification procedures*—(1) *Request for classification as sole community hospital.* (i) The hospital must make its request to its fiscal intermediary.
> (ii) If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:
> (A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.
> (B) The hospital must provide patient origin data from all other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.
> (iii)(A) If the hospital is unable to obtain the information required under paragraph (b)(1)(ii)(A) of this section concerning the residences of Medicare beneficiaries who were inpatients in other hospitals located within a 35 mile radius of the hospital or, if larger, within the hospital's service area, the hospital may request that CMS provide this information.
> (B) If a hospital obtains the information as requested under paragraph (b)(1)(iii)(A) of this section, that information is used by both the intermediary and CMS in making the determination of the residences of Medicare beneficiaries under paragraphs (b)(1)(iii) and (b)(1)(iv) of this section, regardless of any other information concerning the residences of Medicare beneficiaries submitted by the hospital.[12]

Significantly, §§ 412.92(a)(1)(i) and 412.92(b)(1)(ii)(B) each set forth a fraction that represents what will hereinafter be referred to as the "'no more than 25 percent' test":

---

[11] (Emphasis in original).
[12] (Emphasis in original.)

Language for the fraction in § 412.92(a)(1)(i) or the "Subsection (a) Fraction"	"No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area."
Language for the fraction in § 412.92(b)(1)(ii)(B) or the "Subsection (b) Fraction"	"[N]o more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care."

The language used to described the fraction in § 412.92(a)(1)(i) is almost the same as that used to describe the same fraction in § 412.92 (b)(1)(ii)(B). In order to distinguish between them, the fraction described in § 412.92(a)(1)(i) will be hereinafter referred to as the "Subsection (a) Fraction" and the fraction stated in § 412.92(b)(1)(ii)(B) will be hereinafter referred to as the "Subsection (b) Fraction."

The terms "miles," "like hospital" and "service area" as used within § 412.92 are defined in subsection (c) as follows:

> (c) *Terminology.* As used in this section—
> (1) The term *miles* means the shortest distance in miles measured over improved roads. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital.
> (2) The term *like hospital* means a hospital furnishing short-term, acute care. Effective with cost reporting periods beginning on or after October 1, 2002, for purposes of a hospital seeking sole community hospital designation, CMS will not consider the nearby hospital to be a like hospital if the total inpatient days attributable to units of the nearby hospital that provides a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system are less than or equal to 8 percent of the similarly calculated total inpatient days of the hospital seeking sole community hospital designation.
> (3) The term *service area* means the area from which a hospital draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a sole community hospital.[13]

The Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2810 further clarifies the process of qualifying for classification as an SCH. The issue in this case involves whether the Provider met the criteria to be classified as a SCH.

[13] (Emphasis in original.)

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mary Greeley Medical Center ("Provider") is a 220-bed regional referral center located in Ames, Iowa, which is approximately 30 miles north of Des Moines, Iowa. The Provider is located between 25 and 35 miles from 5 other "like" hospitals located in Des Moines, and 36 miles from another "like" hospital located in Marshalltown, Iowa which lies within the Provider's service area.[14]

On February 24, 2009, the Provider applied to the Intermediary for SCH classification. The Provider sought to qualify as an SCH under 42 C.F.R. § 412.92(a)(1)(i) as a hospital that both is located between 25 and 35 miles from other "like" hospitals and satisfies the market share criterion. On April 3, 2009, the Intermediary forwarded the Provider's application to the CMS Regional Office, recommended that the CMS Regional Office accept the Provider's SCH application, and requested the agency's final determination.[15]

The Provider is located in an urban area. Accordingly, shortly thereafter, on April 16, 2009, the Provider also requested rural reclassification under 42 C.F.R. § 412.103(a)(3) on the grounds that it would qualify as a SCH under 42 C.F.R. § 412.92(a)(1)(i) if it were located in a rural area.[16]

On June 12, 2009, the CMS Regional Office denied the Provider's requests for rural reclassification and SCH classification on the grounds that it would not qualify as a SCH if it were located in a rural area because it failed to satisfy the market share criterion.[17] On June 16, 2009, the Intermediary notified the Provider of CMS' denial of its rural reclassification and SCH classification requests because the Provider "was unable to document that no more than 25 percent of the residents of its *service area* who became inpatients were admitted to other like hospitals within its *service area*."[18] In making this denial, the Intermediary determined that "[t]he percentage of discharges to other like hospitals in the applicant's [*i.e.*, Provider's] service area is 41.48% which is greater than the required 25%."[19]

On December 9, 2009, the Provider timely appealed CMS' final determination to the Board. On June 15, 2012, the Board conducted a hearing. Using data from the Provider's 2008 cost reporting period, the Provider has estimated the reimbursement impact of the denial of SCH status to be approximately $6.5 million per cost reporting period.

The Provider was represented by Dennis M. Barry, Esq., of King & Spalding LLP. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

---

[14] *See* Stipulations at ¶¶ 5, 6, 9.
[15] *See id.* at ¶ 4; Provider Exhibits P-1, P-8.
[16] *See* Stipulations at ¶ 4.
[17] *See* Provider Exhibit P-4.
[18] *See* Provider Exhibit P-5 (emphasis in original).
[19] *Id.*

STIPULATIONS OF THE PARTIES:

Before the hearing, the Parties jointly filed the following stipulations of fact:

1. The sole issue under appeal in the above-captioned case (the "Appeal") is whether Wisconsin Physicians Service (the "Intermediary") evaluated market share for Mary Greeley Medical Center (the "Provider") for the correct geographic area when it denied the Provider's request for classification as a sole community hospital ("SCH") on the grounds that the Provider failed to meet the market share criterion under 42 C.F.R. § 412.92(a)(1)(i) (*see* ¶ 3, below).

2. There are no jurisdictional impediments to hearing in the Appeal.

3. The market share test provides that a hospital that is located between 25 and 35 miles from other like hospitals qualifies for sole community hospital ("SCH") status if:

> [n]o more than 25 percent of residents who become hospital inpatients . . . in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area[.]

42 C.F.R. § 412.92(a)(1)(i).

4. The Provider applied for SCH classification on February 24, 2009. The Intermediary forwarded its recommendation to CMS on April 3, 2009, recommending acceptance of the Provider's SCH application and requesting the agency's final determination. On April 16, 2009, the Provider requested rural reclassification under 42 C.F.R. § 412.103(a)(3) on the grounds that it would qualify as a SCH under 42 C.F.R. § 412.92(a)(1)(i) if it were located in a rural area. CMS denied Provider's request for rural reclassification on June 12, 2009 on the grounds that it would not qualify as a SCH if it were located in a rural area. The Intermediary notified the Provider of CMS's denial of its rural reclassification and SCH classification requests on June 16, 2009. The Provider timely filed this Appeal of CMS's final determination on December 9, 2009.

5. The Provider is located in Ames, Iowa, between 25 and 35 miles from five other like hospitals located in Des Moines.

6. The five other like hospitals located within the Provider's 35-mile radius (*see* ¶ 5) are all located in Des Moines, Polk County, Iowa: Broadlawns Medical Center (zip code 50314), Iowa Lutheran Hospital (zip code 50316), Iowa Methodist Medical Center (zip code 50309), Mercy Capitol (zip code 50309), Mercy Medical Center (zip code 50314).

7. As described in the Provider's SCH reclassification request, the Provider's "service area" is a region comprised of 16 zip codes from which it derives 75.64 percent (7,542/9,971) of its inpatients: 50010, 50014, 50036, 50056, 50122, 50124, 50129, 50130, 50156, 50158, 50201, 50212, 50236, 50248, 50595, and 50627. *See* Provider's Final Position Paper, Exhibit 1, page 7.

8. The Provider's 16-zip-code "service area," described in ¶ 7 and used in its SCH classification request, is properly defined in accordance with 42 C.F.R. § 412.92(c)(3) and the Provider Reimbursement Manual (CMS Pub. 15-1) § 2810(A)(2)(c), and as required by 42 C.F.R. § 412.92(b)(1)(ii)(A), as the fewest number of zip codes from which the Provider drew at least 75 percent of its inpatients during the preceding 12-month cost reporting period.

9. Marshalltown Medical and Surgical Center (zip code 50158), which is located 36 miles away in Marshalltown, Marshall County, Iowa, is the only other like hospital besides the Provider located within the Provider's 16-zip-code service area.

10. The Provider's 35-mile radius represents a geographic area of approximately 3,848 square miles ($\pi \times (35)^2$). The geographic region comprised by the Provider's 16-zip-code "service area" (*see* ¶ 7) covers approximately 1,641 square miles (*Source*: www.zip-codes.com).

11. The Provider submitted two separate data sets with its SCH application and performed two separate market share calculations. The Provider's first calculation applied the market share test (*see* ¶ 3) with respect to other like hospitals located within the Provider's 35-mile radius, which covers more square miles than the region comprised by the Provider's 16-zip-code "service area" (*see* ¶ 7). The Provider's second calculation performed the market share test with respect to other like hospitals located within the Provider's 16-zip-code service area, portions of which extend farther than 35 miles from the Provider.

    a. Provider's First Market Share Calculation: "35-Mile Radius" Is Larger
        i. The Provider submitted data showing that 17.34 percent (2,435/14,042) of all service area inpatients were admitted to the five other like hospitals in Des Moines that are located within the Provider's 35-mile radius.
        ii. But if the Intermediary's denominator is correct, the data shows that 18.89 percent (2,435/12,890) of all service area inpatients were admitted to the five other like hospitals in Des Moines that are located within the Provider's 35-mile radius.

    b. Provider's Second Market Share Calculation: "Service Area" Is Larger
        i. The Provider also submitted data showing that 20.74 percent (2,913/14,042) of all service area inpatients were admitted to the only other like hospital located within the Provider's 16-zip-code service area, Marshalltown Medical and Surgical Center.
        ii. But if the Intermediary's denominator is correct, the data shows that 22.60 percent (2,913/12,890) of all service area inpatients were admitted to the only other like hospital located within the Provider's 16-zip-code service area, Marshalltown Medical and Surgical Center.

    Under either of these two approaches, the Provider would satisfy the market share criterion for qualifying as a SCH, irrespective of whether the Provider's denominator or the Intermediary's denominator is correct, since each calculation shows that no more than 25 percent of the residents from the Provider's "service area" (*see* ¶ 7) who became hospital

inpatients during the Provider's fiscal year ending June 30, 2008 were admitted to other like hospitals located within each respective region.

12. Intermediary's Market Share Calculation. The Intermediary performed the market share test (*see* ¶ 3) by evaluating the number of residents from the Provider's 16-zip-code service area who were admitted to any of the six other like hospitals for which the Provider submitted data, including the five Des Moines hospitals located within the Provider's 35-mile radius (*see* ¶ 6) *and* the only other like hospital located within the Provider's 16-zip-code service area, Marshalltown Medical and Surgical Center (*see* ¶ 9).

    a. Data submitted with the Provider's SCH classification request shows that 41.49 percent (5,348/12,890) of all service area inpatients were admitted to the six other like hospitals located within the region comprised by the Provider's 35-mile radius and its 16-zip-code service area.

    b. But if the Provider's denominator is correct, the data shows that 38.09 percent (5,348/14,042) of all service area inpatients were admitted to the six other like hospitals located within the region comprised by the Provider's 35-mile radius and its 16-zip-code service area.

    Under the Intermediary's approach, the Provider would fail to satisfy the market share criterion for qualifying as a SCH, irrespective of whether the Provider's denominator or the Intermediary's denominator is correct, since the Intermediary's calculation shows that more than 25 percent of the residents from the Provider's "service area" (*see* ¶ 7) who became hospital inpatients during the Provider's fiscal year ending June 30, 2008 were admitted to all six of the other like hospitals located within the region comprised by the Provider's 35-mile radius and its 16-zip-code service area.

13. If either of the Provider's market share calculations (*see* ¶¶ 11(a) and 11(b)) represents the correct interpretation of the market share regulation (*see* ¶ 3), then the Provider qualifies as a SCH. If the Intermediary's market share calculation (*see* ¶ 12) represents the correct interpretation of the market share regulation, then the Provider does not qualify as a SCH. By agreeing to these stipulations, neither party concedes that the other party's interpretation of the market share test is correct. Both parties agree, however, that the calculations presented in ¶¶ 11 and 12 (including subparagraphs) are mathematically accurate representations of the data as therein described.[20]

[20] (Emphasis in original)

Paragraphs 11 to 13 of the Stipulations address the application of market share calculation from each party's perspective. During the hearing, the parties recognized that these paragraphs do not accurately represent each party's position with respect to what goes into the denominator of the market share calculation.[21] This led to the second issue being added to this appeal.

PARTIES' CONTENTIONS:

ISSUE 1: WHETHER THE REGIONAL OFFICE PERFORMED THE MARKET SHARE CALCULATION OVER THE CORRECT GEOGRAPHICAL AREA.

PROVIDER'S CONTENTIONS:

The Provider contends that the plain language of the market share regulation requires that the market share test be applied *either* with respect to the other like hospitals located within the Provider's 35-mile radius, *or* with respect to those located within the Provider's "service area," depending on which of these two distinct regions is "larger."

The market share test provides that a hospital, like the Provider, that is located between 25 and 35 miles from other like hospitals qualifies for SCH status if no more than 25 percent of its service area residents are admitted to "other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area."[22] The Provider asserts that the language "or, if larger" clearly requires a size comparison as between the two regions identified in the regulation: (1) the applicant's 35-mile radius; and (2) its "service area." Only those service area resident admissions to other like hospitals that are located within the *larger* of these two distinct regions should be included in the numerator of the market share calculation.

The Provider's 35-mile radius unambiguously describes a circular region with the Provider in the center, which extends 35 miles out from the Provider in all directions. "Service area" is defined in 42 C.F.R. § 412.92(c)(3) as the "area from which a hospital draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a sole community hospital." CMS has explained in PRM 15-1 § 2810(A)(2)(c) that "[a] hospital may define its service area as the lowest number of zip codes from which the hospital draws at least 75 percent of its inpatients . . . ."[23] The Provider's "service area," therefore, is comprised of the 16 zip codes from which it derived 75.64 percent of its inpatients during the Provider's cost reporting period ending June 30, 2008.

The Provider's 35-mile radius describes a geographic area of approximately 3,848 square miles. By contrast, the Provider's 16-zip-code "service area" covers a geographic area of approximately 1,641 square miles. Thus, the Provider argues, the 35-mile radius as applied in this case is not only "larger," but *much* larger than its service area. Accordingly, the market share calculation

---

[21] *See* Provider Post Hearing Brief at 2; Intermediary Post-Hearing Brief at 8; Tr. at 40-41, 57-59; 66; 75-82; 97-104; 109-111.

[22] 42 C.F.R. § 412.92(a)(1)(i).

[23] *Accord* 53 Fed. Reg. 38476, 38510-11 (Sept. 30, 1988).

should include only those service area residents' admissions to other like hospitals located within the Provider's 35-mile radius.[24]

INTERMEDIARY'S CONTENTIONS:

The Regional Office and the Intermediary contend that service area residents' admissions to other like hospitals located within the Provider's 35-mile radius are *always* included in the market share calculation, regardless of whether the Provider's 35-mile radius or its "service area" is "larger." If portions of the Provider's "service area" extend beyond the 35-mile radius, then admissions to other like hospitals located within the Provider's service area are also included in the calculation. Accordingly, the Intermediary contends that, because the outer limit of the Provider's 16-zip-code "service area" extends 45 miles from the Provider, the market share calculation should be performed with respect to all other like hospitals located within the combined region that is comprised of the Provider's 35-mile radius *and* its service area.

The Intermediary contends that the main challenge and the first point in conflict is interpreting 42 C.F.R. § 412.92(a)(1).[25] The Intermediary argues that the language of § 412.92(b) provides a two-step procedure with the first step defining the service area:

> (1) *Request for classification as sole community hospital*
> i. The hospital must make its request to its fiscal intermediary.
> ii. If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:
> (A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.[26]

The Provider's service area zip codes have been identified and its zip codes can be plotted on a map.[27] The Intermediary contends that the service area is defined by identification of zip codes which were outlined on the map.

The second step in § 412.92(b)(1)(ii) requires the establishment of market share:

> (B) The hospital must provide patient origin data from all other hospitals located with a 35-mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.

---

[24] *See* Provider Post Hearing Brief at 12-23.
[25] Stipulations at ¶ 3.
[26] (Emphasis added)
[27] Provider Exhibit P-1 at 6.

The Intermediary argues that the Provider's theory relative to what "hospitals located within a 35-mile radius of it, or if larger, within its service area," requires the application of an additional step of comparing the square mileage of each zip code in the service area to the square miles within the 35 mile radius to determine which of the areas, i.e. service area or area within the 35-mile radius, is "larger." In the present case, the Provider contends that square mileage within the service area zip codes totals 1,641 square miles which is smaller when compared to the area within the 35-mile radius of 3,848 square miles.[28] The Intermediary argues that nothing in the language of the regulation suggests the execution of this procedure.[29]

The Intermediary also argues that the service area determinations exercise in § 412.92(b)(1)(ii)(A) provides the foundation for its position. As in the Provider's approach, hospitals within 35 miles need to be identified. The hospitals within this radius become part of the competitive base.[30] Next, the boundaries of the service area mapped and if there is a hospital in that part of the service area that is further than 35 miles from the applicant, that hospital also becomes part of the competition base.

The Intermediary summarizes its argument saying that "ignoring the Des Moines hospitals makes no sense" just because they are not in the service area. Likewise, it makes no sense to ignore the viable competitors in the service area because it (with a smaller area than 3848 square miles) extends more than 35 miles from the applicant. Pulling back and examining the purpose of identifying what is an SCH, hospitals within 35 miles are competitors by regulation and have to be considered as viable alternate sources of hospital care. Additionally, the regulation requires a further look in the service area for additional hospitals even if more than 35 miles away.[31]

ISSUE 2: WHETHER THE REGIONAL OFFICE USED THE CORRECT DENOMINATOR IN ITS MARKET SHARE CALCULATION.

PROVIDER'S CONTENTIONS:

The Provider contends that the market share test is intended to measure the proportion *of all service area residents who receive inpatient care* who are admitted to other like hospitals located within the relevant region (*i.e.*, the larger of the 35-mile radius *or* the service area). Accordingly, the Provider contends that the appropriate denominator for the market share calculation should be the most comprehensive figure available to the Provider that reflects the total number of inpatient admissions among the Provider's service area residents, regardless of where they are admitted.

The text of the market share regulation itself does not restrict the relevant universe of service area resident inpatients to those who became inpatients at a particular type of hospital or at hospitals located in any particular area. The regulatory language describing the denominator of the market share calculation is unqualified, including *all* "residents who become hospital

[28] Stipulations at ¶10.
[29] MAC's Post Hearing Summary at 11.
[30] *Id.*
[31] *See* Intermediary Post-Hearing Brief at 8-12.

inpatients."[32] This is entirely consistent with the more specific description of the market share denominator that appears under subsection (b) of the SCH regulation: "all of the population . . . residing in the hospital's service area and hospitalized for inpatient care."[33] The clearest reading of this language requires that all inpatient admissions among the Provider's service area residents be included in the analysis, regardless of where they were admitted. There is no language in these regulatory descriptions of the market share denominator that can reasonably be read to proscribe the locations or types of hospitals at which the included service area residents received inpatient care. The language is unconditional.

From a policy standpoint, the question being asked under the market share test should properly be, "*Among service area residents who received inpatient care at any facility*, what percent sought care at other like hospitals located within the relevant region?" The goal of the market share test is to analyze where service area residents go for inpatient care. This analysis requires an examination of *all* of the residents who receive inpatient care at *any* facility. Contemporaneous statements in the September 1, 1983 preamble, which adopted the market share criterion, support this interpretation and indicate that CMS's intent was to assess "utilization [of services] outside of the service area."[34] Thus, it is clear that the market share regulation was originally intended to include residents admitted to out-of-area hospitals within the ambit of its analysis.[35]

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the controversy over the denominator is only relevant if the Provider prevails on its "either - or" numerator argument. The market share denominator issue may only turn the outcome if the provider's argument that its 35-mile radius area is larger is persuasive as to the decision makers. If the Intermediary's position that the numerator includes all the hospitals within 35 miles (including the 5 Des Moines hospitals) and the 6th hospital in the service area, the larger denominator will not produce a market share of less than 25 percent. If the argument that "35 mile radius is larger" stands, the Provider would succeed even with the Intermediary's lower denominator.

To restate the positions, the Provider contends that the denominator is all service area discharges no matter where they occur. The contention adds 1152 discharges outside of the 6 competitors. Those discharges have no bearing on whether the Provider is the hospital of choice (by a 75 to 25% vote) of its service area between competitors. Counting those outside discharges distorts the market share. The same is true in the Provider's "either or options." If the Provider does not want to count discharges from the 5 Des Moines hospitals in one option and the Marshalltown Medical and Surgical Center discharges in the other option, then including those discharges in the denominator count also distorts the market share outcome. The Regional Office and the Intermediary contend that the denominator of the market share calculation should

[32] 42 C.F.R. § 412.92(a)(1)(i).
[33] 42 C.F.R. § 412.92(b)(1)(ii)(B).
[34] 48 Fed. Reg. 39752, 39781 (Sept. 1, 1983).
[35] *See* Provider's Post-Hearing Brief at 24 -35.

include only those service area resident admissions to the Provider itself and to other like hospitals located within the relevant region.[36]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions, and the evidence presented. Set forth below are the Boards findings and conclusions.

Issue 1 addresses the market share calculation versus the correct geographical area and Issue 2 addresses what the denominator is comprised of. The parties contentions are based upon their variant interpretations of the statute at 42 U.S.C. § 1395ww(d)(5)(D)(iii) and the regulations at 42 C.F.R. § 412.92.

At the outset, the Board notes that Issue 2 is not new to the Board. In *Maine Coast Memorial Hospital vs. Blue Cross Blue Shield Association* ("Maine Coast"),[37] the Board examined the entire market share calculation that included an analysis of the statute or regulations under which authority the Board is bound.[38] The Board will apply this rationale to Issue 2 in this case. Accordingly, the Board first addresses Issue 2 and then addresses Issue 1.

ISSUE 2 – WHETHER THE REGIONAL OFFICE USED THE CORRECT DENOMINATOR FOR THE "NO MORE THAN 25 PERCENT" TEST.

The Board first will analyze whether the statute or regulations with which the Board is bound to comply answers Issue 2. The relevant statute states:

> (iii) for purposes of this title, the term *"sole community hospital" means any hospital –*
> (I) that the Secretary determines is located more than 35 road miles from another hospital,
> (II) that, *by reason of factors such as* the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standard promulgated by the Secretary), location, weather conditions, travel conditions, or *absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in the geographic area who are entitled to benefits under part A*, or . . .[39]

The Board finds that, while the statute does not resolve Issue 2, the statute does specify that "absence of other like hospitals" is a factor, and it gives the Secretary discretion on how to interpret and apply this factor. Therefore, the Board looked to regulations and policy to determine how the Secretary has interpreted and applied this factor.

---

[36] *See* Intermediary Post-Hearing Brief at 12.
[37] *Maine Coast Mem'l Hosp. vs. Blue Cross Blue Shield Ass'n,* PRRB Decision No. 2013-D5 (Feb. 21, 2013), *declined review*, Administrator (Apr. 11, 2013).
[38] 42 C.F.R. § 405.1867.
[39] 42 U.S.C. § 1395ww(d)(5)(D)(iii) (emphasis added).

As previously noted, both the Subsection (a) and Subsection (b) Fractions state the "no more than 25 percent" test, and the language that each uses to describe that test is almost identical. The Board notes that the Subsection (b) Fraction is a restatement or paraphrase of the Subsection (a) Fraction and to resolve the question of how to interpret and apply the "no more than 25 percent" test, the Board focuses first on the Subsection (a) Fraction.

The Board finds that 42 C.F.R. § 412.92(a) as its title suggests establishes the "Criteria for classification as a sole community hospital" that the Provider in this case must meet in order to obtain classification as an SCH. Specifically, § 412.92(a) states in pertinent part:

> (a) *Criteria for classification as a sole community hospital.* CMS classifies a hospital as a sole community hospital if . . . it is located in a rural area (as defined in § 412.64) and meets one of the following conditions:
> (1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:
> (i) . . . no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger,[40] within its service area.

The language in § 412.92(a)(1)(i) criteria sets forth the Subsection (a) Fraction with the following language pertinent to the Provider: "no more than 25 percent of Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals." The Board finds that, when this language is read in isolation, there is ambiguity regarding what the denominator of Subsection (a) Fraction is comprised. Specifically, the numerator for the "no more than 25 percent" would be "Medicare beneficiaries who become hospital inpatients in the hospital's service area" and "are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area" while the denominator would be "Medicare beneficiaries who become hospital inpatients in the hospital's service area." On its face, the language for the denominator could be interpreted several different ways depending in part on whether the phrase "in the hospital's service area" modifies "Medicare beneficiaries" or "hospital inpatients.

As a result, the Board must look elsewhere within § 412.92 for guidance on the scope of the "no more than 25 percent" test. Similar to the statute's use of the phrase "absence of other like hospitals," § 412.92 uses the term "other like hospitals." The Board notes that the use of this phrase in the statute as well as subsection (a) and subsection (a)(1)(i) in § 412.92 confirms that the provider applicant is a "like" hospital and suggests that the "no more than 25 percent" test may be a market test for comparison of "like" hospitals (*i.e.*, for comparison of the hospital applicant to "other like hospitals" to the extent they are not absent). The definition of "like hospital" in § 412.92(c)(2) supports this interpretation as the identification of "like hospitals" includes a case-by-case process to exclude certain hospitals that are not similar to the provider applicant and, thus, presumably not a competitor of the provider applicant. However, this does

[40] The Board notes that the Provider's service area may be "larger" and that this is the focus of Issue 1.

not resolve the ambiguity in the subsection (a)(1)(i) language for the "no more than 25 percent" test.

The SCH regulations at 42 C.F.R § 412.92(b) specify "Classification procedures" including what information needs to be submitted for a MAC to process the application and determine whether the Provider met the criteria for classification as an SCH. In particular, 42 C.F.R. § 412.92(b)(1)(ii) describes in two clauses the information that a provider is required to submit where clause (A) requests certain admissions data pertaining to the hospital applicant and clause (B) requests certain admissions data on "all other hospitals":

> (b) *Classification procedures*—(1) *Request for classification as sole community hospital. . . .*
> (ii) If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:
> (A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.
> (B) The hospital must provide patient origin data from all other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.[41]

Significantly, § 412.92(b)(1)(ii)(B) also sets forth the Subsection (b) Fraction using the following language pertinent to the Provider: "no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care." The numerator of the Subsection (b) Fraction would be "the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care" and "admitted to other like hospitals for care" while the denominator is simply "the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care."

As the Subsection (b) Fraction restates or paraphrases the Subsection (a) Fraction, the Board looks to the language of the Subsection (b) Fraction to determine whether it clarifies the Subsection (a) Fraction for purposes of the "no more than 25 percent." In this regard the Board concludes that the placement of the phrase "in the hospital's service area" in the Subsection (b) Fraction confirms that, for purposes of the Subsection (a) Fraction, the phrase "in the hospital's service area" modifies "Medicare beneficiaries."[42] As a result, for purposes of the Subsection

---

[41] (Emphasis in original).

[42] This finding is also consistent with earlier iterations of the "no more than 25 percent" test in 42 C.F.R. § 412.92(a)(1). For example, in the 1985 edition of the C.F.R., the "no more than 25 percent test" was located in 42 C.F.R. § 412.92(a)(2)(i) and stated in pertinent part: "no more than 25 percent of the Medicare beneficiaries in the hospital's service area are admitted to other like hospitals for care."

(a) Fraction, the denominator restated using the § 412.92(a)(1)(ii) language becomes "Medicare beneficiaries [in the service area] who become hospital inpatients." The restated denominator for the Subsection (a) Fraction confirms that the denominator's ambiguity exists in the term "hospital inpatients." In particular, it is unclear whether the term "hospital inpatients" is limited to Medicare beneficiaries who reside in service area and are admitted as inpatients only to "like" hospitals (as opposed to both like and unlike) and whether these hospitals must be located within the 35 mile radius of the hospital applicant or, if larger, the hospital applicant's service area (as opposed to anywhere in the United States).

In reviewing the remainder of subsection (b)(1)(ii)(B), the Board finds that it is inconclusive in resolving the ambiguity in the term "hospital inpatients." The Board agrees with the Provider that subsection (b)(1)(ii)(B) requires the Provider to submit with its application admissions data from all other hospitals (both like and unlike) located *within* the specified geographic area (*i.e.*, the 35-mile radius of the Provider or, if larger, the Provider's service area). Further, the Board agrees with the Provider that the admissions data is being submitted for use with (*i.e.*, "to document") the "no more than 25 percent" test and that the limitation of the admissions data to other hospitals located within the specified geographic area suggests that the test's denominator as applied to the Provider would not include any admissions data from hospitals located outside the specified geographic area. Notwithstanding, the Board finds that this does not mean the denominator must necessarily include *all* of the § 412.92(b)(1)(ii)(B) admissions data from all hospitals (both like and unlike) located within the specified geographic area.[43] For example, the definition of "like hospital" in § 412.92(c)(2) excludes certain otherwise "like" hospitals on a case-by-case basis. While the admissions data required to be submitted under § 412.92(b)(1)(ii)(B) would include admissions data on any hospital that otherwise is excluded under the definition of "like" hospital, it is unclear from the face of § 412.92(a)(1)(i), and in particular the Subsection (a) Fraction, how the admissions data on these excluded hospitals, if any, would be used in the "no more than 25 percent" test. Indeed, this case-by-case exclusion process illustrates why CMS would want hospital applicants to submit the admissions data for all hospitals within the specified geographic area as part of the SCH application packet even though the admissions data for some of these hospitals might ultimately be excluded from use within the "no more than 25 percent" test.[44]

The Board notes that, in analyzing the remainder of § 412.92(b)(1)(ii)(B), the Board refers back to § 412.92(a)(1)(i) and the Subsection (a) Fraction rather than to § 412.92(b)(1)(ii)(B) and the Subsection (b) Fraction because § 412.92(b)(1)(ii)(B) does not specify, in the first instance, the

---

[43] As previously noted, the definition of "like hospitals" in 42 C.F.R. § 412.92(c)(2) excludes certain hospitals on a case-by-case basis that might otherwise be a "like" hospital based on certain criteria showing that that hospital is not similar to the provider applicant (*i.e.*, is not a competitor to the provider applicant). While admissions data must be submitted on these excluded hospitals as part of the application packet pursuant to § 412.92(b)(1)(ii)(B) , the regulation has ambiguity on whether the data for these excluded hospitals is excluded from both the numerator and denominator of the "no more than 25 percent" test or just the denominator.

[44] Moreover, PRM 15-1 § 2810(B)(3)(d) which is derived from the 42 C.F.R. § 412.92(a)(1)(ii) clarifies the regulatory process of excluding certain specialty admissions from both the numerator and denominator of the "no more than 25 percent" test. *See also* 53 Fed. Reg. at 38510-38513, (amending 42 C.F.R. § 412.92(b) to add § 412.92(b)(1)(ii)(B) as it exists in the 2009 edition of the C.F.R.). This manual section illustrates another circumstance in which not all of the admissions data required to be submitted by a provider applicant in § 412.92(b)(1)(ii)(B) would be used in the "no more than 25 percent" test.

criteria or formula for determining whether the Provider can obtain SCH status. Rather, § 412.92(b)(1)(ii)(B) paraphrases the Subsection (a) Fraction for the "no more than 25 percent" test (*i.e.*, the criteria or formula that is found in § 412.92(a)(1)(i)). Further, it is clear that § 412.92(b)(1)(ii)(B) was never meant to reflect the full universe of data (*i.e.*, "document" in full the data) to be included in the denominator of the "no more than 25 percent" test because the denominator clearly includes certain admissions data from the provider applicant and that data is requested in clause (A) (as opposed to clause (B)) of § 412.92(b)(1)(ii).

Based on the above analysis and findings, the Board concludes that § 412.92 is ambiguous about whether all of the admissions data specified in § 412.92(b)(1)(ii)(B) must be used in the "no more than 25 percent" test.

Having found the statute and the regulation ambiguous as to the question, the Board examined CMS policy as reflected in the preambles to proposed and final rules. First, the Board reviewed the preambles to the proposed and final rules which put in place the regulatory language at issue. CMS promulgated the language in controversy (except the 50-mile limit subsequently was reduced to 35-miles) as part of the final rule published on September 30, 1988 ("September 1988 Final Rule").[45] In the preamble to the September 1988 Final Rule, CMS clarified its policy for the "no more than 25 percent" test with the following discussion:

> Comment: One commenter pointed out an inconsistency between an SCH criterion as presented in the regulatory text and as discussed in preamble language. That is, the regulatory text a[t] § 412.92(a)(2)(i) states that we will measure whether more than 25 percent of the residents who become inpatients or 25 percent of the Medicare inpatients within a hospital's service area are admitted to other like hospitals for care. However, the preamble of the May 27, 1988 proposed rule states that this requirement can be satisfied if the hospital submits patient origin data from all other hospitals located within the larger of its service area or a 50-mile radius. The commenter noted that the regulatory test would require a hospital to identify every person within its service area or the 50-mile radius who was admitted to any hospital for treatment. Under the preamble language, a hospital seeking SCH status would have to show only that it admitted 75 percent of all inpatients admitted to any hospital located within the larger of its service area or a 50-mile radius. The commenter also asked about what assistance is available from HCFA if neighboring hospitals are uncooperative in providing data on admissions to their facilities.
>
> Response: We agree with the commenter that the language is confusing. We also recognize the difficulty of identifying every resident or Medicare beneficiary who became an inpatient during a particular period of time. Therefore, we are revising §412.92(a)(2)(i) to clarify that *a hospital seeking SCH status must*

[45] 53 Fed. Reg. 38476 (Sept. 30, 1988).

> *show that* during the cost reporting period ending before it files for SCH status, *it admitted at least* 75 percent of all the hospitalized residents or *75 percent of all the Medicare beneficiaries who were admitted to any like hospital located within the larger of the requesting hospital's service area or a 50-mile radius.*
>
> We also recognize that there are instances in which a hospital may experience difficulty in collecting the data to show the percentage of patients it admits from its service area. . . . We are therefore offering to assist hospitals in making available data from Medicare's central office records. Hospitals seeking this assistance should address their request to their intermediary.
>
> The hospital must furnish its full name, address and Medicare provider number and state that it is requesting patient origin data so that it may qualify as an SCH. *The hospital must furnish a complete listing of zip codes within its service area and it must provide the full name, address and, if available, the Medicare provider number of every other hospital located within the larger of its service area or a 50-mile radius. . . .*
>
> After the intermediary verifies the information furnished and forwards the hospital's request to HCFA's central office, *HCFA* will respond as rapidly as possible and *will provide a count by zip code of the number of Medicare discharges from each of the identified hospitals* for the one year period representing the requesting hospital's most recently completed cost reporting period. . . .
>
> Hospitals should be aware that if they fail to achieve SCH status based on HCFA-furnished data on Medicare patient origin, they may not substitute other patient origin data for the same time period to *demonstrate that the hospital seeking SCH status admitted at least 75 percent of all Medicare beneficiaries who were admitted to this hospital and all like hospitals within its service area or, if larger, a 50-mile radius.*[46]

The Board finds that the September 1988 Final Rule which implemented the language in controversy clarified that, of the admissions data specified in 42 C.F.R. § 412.92(b)(1)(ii)(B), only the admissions data that pertains to the hospital applicant and other "like" hospitals located within the larger of a 35-mile radius of the hospital applicant or the hospital applicant's service area would be included in the denominator of the "no more than 25 percent" test. In limiting the denominator to the inpatient admissions to "like" hospitals, CMS created a denominator based on homogenous units (*i.e.*, "like" hospitals), thereby allowing CMS to interchangeably describe this

[46] *Id.* at 38511-38512 (emphasis added).

test as either losing "no more than 25 percent"[47] of the market or keeping "at least 75 percent" of the market (*i.e.*, allowed CMS to describe the test from two perspectives – the glass one-quarter empty or the glass three-quarters full).[48] Finally, the above excerpt demonstrates CMS' expectation as reflected in § 412.92(b)(1)(ii)(A) and (B) that inpatient admissions data will be gathered for the hospital applicant as well as "every other hospital" located within a 35-mile radius (previously a 50-mile radius) of the hospital applicant or, if larger, the hospital applicant's service area, even though only the inpatient admissions data relating to the provider applicant and "like" hospitals is relevant to the "no more than 25 percent" test.

The Board finds subsequent final rules through the years reaffirmed CMS' interpretation of the "no more than 25 percent" test and further describe it as a "market share test" and a comparison with "like" hospitals. Examples include:

1. An excerpt from the final rule published on September 1, 1989.—

> As clarified in the September 30, 1988 final rule (53 FR 38510), a hospital located between 25 and 50 miles of a *like* hospital may qualify as an SCH if, during the cost reporting period ending before it applies for SCH status, it admitted at least 75 percent of all the hospitalized residents or 75 percent of all the Medicare beneficiaries who were admitted to any *like* hospital located within the larger of the requesting hospital's service area or a 50 mile radius. . . .
>
> We have concluded from our analysis of the Systemetrics data that *the current market share test* is inappropriate for hospitals that are located more than 35 miles from a *like* hospital. . . .
>
> Therefore, effective October 1, 1989, we proposed to modify our SCH criteria as set forth at § 412.92(a)(1) and (2) by eliminating the market share test for hospital located more than 35 miles from a *like* hospital.[49]

2. Another excerpt from the final rule published on September 1, 1989.—

> Although we are not accepting any of the commenter's specific suggestions at this time, we have concluded that the geographic area considered in the market share test is too broad. *Under current policy*, a hospital may qualify as an SCH if it admitted at least 75 percent of all the hospitalized residents or 75 percent of all the Medicare beneficiaries who were admitted to any *like* hospitals located within the larger of the requesting hospital's service area or a 50-mile radius. Consistent with our decision to eliminate *the*

[47] 42 C.F.R. §412.92(a)(1).
[48] *See* PRM 15-1 § 2810(B)(3)(d) (providing an example showing the resulting percentage as 76.2 percent).
[49] 54 Fed. Reg. 36452, 36481 (Sept. 1, 1989) (emphasis added).

market share test for hospitals located more than 35 miles from a *like* hospital, we are narrowing the geographic area to take into account admissions to *like* hospitals located within the larger of the requesting hospital's service area or a 35-mile radius. To implement this policy, we are revising § 412.92(a)(2)(i) and (b)(1)(ii)(B).[50]

3. Excerpt from the final rule published on August 1, 2001 ("August 2001 Final Rule").—

Comment: Several commenters were concerned with the following issues related to the qualifying criteria for sole community hospitals: . . . (4) including competing hospitals within a 35-mile radius of the requesting hospital as opposed to a 35-road-mile distance; . . . (8) CAHs as like hospitals; . . .

Response: . . . Fourth, we believe it is reasonable to examine a hospital's competitors within a 35-mile radius. Most competing hospitals will not be at the outer limit of the 35-mile radius, and, if these hospitals are not truly competitors, the discharge data will bear out that fact. Also, we examine a hospital's service area based on discharges within zip code areas, and, often, this will exceed a 35-mile radius. Therefore, we believe the 35-mile radius is reasonable. . . .

Eighth, we do not consider CAHs like hospitals to be SCHs. CAHs are generally smaller with a very limited length of stay, while SCHs operate as full-service acute care hospitals.[51]

4. Excerpt from the final rule published on August 1, 2002.—

We believe that limiting eligibility for SCH status to hospitals without SCH like hospitals in their service area is a way to identify those hospitals that truly are the sole source of short-term acute-care inpatient services in the community. A limited-service, specialty hospital, by definition, would not offer an alternate source of care in the community for most inpatient services and, therefore, we believe, should not be considered a "like" hospital with the effect of negating SCH status of a hospital that is the sole source of short-term acute care inpatient service in the community. Therefore, in the May 9, 2002 proposed rule, we proposed to amend the definition of SCH like hospitals under § 412.92(c)(2), effective with cost reporting periods beginning on or after October 1, 2002, to exclude any hospital that provides no more than a very

[50] *Id* at 36482 (emphasis added).
[51] 66 Fed. Reg. 39828, 39876 (Aug. 1, 2001) (emphasis in original).

> small percent of the services furnished by the SCH. We believe the percentage of overlapping services between the SCH and the limited service facility should be sufficiently small so that we can ensure that only hospitals that truly are the sole source of short-term acute care in their community qualify for SCH status.[52]

The Board finds that these same final rules are absent of comparisons of "like" hospital data to total hospital (like and unlike) data. Accordingly, the Board rejected the Provider's proposed interpretation of the "no more than 25 percent" test.

In conclusion, the Board finds that the statute and regulation have ambiguity as to whether the denominator of the "no more than 25 percent" test should include the admissions data from only "like" hospitals or all hospitals (both like and unlike). The Board finds the Intermediary's position that resident admissions to other "like" hospitals located within the a 35 mile radius of the hospital applicant or, if larger, the hospital applicant's service area are properly includable in the market share calculation.

ISSUE 1: WHETHER THE REGIONAL OFFICE PERFORMED THE MARKET SHARE CALCULATION OVER THE CORRECT GEOGRAPHICAL AREA.

At the outset, the Board notes that Issue 1 affects those discharges that are included in both the numerator and denominator of the market share test (*i.e.*, the "no more than 25 percent" test) and the Provider must have a resulting percentage that is 25 percent or less pursuant to 42 C.F.R. § 412.92(a)(1)(i). Based on the resolution of Issue 2, Issue 1 involves three potential outcomes that essentially result in the following formulas being applied to the Provider with the resulting percentages shown to the right:

Potential Formulas		Percentage
1. Expressed as a percentage, the discharges from other "like" hospitals located within the 35 mile radius of the Provider divided by the sum of the discharges from the Provider and the discharges included in the numerator.	$\frac{2435}{7542+2435}$	24.4%
2. Expressed as a percentage, the discharges from *any* other "like" hospitals located within the Provider's service area divided by the sum of the discharges from the Provider and the discharges included in the numerator.	$\frac{2913}{7542+2913}$	27.9%
3. Expressed as a percentage, the discharges from *any* other "like" hospitals located within either the 35 mile radius of the Provider or, if larger, the Provider's service area divided by the sum of the discharges from the Provider and the discharges included in the numerator.	$\frac{2435+2913}{7542+5348}$	41.5%

[52] 67 Fed. Reg. 49982, 50054 (Aug. 1, 2002).

This chart illustrates that, based on the Board's resolution of Issue 2, there is only one way for the Provider to have market share test result in a percentage of 25 percent or less. Specifically, in order for the Provider to prevail, the Board must determine that the appropriate geographic area to be applied in the market share calculation for the Provider is the area bound by a 35 mile radius from the Provider. Accordingly, the Provider contends that the first formula represents the appropriate way to conduct the market share test delineated in 42 C.F.R. § 412.92(a)(1)(i) for the Provider because the words "or, if larger," in this regulation require a geographical size comparison between Provider's service area (*i.e*1641 square miles) and the area of a 35 mile radius (*i.e.* 3848 square miles).[53] However, as explained below, the Board disagrees and finds that the Provider's interpretation is not consistent with the guidance on the market share test.

The relevant language in the 42 C.F.R. § 412.92(a)(1)(i) for this issue is "other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area." On its face, this regulatory language could have multiple interpretations, including the one advocated by the Provider.

In this case, it appears that the CMS Regional Office has interpreted and applied this language to mean *any* other like hospital located within *either* a 35-mile radius of the hospital, *or*, if larger, its service area. Under this interpretation, a like hospital located within the hospital applicant's service area is always included in the market share test. But it would also include those hospitals within the 35-mile radius. The Board finds that this interpretation does not reflect the clear intent of the change in the regulation as discussed in the preamble to the September 1989 Final Rule.

The September 1989 Final Rule changed both how the market share test is triggered and how the market share test is applied by reducing the 50 miles that was used in each down to 35 miles. Specifically, the trigger for the market share test was changed from "[t]he hospital is located between 25 and *50 miles* from other like hospitals" to "[t]he hospital is located between 25 and *35 miles* from other like hospitals."[54] The market share test itself was changed from "[n]o more than 25 percent of Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located with a *50-mile radius* of the hospital, or, if larger, within its service area" to "[n]o more than 25 percent of Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located with a *35-mile radius* of the hospital, or, if larger, within its service area."[55]
The following preamble discussion describes the reasoning behind the regulatory changes and focuses on the trigger for the market share test:

> With the deterioration in the financial condition of many rural hospitals, our ability to define appropriately those hospitals that represent the *sole source of care reasonably available to Medicare beneficiaries* has become increasingly important. In this regard, our criteria for SCH designation have remained largely unchanged since the beginning of the prospective payment system. The

[53] *See* Provider Powerpoint Presentation at Slide 10.
[54] *Compare* 42 C.F.R. § 412.92(a)(1) (1988) with 42 C.F.R. § 412.92(a)(1) (1989) (emphasis added).
[55] *Compare* 42 C.F.R. § 412.92(a)(1)(i) (1988) to 42 C.F.R. § 412.92(a)(1)(i) (1989).

> regulations reflect an assumption that any hospital located more than 50 miles from the nearest like hospital is the sole source of care reasonably available; conversely, it is assumed that a hospital located within 25 miles of a like hospital would not be the sole source of care reasonably available unless weather conditions make other hospitals inaccessible at least one month per year.
>
> An analysis performed by Systemetrics under contract to ProPAC found that there is *an interrelationship between the definition of market area* ***and*** *market share*. Generally speaking, the more broadly a hospital's *market area* is defined, the lower the hospital's market share percentage will be. . . .

Further, the following discussion in preamble to the September 1989 Final Rule demonstrates the range of options CMS considered in revising the market share test generally and in defining the "market area" or "geographic area" over which to apply the "market share test":

> Comment: One commenter suggested numerous revisions to our qualifying criteria ranging from redefining the service area as the smaller of a 35-mile radius from the hospital or the area from which a hospital draws at least 50 percent of its patients. The commenter proposed that we lower the market share test from 75 percent to 60 percent and that we lower from 35 miles to 25 miles the distance from another hospital as the presumptive proof of SCH status. The stated goal of all of these revisions was not only to assure reasonable access for Medicare beneficiaries, but also to improve financial benefits to rural hospitals.
>
> Response: We do not agree with the premise for the commenter's suggestions. All of them would liberalize the SCH provisions beyond what we believe was Congressional intent in establishing this provision. For instance, granting SCH status to any hospital more than 25 miles from any other hospital would mean that a beneficiary located between the two hospitals would be no more than 12.5 miles from a hospital; we do not believe such a short distance reflects an accessibility problem.
>
> Redefining the service area as the commenter suggested would result in a significant increase in the number of rural hospitals qualifying as SCHs and would include some hospitals that we believe do not represent the sole source of care reasonably available to Medicare beneficiaries. *If a significant portion of the residents in a hospital's service area seek care from other hospitals, this indicates that alternative sources of inpatient care are reasonable available.*

> Although we are not accepting any of the commenter's specific suggestions at this time, we have concluded that the geographic area considered in the market share test is too broad. Under current policy, a hospital may qualify as an SCH if it admitted at least 75 percent of all hospitalized resident or *75 percent of all the Medicare beneficiaries who were admitted to any like hospitals located within the larger of the requesting hospital's service area or a 50-mile radius*. Consistent without our decision to eliminate the market share test for hospitals located more than 35 miles from a like hospital, we are narrowing the geographic area to take into account *admissions to like hospital located within the larger of the requesting hospital's service area or a 35 mile-radius*. To implement this policy, we are revising § 412.92(a)(2)(i) and (b)(1)(ii)(B).[56]

The use of the phrase "within the larger of the requesting hospital's service area or a 35-mile radius" suggests that CMS contemplated that the provider-applicant's "market area" could be "larger" than the 35-mile radius area. This discussion did not, however, justify using a "market area" in the market share test which includes *both* like hospitals within the 35-mile radius *and* the service area as the Intermediary proposes. Rather, the operative words in the phrase are "larger of" and they require a comparison between "the requesting hospital's service area and "a 35-mile radius."[57] As a result, the Board rejects the Intermediary's determination.

The Board recognizes that the above preamble discussion (with the radius changing from 50 miles down to 35 miles) suggests that the competitors relevant for the market share test would be "*any* like hospitals located *within the larger of* the requesting hospital's service area *or* a 35-mile radius."[58] For the Board, the central question in this case is what does the term "larger" mean in the phrase "any like hospitals located within the larger of the requesting hospital's service area or a 35-mile radius"? Unfortunately, neither the controlling regulation nor CMS guidance define this term. As this term could refer to a range of things (*e.g.* a comparison of square miles, distance away from the hospital applicant, or the resulting percentage under the market share test), the Board considered the nature and purpose of the market share test in determining what that term would mean in the context of this preamble language.

The Board considered but ruled out the term "larger" meaning a comparison of the resulting percentage under the market share test (*i.e.* does the market share test result in a larger percentage, using as the numerator, the inpatient admissions from only the other like hospitals

---

[56] *Id.* at 36482 (emphasis added).

[57] The Board notes that this phrase with operative words "larger of" is used in other places in the September 1989 Final Rule as well as in other preambles to final rules.

[58] (Emphasis added.) Similarly, PRM 15-1 § 2810(B)(3)(c) includes similar conflicting language and does not add any clarification. For example, compare: (1) "In order to document that no more than 25 percent of the residents or, if applicable, Medicare beneficiaries from the hospital's service area were admitted to other like hospitals for care, admissions data from all hospitals located within 35 miles of the requesting hospital or, if larger, the requesting hospital's service area, must be analyzed" and (2) "it [the hospital applicant] must provide the full name and address and, if available, the Medicare provider number of every other hospital located within *the larger of* the hospital's service area or a 35-mile radius." (Emphasis added.)

located in the service area rather than the inpatient admissions from only the other like hospitals located within a 35-mile radius of the hospital applicant). The Board ruled out this potential meaning because its review of the preamble discussion suggests that the term "larger" was grounded in geography (*e.g.* distance or square miles). An example is the following discussion in the preamble to the August 2001 Final Rule discussing the documentation that hospital is required to submit: "[T[he hospital must provide patient origin data from all other hospitals located with a 35-mile radius of it or, if larger, within its service area."[59]

Further, as explained below and contrary to the Provider's position, the Board believes that the term "larger" refers not to square miles as the Provider advocates but rather the geographic length or width and whether the service area extends outside the geographic boundary of the 35-mile radius circle. Thus, one interpretation of the language in the regulation, and that which the Board accepts, is that the service area is "larger" because it exceeds the geographic boundary of the 35-mile radius. Consistent with the regulatory intent to use "the larger of" the 35-mile radius area or the service area (*i.e.* one but not both), the correct area in which to measure market share in this case is the service area.

The regulation requires the applicant hospital to define its service area by looking at the fewest number of zip codes from which it draws 75 percent of its inpatients. The zip codes defining the service area do not have to be contiguous[60] and may fall outside or "exceed" the boundaries of the 35-mile radius in part or in whole.[61] The regulation appears to acknowledge that the service area may, in fact, be "larger" not necessarily in square miles as the Provider advocates but in distance from the applicant hospital and that it is not unreasonable to compare the market share of these hospitals to the applicant hospital. The Board finds that the defining the term "larger" in terms of distance rather than square miles to be inherently more rational. The Board notes that the likelihood that a service area "will exceed" a 35-mile radius from a hospital applicant is greater than the square mileage of a service area being greater than the area a circle with a 35-mile radius and that, whenever the square miles of a hospital applicant's service area is greater than the area of a circle with a 35-mile radius, then it necessarily means that service area would exceed the boundaries of the 35-mile radius from the hospital applicant.[62] Further, the Board notes that any other like hospital located within a hospital applicant's service area clearly would be natural competitors to that applicant. As the market area where the competitors are located is relevant to the market share test, it makes sense to define "larger" in terms of distance to ensure that any other like hospital located within the service area is always considered.

The Board concludes, therefore, that the service area for the Provider in this case is, indeed, larger than the 35-mile radius and that the service area should be used in applying the market share test. The only like hospital in the service area is the Marshalltown Medical and Surgical Center which discharges more than 25 percent (*i.e.* 27.9 percent) of the Medicare beneficiaries who reside in the service area. Thus, while the Board disagrees with the Intermediary's method

---

[59] 66 Fed. Reg. at 39875.

[60] *See* 61 Fed. Reg. 46166, 46203 (Aug. 30, 1996) (confirming that, as of October 1, 1988, CMS began using the least number of the zip codes without regard to whether the zip codes were contiguous to establish a hospital applicant's service area, *i.e.*, the area from which the hospital applicant draws 75 percent of its inpatients).

[61] *See supra* note 51 and accompanying text (excerpt from the preamble to the August 2001 Final Rule).

[62] *See* 66 Fed. Reg. at 39875 (noting that a hospital applicant's service area "often . . . will exceed a 35-mile radius").

of calculating market share in this case, the alternative calculation that the Board has determined to be the best interpretation of the language and intent of the regulation upholds the Intermediary's determination to deny SCH status to the Provider.

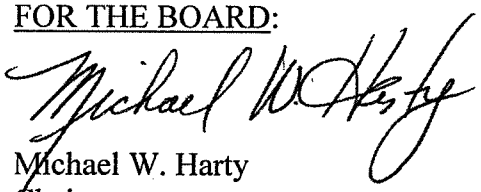
DECISION AND ORDER:

The Board finds that the Intermediary and Regional Office properly denied the Provider's request for classification as a Sole Community Hospital on the grounds that the Provider failed to meet the market share criteria under 42 C.F.R. § 412.92(a)(1)(i).

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: SEP 10 2014