PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2020-D22

PROVIDER –
AnMed Health

PROVIDER NO.: 42-0027

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

HEARING DATE –
April 23, 2019

REPORTING PERIOD: Discharges on or after August 25, 2017

CASE NO. – 18-0556

INDEX

ISSUE STATEMENT

Whether the denial of the Provider's request for sole community hospital ("SCH") designation by the Centers for Medicare and Medicaid Services ("CMS") and the Medicare Contractor was proper.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that CMS and the Medicare Contractor improperly denied the request of AnMed Health ("AnMed") for SCH designation and that AnMed should be approved for an SCH designation effective for discharges on or after August 25, 2017.

INTRODUCTION

AnMed is an acute care hospital located in Anderson, South Carolina, and the Medicare contractor[2] assigned to AnMed is National Government Services, Inc. ("Medicare Contractor" [3]). AnMed operates two campuses:

1. The Medical Center Campus, which is located at 800 North Fant Street, houses a 461 bed acute care hospital and is AnMed's main campus.[4] The Board will refer to this as simply "the AnMed Main Campus."

2. AnMed also operates the Women's and Children's Hospital which is a 72-bed facility located at 2000 E. Greenville Street and is known (and will be referred to herein) as the "North Campus." The Board will refer to this as the "AnMed North Campus."[5]

AnMed filed a request with the Medicare Contractor for SCH designation on December 21, 2016.[6] The Medicare Contractor denied the request on July 25, 2017, stating that AnMed did not meet the distance requirement set forth in 42 C.F.R. § 412.92(a). The Medicare Contractor utilized the locations of both the AnMed Main Campus and the AnMed North Campus in evaluating the distance criteria of "between 25 and 35 miles from other like hospitals." The Medicare Contractor found that the AnMed North Campus was less than 25 miles from two other "like" hospitals – Baptist Easley Hospital and Greenville Memorial Hospital.[7] On August 11, 2017, AnMed disagreed with the Medicare Contractor's application of the § 412.92(a)

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[1] Transcript ("Tr.") at 5.
[2] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[3] Palmetto GBA was AnMed's Medicare contractor at the time the SCH determination was made and National Government Services, Inc. serves in that capacity now. The term "Medicare Contractor" refers to both Medicare contractors as relevant.
[4] Tr. at 67. *See also* Medicare Contractor Final Position Paper at 4.
[5] Provider's Responsive Brief at 3. *See also* Tr. at 21, 50.
[6] Provider Exhibit P-1.
[7] Provider Exhibit P-2.

requirement and submitted a reconsideration request based on the fact that the AnMed Main Campus was more than 25 miles from other "like" hospitals.[8] On October 12, 2017, the Medicare Contractor denied the reconsideration request.[9]

AnMed timely appealed the denial of SCH designation to the Board, and met the jurisdictional requirements for a hearing. The Board conducted a live hearing on April 23, 2019. AnMed was represented by Barbara Straub Williams, Esq. of Powers, Pyles, Sutter & Verville, P.C. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services.

STATEMENT OF FACTS

The Medicare program reimburses most participating hospitals for the operating costs of their inpatient hospital services through the Inpatient Prospective Payment System ("IPPS").[10] IPPS provides Medicare payment for hospital inpatient operating costs at predetermined, specific rates for each hospital discharge with certain additional add-on payments or adjustments.

The Medicare program allows special treatment under IPPS for a facility that qualifies to be an SCH. CMS regulations at 42 C.F.R. § 412.92 set forth the special treatment of facilities designated as SCHs and establish the criteria that must be met in order for a hospital to be designated as an 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).[11] In particular, 42 C.F.R.§ 412.92(a)(1) (2017) establishes the following criteria that a hospital must meet to obtain an "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:
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> (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;
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> (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

[8] Provider Exhibit P-3.
[9] Provider Exhibit P-4.
[10] *See* 42 U.S.C. § 1395ww(d).
[11] 42 U.S.C. § 1395ww(d)(5)(D)(iii).

> 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
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> (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.[12]

The terms "miles," "like hospital," and "service area" as used within § 412.92 (2017) 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 <u>of the hospital</u>**.
>
> (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.
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> (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 regulation at 42 C.F.R. § 413.65 (2017) established requirements for provider-based departments and facilities and, in subsection (a)(2), defines the terms "main provider" and "remote location" as follows:

> *Main provider* means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

[12] (Italics emphasis in original and bold, underline emphasis added.)
[13] (Italics emphasis in original and bold, underline emphasis added.)

* * *

> *Remote location of a hospital* means a facility or an organization that is either created by, or acquired by, a hospital that is a **main provider** for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital comprises both the specific physical facility that serves as the site of services for which separate payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. The Medicare conditions of participation do not apply to a remote location of a hospital as an **independent** entity. For purposes of this part, the term "remote location of a hospital" does not include a satellite facility as defined in §§ 412.22(h)(1) and 412.25(e)(1) of this chapter.[14]

In the FY 2019 IPPS Final Rule, CMS amended the SCH regulations to add § 412.92(a)(4).[15] This amendment was effective October 1, 2018 and requires that, if a hospital is comprised of a "main provider" and one or more "remote locations" and applied to be an SCH, then the main provider and the remote location(s) must each separately satisfy the § 412.92(a)(1) distance requirements in order for the hospital qualify as an SCH. CMS stated in the FY 2019 IPPS Final Rule that through this amendment, it was clarifying existing SCH policies already in effect, not changing policy.[16]

The Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2810 further clarifies the process of qualifying for designation as an SCH and includes detailed instructions on how to submit a request for SCH designation. In particular, it describes the documentation that a hospital must submit to substantiate its request for SCH designation. PRM 15-1 § 2810 reflects the documentation requirements of 42 C.F.R. § 412.92(b).

The issue in this case is whether the Medicare Contractor should measure the distance to a like hospital from both the front entrance of the AnMed Main Campus and the front entrance of the AnMed North Campus ***or*** only from the front entrance of the AnMed Main Campus, to determine if AnMed meets the requirement in 42 C.F.R. § 412.92(a)(1) (2017) that AnMed be "located between 25 and 35 miles from other like hospitals."

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[14] (Bold emphasis added.) The Secretary originally promulgated these definitions as part of the final rule at 65 Fed. Reg. 18434, 18538 (Apr. 7, 2000) and only minor modifications were made between then and the time at issue.
[15] 83 Fed. Reg. 41144, 41702 (Aug. 17, 2018).
[16] *Id.* at 41369-41374.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor denied AnMed's application for SCH designation based on its determination that the AnMed North Campus is a "remote location" as defined in 42 C.F.R. § 413.65(a)(2) and this location is does not meet the § 412.92(a)(1) distance requirements since it is not located 25 miles or greater from other like hospitals.[17] AnMed maintains that the Medicare Contractor's denial of its request for SCH designation is contrary to the plain meaning of the Medicare regulations governing SCHs that were in effect at the time of the application. AnMed position revolves primarily around the following definition of "miles" in § 412.92(c)(1):

> 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*.[18]

AnMed maintains that the use of the term "the hospital" should have one meaning throughout § 412.92 and that, with regard to the phrase "the front entrance of the hospital" in § 412.92(c)(1), AnMed consists of only one "hospital" and "the front entrance of the hospital" necessarily refers to one entrance, the main entrance. Under this interpretation, Anmed's "front entrance" would be the main or front entrance to the AnMed Main Campus located at 800 North Fant Street.[19] According to AnMed, the above regulation establishing the mileage standard is stated in the singular: the distance is measured to "*the* front entrance of *the* hospital," not to entrance**s** or hospital**s** or to location**s**/campuse**s**. AnMed argues that it is nonsensical to suggest that a hospital can have "the front entrance" on two separate buildings that are several miles apart. Thus, AnMed believes "the front entrance of the hospital" plainly refers to a single entrance on a single building and, in this instance, the 800 North Fant Street entrance.[20]

AnMed recognizes that 42 C.F.R. § 412.92(a) (as amended by the FY 2019 IPPS Final Rule) *now* requires that the distance to a like hospital be measured from the main hospital and all remote locations. However, AnMed asserts that this is a change in CMS policy and that this change cannot be applied retroactively without Congressional approval.[21]

In support of its position, the Medicare Contractor points out that: (1) the AnMed North Campus location provides *inpatient* hospital services including adult surgery, inpatient pediatric care, maternity services and joint replacement surgery; and (2) when AnMed files its cost report it combines the cost and statistical data of the AnMed North Campus with the information for the AnMed Main Campus and files one cost report using the same CMS Certification Number

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[17] Provider Exhibit P-2.
[18] *See* Provider's Final Position Paper at 10 (quoting 42 C.F.R. § 412.92(c)(1) (emphasis added)).
[19] At the hearing, the AnMed's witness confirmed that the North Campus does not have an emergency room on location and testified to his understanding that, under South Carolina law, the AnMed North Campus would not be licensed as a hospital if it did not have the ability to access the emergency department at the AnMed Main Campus. *Tr.* at 34-36.
[20] *See* Provider's Final Position Paper at 10-11.
[21] *Id.* at 9, 26-31.

("CCN").[22] Therefore, the Medicare Contractor argues that it is appropriate to separately consider whether either campus is "the hospital" under 42 C.F.R. § 412.92 and that both locations must be evaluated and separately meet the § 412.92(a)(1) distance requirements, specifically the requirement specifying that "the hospital" be located "between 25 and 35 miles from other like hospitals." More specifically, the Medicare Contractor contends that AnMed did not meet the § 412.92(a)(1) criteria to be designated as an SCH because the AnMed North Campus is less than 25 miles from two like hospitals, Baptist Easley (23.3 miles) and Greenville Hospital Center (24.9 miles).[23]

The Medicare Contractor recognizes that the FY 2019 IPPS Final Rule added the requirement in § 412.92(a)(4) that both the "main provider" and any "remote locations" must separately meet the § 412.92(a)(1) distance requirements but disagrees with AnMed that this requirement was a new CMS SCH policy. The Medicare Contractor contends that the new § 412.92(a)(4) simply reiterates current CMS policy that was in effect during the time period at issue. In support of this assertion, the Medicare Contractor points to the following discussion in the preamble to the FY 2019 IPPS Final Rule:

> To qualify for SCH status, for example, it would be insufficient for only the main campus, and not the remote location, to meet distance criteria. Rather the main campus and its remote location(s) would each need to meet at least one of the criteria at § 412.92(a). Specifically, the main campus and its remote location must be each located more than 35 miles from other like hospitals, or if in a rural area, be located between 25 and 35 miles from other like hospitals if meeting one of the criteria at § 412.92(a)(1) (and each meet the criterion at § 412.92 (a)(1)(iii) if applicable), or between 15 and 25 miles from other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years, or travel time to the nearest hospital is at least 45 minutes. We believe this is necessary to show that the hospital is indeed the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under Medicare Part A, as required by section 1886(d)(5)(D)(iii)(II) of the Act. For hospitals with remote locations that apply for SCH classification under § 412.92(a)(1)(i) and (ii), combined data are used to document the boundaries of the hospital's service area using data from across both locations, as discussed earlier, and all like hospitals within a 35-mile radius of each location are included in the analysis.[24]

Following a review of the parties' position papers and evidence presented at hearing, the Board finds that a plain reading of § 412.92 confirms that the term "the hospital"[25] as used therein

[22] Medicare Contractor Final Position Paper at 8.
[23] *See id.* at 9-10.
[24] *See id.* at 9 (referencing 83 Fed. Reg. 41144, 41370 (Aug. 17, 2018)).
[25] The Board notes that, for purposes of participating in the Medicare program pursuant to 42 C.F.R. Part 489, "the hospital" is a unit which would necessarily encompass both the hospital's "main provider" location and any

necessarily encompasses both the AnMed Main Campus and the AnMed North Campus; and (2) the distance requirements specified in § 412.92(a)(1) should have only been measured from the AnMed Main Campus located at 800 North Fant Street where "the front entrance of the hospital" is located in this instance, and not from the remote location (*i.e*., the AnMed North Campus). Although the Medicare Contractor points out that CMS stated in the FY 2019 IPPS Final Rule that it was clarifying its longstanding policy to include remote location in the distance calculation, the Board finds no support for this statement. Rather, the Board finds that the regulation at 42 C.F.R. § 412.92(c)(1) (2017) is very specific in determining mileage by measuring "paved surface up to *the* front entrance of *the* hospital" and makes no mention of remote locations or multiple front entrances.[26] Absent evidence to the contrary the Board finds that the plain meaning of "the front entrance of the hospital" as used in § 412.92(c)(1) references a single entrance on a single building as does the usage of "the hospital" in the following phrase from § 412.92(a)(1): "The hospital is located between 25 and 35 miles from other like hospitals."

Additionally, in the FY 2002 IPPS rulemakings (both the proposed and final rules) when CMS discusses how mileage is to be calculated from an SCH to a like hospital, CMS states the mileage calculation is to include "paved surfaces up to the front entrance of the hospital." CMS goes on to state:

> This definition provides consistency with the interpretation of the MGCRB when considering hospital reclassification applications. The MGCRB measures the distance between the hospital and the county line of the area to which it seeks reclassification beginning with paved area outside the front entrance of the hospital. This provides a consistent, national definition that is easily recognizable for each hospital. Finally, rounding of mileage is not permissible. This is also consistent with *the MGCRB definition of mileage*.[27]

Based on this CMS statement, the Board finds that § 412.92(c)(1) must be interpreted consistent with then-existing MGCRB definition of "miles" where distance from the hospital is measured based on paved surfaces from the front door of the main hospital.[28]

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associated "remote location[s]" as those two terms are defined in 42 C.F.R. § 413.65(a)(2) for purposes of "provider-based determinations" under § 413.65. Hence, § 412.92(a) begins with the words: "CMS classifies ***a hospital*** as a sole community hospital if it is . . . ." (Emphasis added.)

[26] (Emphasis added.) In this regard, the Board notes that the article "the" was used in two key instances rather than the article "an": "*the* front entrance of *the* hospital." Further, all of the nouns in this phrase are singular. This coupled with the Secretary's concession in the preamble to the FY 2019 IPPS Final Rule that the then-existing § 412.92(a) requirements for SCH designation did not address multicampuses. *See infra* notes 32-35 and accompanying text. Further, the Board notes that PRM 15-1 § 2810 (Rev. 479) addresses the requirements to be designated an SCH and, in particular, describe in great detail the information and documentation that must be included in an SCH application. However, these provisions do not require information on a hospital applicant's remote locations much less require distance measurements from remote locations to other like hospitals.

[27] 66 Fed. Reg. 22645, 22685 (May 4, 2001) (proposed rule); 66 Fed Reg. 39828, 39874-39875 (Aug. 1, 2001) (emphasis added) (final rule) (copy at Exhibit P-9).

[28] *See* 83 Fed. Reg. at 41369-41370.

Indeed, in the context of another rulemaking, the Secretary made clear that the then-existing § 412.92(a) requirements for SCH designation did *not* address multicampuses. Specifically, in the FY 2008 IPPS Final Rule, CMS formally adopted a rule applicable to Critical Access Hospitals ("CAHs") that stated, when a *CAH* has a remote location, distance is to be measured from *both a main campus and a remote location* in determining if a CAH continues to meet the distance requirements relative to other facilities as specified in 42 C.F.R. § 485.610(c).[29] In the comments to the FY 2008 IPPS Final Rule, an ***SCH*** expressed concerns regarding the loss of ***its*** special reimbursement status if it met community needs by developing provider-based or off-campus services and questioned why CMS was treating CAHs *differently*. In its response, CMS stated the following:

> Ultimately though, the distance-based requirement, as one of the requirements to become certified as a CAH, is provided for in the statute and in the regulation. We believe that the distance requirement is a statutory requirement that reflects the intent of the *CAH* program to provide hospital-level services in essentially small rural communities. Our proposal reflects this understanding and ***the special status of CAHs*** **(*as opposed to other rural entities***) and should not limit access to care.[30]

As explained in the FY 2008 IPPS Final Rule the application of the distance requirement to remote locations of CAHs was specifically tied to the intent of the CAH statute and the special status of CAHs compared to other rural providers. Based on CMS' own comments, the Board finds that this new requirement, utilizing a CAH's remote location's distance to other hospitals, was *not* intended to apply to SCHs.[31]

Finally, as noted in the FY 2019 IPPS Final Rule, CMS became aware of an increase in the number of multicampus hospitals and expanded 42 C.F.R § 412.92 to include multicampus hospitals. In this regard, the preamble to this Rule states in pertinent part:

> As discussed in the FY 2019 IPPS/LTCH PPS proposed rule (83 FR 20358 through 20360), *we have received an increasing number of inquiries regarding the treatment of multicampus hospitals as the number of multicampus hospitals has grown in recent years*. While the regulations at § 412.230(d)(2)(iii) and (v) for geographic reclassification under the MGCRB include criteria for how multicampus hospitals may be reclassified, *the regulations at § 412.92 for sole community hospitals* (SCHs), § 412.96 for rural referral centers (RRCs), § 412.103 for rural reclassification, and § 412.108 for Medicare-dependent, small rural hospitals (MDHs) *do **not** directly address multicampus hospitals*. Thus, in the FY 2019 proposed rule, *we proposed to codify in these regulations the*

[29] *See* 72 Fed. Reg. 66580, 66877-66882 (Nov. 27, 2007) (adopting revisions at 42 C.F.R. § 485.610(e)(2) to address multicampus CAHs) (copy at Exhibit P-14).
[30] *Id.* at 66880-66881 (Emphasis added).
[31] *See also* Provider's Final Position Paper at 14.

> *policies for multicampus hospitals that we have developed in response* to recent questions regarding CMS' treatment of multicampus hospitals for purposes other than geographic reclassification under the MGCRB.
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> ***
>
> To qualify for SCH status, for example, it would be insufficient for only the main campus and not the remote location, to meet distance criteria. Rather, the main campus and its remote location(s) would each need to meet at least one of the criteria at §412.92(a).[32]

The Board finds that, in this preamble discussion, the Secretary has conceded that the then-existing "regulations at § 412.92 for sole community hospitals (SCHs)… do ***not*** directly ***address*** multicampus hospitals" and, hence, "we proposed *to codify* in these regulations *the policies* for multicampus hospitals that we developed in response to recent questions regarding treatment of multicampus hospitals."[33] Moreover, this preamble discussion makes clear that the Secretary's prior multicampus policy was initially developed and applied in the context of MGCRB reclassification and that the application of such policies to the § 412.92(a) requirements for SCH designation was new, inasmuch as that application was "developed in response to *recent* questions regarding CMS' treatment of multicampus hospitals for purposes other than geographic reclassification under the MGCRB."[34] Accordingly, the Board must conclude that, *for purposes of the § 412.92(a) requirements for designation as an SCH*, the multicampus policies published in the FY 2019 IPPS Final Rule were ***not*** in place at the time of AnMed's SCH application and that the FY 2019 IPPS final rule was not a clarification of long-standing policy *as it relates to § 412.92(a) requirements for SCH designation*.[35] Rather, this announced to the provider community a clear change in policy on the § 412.92(a) requirements for SCH designation and, therefore, cannot be applied retroactively to AnMed's 2017 SCH application.

The Supreme Court's recent decision in *Azar v. Allina Health Services* ("*Allina*")[36] supports the Board's decision that the policy underlying the revisions made to § 412.92 by FY 2019 IPPS Final Rule is a "substantive policy" change and cannot be applied retroactively. In *Allina*, the

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[32] 83 Fed. Reg. 41144, 41369-41370 (Aug. 17, 2018) (emphasis added).

[33] *Id.* (emphasis added); *see also id.* at 41372 (stating "Thus, the policies discussed in the proposed rule are our existing policies currently in effect, and our intent was to provide greater clarification of these policies *by codifying them in the regulations*." (emphasis added)).

[34] *Id.* The Board notes that the Secretary has recognized that MGCRB policy is separate and distinct from the § 412.92(a) requirements for SCH designation (*i.e.*, multicampus policies adopted in the MGCRB context do not automatically apply to other contexts). For example, when the Secretary adopted the "miles" definition in § 412.92 as part of the FY 2002 IPPS rulemaking, he made clear he was proposing to adopt the MGCRB definition of "miles" for purposes of providing "a consistent, national definition that is easily recognizable for each hospital" and "consistent with the MGCRB definition of 'miles'." 66 Fed. Reg. 22646, 22685 (May 4, 2001) (proposed rule for FY 2002 IPPS). Thus, there was not a wholesale incorporation of MGCRB policies into the § 412.92(a) requirements for SCH designation.

[35] The Board notes that the Medicare Contractor has not produced any written CMS policy statements (*e.g.*, manuals, memoranda, or transmittals) issued prior to the FY 2019 IPPS Final Rule that provide notice to the provider community of any multicampus policy being applied to the § 412.92(a) requirements for SCH designation.

[36] 139 S. Ct. 1804 (2019).

Supreme Court ruled on the scope of Medicare policy issuances that are subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) by making clear that the "the government's 2014 announcement of the 2012 Medicare fractions [to be used in DSH calculations for FY 2012]" where the Agency "'le[t] the public know [the agency's] current . . . adjudicatory approach' to a critical question involved in calculating payments for thousands of hospitals nationwide" was a "statement of policy . . . that establishes or changes a substantive legal standard" as that phrase is used in 42 U.S.C. § 1395hh(a)(2) and, thus, was subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2).[37] Moreover, it is clear that applying a multicampus policy is substantive as highlighted by the substantive nature of the comments that the Secretary received when, in 2007, he codified the CAH multicampus policy at 42 C.F.R. § 485.610(e)[38] and when, in 2018, he later codified the SCH multicampus policy at 42 C.F.R. § 412.92(a)(4).[39]

Applying the concepts of the *Allina* decision to 42 C.F.R. § 412.92 casts further doubt on the Secretary's claim in the preamble to the FY 2019 IPPS Final Rule that considering remote locations in the measurement of miles from a like hospital for purposes of the § 412.92(a) requirements for SCH designation was truly his policy prior to the FY 2019 IPPS Final Rule. To illustrate this, the Board looks to 42 C.F.R. § 412.92(b) as it existed prior to the FY 2019 IPPS Final Rule. First, § 412.92(b)(3)(ii) (2017) lists the following five specific events, that if any of them occur, a hospital's SCH classification would be affected and the SCH and must communicate that event to its Medicare contractor within thirty days:

> (A) The opening of a new hospital in its service area.
>
> (B) The opening of a new road between itself and a like provider within 35 miles.
>
> (C) An increase in the number of beds to more than 50 if the hospital qualifies as a sole community hospital under paragraph (a)(1)(ii) of this section.
>
> (D) Its geographical classification changes.
>
> (E) Any changes to driving conditions that result in a decrease in the amount of travel time between itself and a like provider if the hospital qualifies as a sole community hospital under paragraph (a)(3) of this section.

Second, the Secretary includes the following catchall reporting requirement in § 412.92(b)(iii) (2017):

> A sole community hospital *must report* to the fiscal intermediary if it becomes aware of ***any change that would affect its classification***

[37] *Id.* at 1810, 1817 (citations omitted).
[38] *See* 72 Fed. Reg. at 66878-66882; *see also supra* notes 29-31 and accompanying text.
[39] *See* 83 Fed. Reg. at 41702.

> as a sole community hospital *beyond the events listed in paragraph (b)(3)(ii)* of this section within 30 days of the event. If CMS determines that a sole community hospital has failed to comply with this requirement, CMS will cancel the hospital's classification as a sole community hospital effective with the date the hospital became aware of the event that resulted in the sole community hospital no longer meeting the criteria for such classification, consistent with the provisions of § 405.1885 of this chapter.[40]

Clearly, if the opening of a remote location affected a hospital's continued status as an SCH in 2017, then CMS would (and should) have either: (a) listed the addition (or change in location) of a remote location with the other sentinel event that required reporting; or (b) clearly stated the requirement elsewhere in § 412.92 so that SCHs would have clear and proper notice that the § 412.92(b)(iii) catchall reporting requirement (including the stiff penalty for noncompliance) applied.

In summary, the Board concludes that, *at the time of AnMed's SCH determination in 2017* ***and*** *for purposes of an SCH application*, CMS did not have a "longstanding" policy with regard to the application of the distance requirement to remote locations and the § 412.92(a) requirements for SCH designation cannot be construed to include such a policy. As such, the Board finds that the Medicare Contractor improperly denied AnMed's request for a SCH designation based on the Medicare Contractor's determination that the AnMed North Campus was less than 25 miles from a like hospital. The Board concludes that AnMed satisfied the regulation at 42 C.F.R. § 412.92(a)(1) (2017) because "the front entrance to ***the*** *hospital*" is located at 800 North Fant Street and this entrance meets the § 412.92(a)(1) requirement that it be "located between 25 and 35 miles from other like hospitals."

DECISION AND ORDER:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly denied AnMed's request for a SCH designation and that AnMed should be approved for an SCH designation effective for discharges on or after August 25, 2017.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

9/4/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

[40] (Emphasis added).