PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

On the Record
2023-D15

PROVIDER –
Florida Hospital of Flagler

Provider No. –
10-0118

vs.

MEDICARE CONTRACTOR –
First Coast Service Options, Inc.

DATE OF HEARING –
January 11, 2022

Cost Reporting Period Ended –
December 31, 2013

CASE NO.
14-0443

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor's determination to classify the Provider as a Medicare-dependent hospital ("MDH") effective June 6, 2013, as opposed to October 1, 2012, was proper?[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board" or "PRRB") finds that the Medicare Contractor properly classified Florida Hospital of Flagler ("Florida Hospital" or "Provider") as an MDH, effective June 6, 2013.

INTRODUCTION

Florida Hospital is an acute care hospital located in Altamonte Springs, Florida.[2] The Provider's assigned Medicare Contractor[3] is First Coast Service Options, Inc. ("Medicare Contractor").

The Florida Hospital states that, "[i]n order to qualify for MDH status under the 2012 MDH program, [it] reclassified from an urban to a rural hospital designation."[4] On August 31, 2012, Florida Hospital requested cancellation of its rural status, as the MDH program was set to expire on September 30, 2012, so that it would not be paid under the lower rural wage-index after the MDH program expired.[5] On September 25, 2012, CMS "approved [Florida Hospital's] request for cancellation of rural status effective January 1, 2013."[6]

On January 2, 2013, the American Taxpayer Relief Act of 2012 ("ATRA")[7] was enacted and ATRA § 606 provided for a one-year extension of the MDH program retroactively effective from October 1, 2012, to September 30, 2013. On January 3, 2013, Florida Hospital "submitted a request for reclassification of its designation from urban to a rural based hospital in order to continue as an MDH status pursuant to the extended MDH program under ATRA."[8] On January 23, 2013, CMS approved Florida Hospital's request for reclassification to rural status effective January 10, 2013.[9]

On March 7, 2013, CMS published a policy in the Federal Register that MDHs would have to reapply for MDH status and the MDH status would not be effective until 30 days after the Medicare Contractor approved the request ("the Notice of Extension"). Per the Notice of Extension, Florida Hospital would be deemed an MDH only for the period of October 1, 2012,

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[1] Provider's Appeal Request, Statement of the Issue at 1 (Nov. 1, 2013).
[2] Provider's Final Position Paper (hereinafter "Provider's FPP") at 1 (July 28, 2021).
[3] CMS's payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs"), but 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 and relevant.
[4] Provider's FPP at 1.
[5] *Id*. at 1-2, Ex. P-3.
[6] Provider's Appeal Request, Statement of the Issue at 1; *id*. at 2, Ex. P-4.
[7] Pub. L. 112-240, 126 Stat 2313 (2013).
[8] Provider's FPP at 2, Ex. P-5.
[9] *Id.*, Ex. P-7.

through December 31, 2012. On March 19, 2013, Florida Hospital submitted a request for reclassification as an MDH.[10] On April 3, 2013, Florida Hospital submitted a supplemental letter requesting a retroactive effective date of October 1, 2012, for its MDH status in order to receive MDH payments for an uninterrupted period from October 1, 2012, through October 1, 2013.[11] On May 7, 2013, the Medicare Contractor approved Florida Hospital's request to be classified as an MDH with an effective date of June 6, 2013.[12]

Florida Hospital timely appealed the Medicare Contractor's final decision and met all of the jurisdictional requirements for a hearing before the Board. The Board approved a record hearing on January 11, 2022. Florida Hospital was represented by Daniel Hettich of King & Spalding, LLP. The Medicare Contractor was represented by Wilson Leong of Federal Specialized Services.

STATEMENT OF FACTS

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments. Among these special adjustments is an additional payment to certain hospitals that are classified as Medicare-dependent small rural hospitals ("MDHs"). The Omnibus Budget Reconciliation Act of 1989 created this category of hospitals.[13] *Initially*, in order to be classified as an MDH, a hospital was required to meet all of the following criteria:

- The hospital is located in a rural area
- The hospital has 100 or fewer beds
- The hospital is not classified as a sole community hospital
- The hospital has no less than 60 percent of its inpatient days or discharges attributable to inpatients receiving Medicare Part A benefits during its cost reporting period beginning in fiscal year 1987.[14]

The MDH program has been extended a number of times throughout the years.[15] For purposes of this case, two extensions are relevant. First, § 3124 of the Patient Protection and Affordable

[10] *Id*. at 2, Ex. P-8; Provider's Appeal Request, Statement of the Issue at 1.
[11] *Id*. at 2-3, Ex. P-9.
[12] *Id.*, Ex. P-1.
[13] Pub. L. 101-239, § 6003(f), 103 Stat. 2106, 2144 (1989).
[14] *Id.*
[15] The following are examples of enacted legislation extending the MDH program:
- § 13501(e) of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. 103-66, 107 Stat. 312, 575-76 (1993)) extended the MDH provision through fiscal year 1994 and limited the Federal payment adjustment. However, the MDH provision expired effective with cost reporting periods on or after October 1, 1994.
- § 4204 of the Balanced Budget Act of 1997 (Pub. L. 105-33, 111 Stat. 251, 375 (1997)) reinstated the MDH special payment for discharges occurring on or after October 1997 and before October 1, 2001.
- § 404(a) of the Medicare Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106-113, Appendix F at § 404, 113 Stat. 1501, 1501A-372 (1999) extended the MDH provision to discharges occurring before October 1, 2006.

Care Act ("ACA")[16] extended the MDH program authorized by 42 U.S.C. § 1395ww(d)(5)(G) through FY 2012 and was set to expire on September 30, 2012. On January 2, 2013, the American Taxpayer Relief Act of 2012 ("ATRA")[17] was enacted and ATRA § 606 provided for a one-year extension of the MDH program effective from October 1, 2012 to September 30, 2013. Specifically, ATRA § 606 is entitled "Extension of the Medicare-Dependent Hospital (MDH) Program" and amended 42 U.S.C. §§ 1395ww(d)(5)(G)(i) and 1395ww(d)(5)(G)(ii)(II) by striking "October 1, 2012" and inserting "October 1, 2013." In addition, ATRA § 606 made conforming amendments to §§ 1395ww(b)(3)(D)(i) and 1395ww(b)(3)(D)(iv).

Two months after the enactment of ATRA, CMS took the following actions to implement the ATRA § 606 retroactive extension of the MDH program:

1. On March 1, 2013, CMS released Change Request 8214;

2. On March 7, 2013, CMS published a Federal Register notification related to the extension and notified providers regarding the process in order to continue under the program (the "Notice of Extension").[18]

According to the Notice of Extension, all hospitals classified as MDHs when the program expired October 1, 2012, would be reinstated as MDHs effective October 1, 2012, without the need to reapply for MDH classification. However, there are two exceptions that require hospitals to reapply for MDH classifications: (1) MDHs that classified as sole community hospitals ("SCHs") on or after October 1, 2012; and (2) MDHs that requested a cancellation of their rural classification under § 412.103(b) in advance of the expiration of the MDH provision.[19] Any hospital that reapplied had to demonstrate that they met the following MDH criteria set forth in 42 C.F.R. § 412.108(a) (2013):

> (a) *Criteria for classification as a Medicare-dependent, small rural hospital—*
>
> (1) *General considerations*. For cost reporting periods beginning on or after April 1, 1990, and ending before October 1, 1994, or for discharges occurring on or after October 1, 1997, and before October 1, 2013, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area (as defined in subpart D of this part) and meets all of the following conditions:
>
> (i) The hospital has 100 or fewer beds as defined in §412.105(b) during the cost reporting period.
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> (ii) The hospital is not also classified as a sole community hospital under §412.92.

[16] Pub. L. 111-148, § 3124, 124 Stat. 119, 424 (2010).
[17] Pub. L. 112– 240, 126 Stat. 2313 (2013).
[18] 78 Fed. Reg. 14689, 14691-92 (Mar. 7, 2013).
[19] *Id*. at 14691.

> (iii) At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the hospital's cost reporting period or periods as follows, subject to the provisions of paragraph (a)(1)(iv) of this section:
>
> (A) The hospital's cost reporting period ending on or after September 30, 1987 and before September 30, 1988.
>
> (B) If the hospital does not have a cost reporting period that meets the criterion set forth in paragraph (a)(1)(iii)(A) of this section, the hospital's cost reporting period beginning on or after October 1, 1986, and before October 1, 1987.
>
> (C) At least two of the last three most recent audited cost reporting periods for which the Secretary has a settled cost report.
>
> (iv) If the cost reporting period determined under paragraph (a)(1)(iii) of this section is for less than 12 months, the hospital's most recent 12-month or longer cost reporting period before the short period is used.

Florida Hospital's contention is as follows:

> CMS' interpretation in the Notice of Extension and the [Medicare Contractor's] application of the limited timeframe is contrary to the obvious intent of Congress when it implemented the extension through ATRA.CMS errs in its narrow interpretation of the ATRA extension of the MDH program and incorrectly limits the Provider's reimbursement from October 1, 2012, through December 31, 2012. Since the Provider met the requirements of an MDH both prior to and following the extension of the MDH program under ATRA,... [Florida Hospital] requests that the Board instruct the [Medicare Contractor] to issue a determination finding that the Provider is qualified to receive the uninterrupted MDH payments from October 1, 2012, through October 1, 2013, as required under ATRA.[20]

In the alternative, Florida Hospital asserts its MDH status "should only be denied for the 9 days it was not classified as rural" (January 1-10, 2013).[21]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Florida Hospital maintains that, in the absence of any notice from CMS before the expiration of the MDH program, it took what it believed to be fiscally prudent steps (*i.e.*, cancelling its rural

[20] Provider's FPP at 3.
[21] *Id.*

classification under 42 C.F.R. § 412.103(b)) and was later penalized with a negative reimbursement impact of $3,146,312 due to a six-month lapse in its MDH status (January 1, 2013, through June 5, 2013). According to Florida Hospital, had CMS clarified immediately after the January 2, 2013 MDH program extension that certain MDHs like it would need to reapply for MDH status, the hospital's damages could have been mitigated. As a result, Florida Hospital maintains that it was prejudiced by CMS not publishing the reapplication policy until over two months after the program had been extended.[22]

Further, Florida Hospital asserts that, according to the Notice of Extension, all hospitals (with two exceptions) classified as MDHs when the program expired on October 1, 2012, would be automatically reinstated as MDHs effective October 1, 2012, without the need to reapply for MDH classification. However, the two exceptions to the automatic reinstatement that require hospitals to reapply for MDH classification are: 1) MDHs that classified as SCHs on or after October 1, 2012; and 2) MDHs that requested a cancellation of their rural classification under 42 C.F.R. § 412.103(b) in advance of the expiration of the MDH provision. Florida Hospital contends that the second exception applies in the instant case because Florida Hospital requested cancellation of its rural classification on August 31, 2012 which was granted by CMS with an effective date of January 1, 2013. Florida Hospital argues that:

> CMS never provides an adequate justification for treating these two scenarios differently.... providers that did nothing and simply waited for the expiration of the MDH program received seamless MDH status while providers that were pro-active were penalized with a many-month lapse in MDH status. There is simply no rational policy reason to support this stark distinction between provider types and CMS offers none.[23]

Florida Hospital asserts that providers cannot be held to unwritten standards because, consistent with the Administrative Procedures Act ("APA"),[24] regulated parties have a right to know the rules under which they will be governed.[25] Florida Hospital contends that Congress clearly intended a seamless transition and extension of the MDH program, as evidenced by the fact that it made the MDH extension retroactive to October 1, 2012, so that there would be no gap in MDH status. Accordingly, Florida Hospital contends that CMS' policy of requiring certain MDHs to engage in a reapplication process spanning many months must be overturned because it fails to give effect to Congress' clear intention to allow qualifying hospitals to benefit from an uninterrupted flow of reimbursement under the MDH program.[26]

Florida Hospital concedes that, "if CMS were merely denying the Provider MDH status for the nine days that it was classified as urban, the Provider would probably not be appealing."[27] However, Florida Hospital determined it must pursue the instant appeal because CMS introduced

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[22] *Id*. at 3-4.
[23] *Id.* at 7.
[24] 5 U.S.C. Ch. 5, Subch. II.
[25] Provider's FPP at 7.
[26] *Id.* at 11.
[27] *Id.* at 12.

the following delays that it asserts are in direct contravention of the statute and of Congress' clear intent.

1. CMS did not inform hospitals that they needed to reapply until over two months after Congress extended the MDH program;

2. It took an additional seven weeks to issue a determination on Florida Hospital's MDH application; and

3. The Medicare Contractor's determination to grant MDH status did not take effect until 30 days after it was issued.[28]

Florida Hospital maintains CMS' current interpretation of the ATRA extension is not reasonable and is arbitrary and capricious for the following reasons:

1. CMS has provided no explanation for the inconsistent interpretation of the exact same phrase to providers who did nothing versus providers who requested to change their rural classification in anticipation of the MDH program expiration. CMS' approach of applying different interpretations of the same statute, so as to reduce MDH payments to those providers who took action in advance of the program expiration, is the epitome of arbitrary and capricious action and must be reversed.[29]

2. There is simply no rational policy reason for CMS to allow uninterrupted MDH status to those MDHs that did nothing while imposing a six-month loss of MDH status on other providers that took the only logical course available to them. When CMS distinguishes between similarly situated parties, CMS must provide a rational justification for doing so and it has not done that here.[30]

3. CMS' reapplication policy originates only from the informal CMS Notice of Extension. Accordingly, the Medicare Contractor's application of that policy prohibiting Florida Hospital from obtaining uninterrupted reimbursement for MDH status, imposes new substantive requirements on it in violation of the rulemaking procedures at APA § 553.[31] Because the Medicare Contractor has applied the Notice of Extension in a manner that effectively creates a substantive change to the MDH program requirements (including a change to the ATRA extension), CMS and the Medicare Contractor's application of a substantive policy change that was

[28] *Id*.
[29] *Id.* at 14.
[30] *Id*. at 14-15.
[31] *Id.* at 15.

> implemented without observing the requisite notice and comment rulemaking procedures constitutes a violation of APA § 553.[32]

In further support of these contentions, Florida Hospital argues that the Medicare Contractor's determination improperly "punishes the Provider for attempting to comply with the impending expiration of the MDH program and with CMS' prior clarification that all hospitals will not have MDH status effective January 1, 2013."[33] Florida Hospital asserts that CMS' Notice of Extension "affects [it's] rights by denying uninterrupted reimbursement to which it would otherwise be entitled."[34] Therefore, the Notice of Extension "is a substantive rule that cannot be imposed without following the APA's rulemaking procedures."[35]

Accordingly, Florida Hospital requests that the Board instruct the Medicare Contractor to issue a determination finding that it is qualified to receive the uninterrupted MDH payments from October 1, 2012, through October 1, 2013. As an alternative, Florida Hospital maintains that the Board should instruct the Medicare Contractor to issue a determination that its MDH effective date was the date the Medicare Contractor received the complete MDH application on March 19, 2013.[36]

The Medicare Contractor responds by pointing out that Florida Hospital is asking the Board to alleviate the consequences of its August 31, 2012 decision to cancel its MDH status by declaring its MDH classification retroactive to October 1, 2012, but it fails to explain how the Board is supposed to accomplish this feat. The Medicare Contractor maintains Florida Hospital's Final Position Paper fails to provide anything other than specious arguments and references to fairness. The Medicare Contractor asserts its classification date was proper, was in accordance with the applicable regulations, and should be upheld.[37] The Medicare Contractor maintains Florida Hospital is not entitled to retroactive classification as an MDH because the March 7, 2013 Notice of Extension[38] states that, if a provider cancelled its rural status, its MDH status will not be retroactive to October 1, 2012. Instead, after a provider reapplies for MDH status, its MDH status will be applied prospectively, based on the date the hospital is notified that it again meets the requirements for MDH status.[39] The Medicare Contractor contends that, according to the regulations at 42 C.F.R. § 412.108, one of the criteria for a hospital to meet the classification of an MDH is that it must be considered a rural hospital. Since Florida Hospital's requested change in status to urban was granted, it cannot at this point retroactively go back to its status as an MDH. It must establish itself as rural hospital again and then reapply for its MDH status, which it did. The Medicare Contractor maintains that, following the Provider's application for MDH status, it had a time limit of 90 days to respond, which it did, in compliance with the regulations. The effective date of the MDH status is 30 days after the date the MAC provides written notification. The Medicare Contractor argues its handling of this issue was proper and in accordance with the regulations.[40]

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[32] *Id.* at 17.
[33] *Id*.
[34] *Id.* at 18.
[35] *Id*.
[36] *Id.* at 13.
[37] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3 (Aug. 27, 2021).
[38] 78 Fed. Reg. 14689, 14692 (March 7, 2013).
[39] Medicare Contractor's FPP at 5.
[40] *Id.* at 5-6.

The Medicare Contractor further asserts there is no regulatory basis, for the time period in question, permitting the Board to declare that Florida Hospital's effective date as an MDH to be March 19, 2013, the date the Medicare Contractor received the complete MDH application. The Medicare Contractor contends the remainder of Florida Hospital's Position Paper argues for fairness in the treatment of providers that cancelled their rural status and providers that did not. The Medicare Contractor argues the Board in not an equitable body. Thus, it is bound by the applicable regulations and those regulations provide that MDH classification is not retroactive. The Medicare Contractor asserts Florida Hospital has not been denied anything. Congress established criteria for retroactive application of MDH status and Florida Hospital does not meet those criteria. The Medicare Contractor requests that the Board uphold its decision.[41]

The regulation at 42 C.F.R. § 405.1867 (2013) provides:

> In exercising its authority to conduct proceedings under this subpart, the Board *must comply with all* the provisions of Title XVIII of the Act and *the regulations issued thereunder* as well as CMS Rulings issued under the authority of the Administrator . . . . *The Board shall afford* ***great weight*** *to interpretive rules, general statements of policy,* and rules of agency organization, procedure, or practice established by CMS.

On January 2, 2013, ATRA § 606 was enacted which provided for a one-year extension of the MDH program retroactively effective from October 1, 2012, to September 30, 2013. On March 7, 2013, CMS published a notice in the Federal Register (the "Notice of Extension") which notified providers of the process for determining whether it qualified under the one-year extension of the MDH program. The Notice of Extension stated:

> Since MDH status is now extended by statute through the end of FY 2013, generally hospitals that previously qualified for MDH status will be reinstated as an MDH *retroactively* to October 1, 2012. *However, in the following two situations, the effective date of MDH status may* ***not*** *be* ***retroactive*** *to October 1, 2012*.
>
> 1. MDHs That Classified as Sole Community Hospitals (SCHs) on or After October 1, 2012. . . .
>
> 2. MDHs That Requested a Cancellation of Their Rural Classification Under § 412.103(b).
>
> One of the criteria to be classified as MDH is that the hospital must be located in a rural area. To qualify for MDH status, some MDHs reclassified from an urban to a rural hospital designation, under the regulations at § 412.103(b). *With the expiration of the MDH provision, some of these providers may have* ***requested a***

[41] *Id*. at 6-7.

> ***cancellation of their rural classification***. Therefore, in order to qualify for MDH status, these hospitals must request to be reclassified as rural under § 412.103(b) and must reapply for MDH status under § 412.108(b).
>
> Any provider that falls within either of the two exceptions listed . . . may not have its MDH status automatically reinstated effective October 1, 2012. That is, if a provider . . . cancelled its rural status effective October 1, 2012, its MDH status will not be retroactive to October 1, 2012, but will instead be applied prospectively based on the date the hospital is notified that it again meets the requirements for MDH status in accordance with § 412.108(b)(4) after reapplying for MDH status. Once granted, this status will remain in effect through FY 2013, subject to the requirements at § 412.108. However, if a provider . . . cancelled its rural status effective on a date later than October 1, 2012, MDH status will be reinstated effective from October 1, 2012 but will end on the date on which the provider changed its status to an SCH or cancelled its rural status. Those hospitals may also reapply for MDH status to be effective again 30 days from the date the hospital is notified of the determination, in accordance with § 412.108(b)(4). Once granted, this status will remain in effect through FY 2013, subject to the requirements at § 412.108. Providers that fall within either of the two exceptions will have to reapply for MDH status according to the classification procedures in 42 CFR 412.108(b).[42]

The Notice also confirmed that CMS' position was that polices being published in the Notice are interpretive and are not subject to APA rulemaking:

> The policies being publicized in this notice do not constitute agency rulemaking. Rather, the Congress, in the ATRA, has already required that the agency make these changes, and we are simply notifying the public of the extension of the changes to the payment adjustment for . . . the MDH program for an additional year effective October 1, 2012. As this notice merely informs the public of these extensions, it is not a rule and does not require any notice and comment rulemaking. To the extent any of the policies articulated in this notice constitute interpretations of the Congress's requirements or procedures that will be used to implement the Congress's directive; they are interpretive rules, general statements of policy, and rules of agency procedure or practice, which are not subject to notice and comment rulemaking . . . .

[42] 78 Fed. Reg. 14689, 14691 (March 7, 2013).

> [T]his notice does not propose to make any substantive changes to the policies or methodologies already in effect as a matter of law, but simply applies rate adjustments under the ATRA to these existing policies and methodologies. As the changes outlined in this notice have already taken effect, it would also be impracticable to undertake notice and comment rulemaking.[43]

Although Florida Hospital contends that CMS' Notice of Extension and the Medicare Contractor's application of the limited timeframe of October 1, 2012, through December 31, 2012, is contrary to the intent of Congress and that CMS erred in its narrow interpretation of the MDH ATRA extension and incorrectly limited its reimbursement from October 1, 2012, through December 31, 2012, the Board finds otherwise. The Board finds that CMS' policy, as published in the Notice of Extension, is *not* contrary to the intent of Congress, but rather, is in line with Congressional intent as it notified providers that the MDH deadline had been extended by a year and advised providers about the process to continue under the MDH program given the extended deadline.[44] CMS advised providers that hospitals that previously qualified for MDH status will be automatically reinstated as an MDH retroactively to October 1, 2012. However, in the cases of MDHs that classified as SCHs on or after October 1, 2012, and MDHs that requested a cancellation of their rural classification under § 412.103(b), as in the instant case, their effective dates of MDH status may not be automatically retroactive to October 1, 2012. In order to qualify for MDH status, these hospitals must request to be reclassified as rural under § 412.103(b) and must reapply for MDH status under § 412.108(b). CMS advised that if a provider cancelled its rural status effective on a date later than October 1, 2012, as in the instant case, its MDH status will be reinstated effective from October 1, 2012, but will end on the date on which the provider cancelled its rural status. Thus, any MDH that had cancelled its MDH status was required to comply with the following application process set forth in 42 C.F.R. § 412.108(b):

> (b) *Classification procedures*.
>
> (1) The fiscal intermediary determines whether a hospital meets the criteria specified in paragraph (a) of this section.
>
> (2) A hospital must submit a written request along with qualifying documentation to its fiscal intermediary to be considered for MDH status based on the criterion under paragraph (a)(1)(iii)(C) of this section.
>
> (3) The fiscal intermediary will make its determination and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation.
>
> (4) A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides

[43] *Id*. at 14692.

> written notification to the hospital. An approved MDH status determination remains in effect unless there is a change in the circumstances under which the status was approved.

Indeed, CMS' reapplication policy appears to be rooted, in part, in the following policy adopted through rulemaking as part of the FY 2007 IPPS Final Rule:

> Currently, the regulations do not contain an explicit requirement that an SCH report to CMS or the fiscal intermediary a change in circumstances that would affect its status as an SCH. Likewise, the current regulations for MDHs do not contain an explicit requirement that an MDH report to CMS or the fiscal intermediary a change in the circumstances affecting its MDH status. However, the fiscal intermediary is required to evaluate on an ongoing basis whether a hospital continues to qualify for MDH status.
>
> We have become aware of several hospitals that have been paid based on SCH or MDH status even after the original circumstances that led to the respective classification changed. In the FY 2007 IPPS proposed rule (71 FR 24104), we proposed to amend § 412.92(b)(3) for SCHs and § 412.108(b)(4) for MDHs to require an SCH or MDH to report to its appropriate CMS Regional Office when the circumstances under which the hospital was approved for SCH or MDH status have changed. The CMS Regional Office would then determine whether the SCH or MDH continues to meet the criteria for classification under § 412.92 or § 412.108. If an SCH or MDH no longer meets these criteria, the CMS Regional Office would issue a letter canceling the classification within 30 days of its determination. If the circumstances affecting a hospital's SCH or MDH classification change and the hospital does not disclose the information to the CMS Regional Office, CMS would cancel the hospital's SCH or MDH designation effective on the earliest discernable date on which the fiscal intermediary can determine that the hospital no longer met the criteria for classification.
>
> For MDHs, this reporting requirement is in addition to the fiscal intermediary's ongoing evaluations of whether a hospital continues to qualify for MDH status as set out in our existing regulations at § 412.108(b)(5).
>
> ****
>
> After consideration of the public comments received, we are finalizing a change to the regulations to specify that SCHs and MDHs will be required to report to the fiscal intermediary specific changes it becomes aware of that would affect the criteria under which it was eligible for such designation. . . . An MDH will be

> required to report if there is a change to the number of beds in the facility that increase the bed count to more than 100 and/or if its geographic classification changed from rural to urban.[45]

In this regard, the Board notes that Florida Hospital did *not* include as part of the record its letter to CMS, dated August 31, 2012, requesting cancellation of its reclassification from urban to rural. Rather, Florida Hospital only included in the record the notice that CMS sent it granting its request for cancellation of its rural status effective January 1, 2013.[46] As a result, it is unclear why Florida Hospital requested cancellation and whether it included any explanation in its cancellation request.[47] Accordingly, it is entirely consistent with the policy announced in the FY 2007 IPPS Final Rule to require Florida Hospital to reapply for rural status and, once that is obtained, to reapply for MDH status. Indeed, to this point, *on January 2, 2013*, when the ATRA extension was enacted, Florida Hospital was ***not*** an MDH because Florida Hospital, on its own initiative, had canceled its rural status effective January 1, 2013. As such, it is *not* similarly situated to other hospitals that maintained compliance with all of the criteria needed to qualify as an MDH.

Moreover, the following discussion in the preamble to the FY 2013 IPPS Final Rule (as published on August 31, 2012), highlights the fact that the provider community was aware of the risk associated with cancelling their rural status in anticipation of the MDH expiration:

> 7. Cancellation of Acquired Rural Status Due to MDH Expiration
>
> As we discussed in the FY 2011 IPPS/LTCH PPS final rule (75 FR 50286 and 50287) and in the FY 2012 IPPS/LTCH PPS final rule (76 FR 51683 through 51684), section 3124 of the Affordable Care Act extended the MDH program from the end of FY 2011 (for discharges occurring before October 1, 2011) to the end of FY 2012 (for discharges occurring before October 1, 2012). Accordingly, beginning with FY 2013, there will no longer be an MDH designation, and those hospitals that were formerly MDHs will be paid based solely on the Federal rate.
>
> *Comment*: Several commenters requested CMS to permit hospitals to revisit any geographic reclassification decisions that would impact their ability to qualify for MDH status in the event that the Congress extends the MDH program. In particular, in anticipation of the September 30, 2012 expiration of the MDH program, the commenters stated that s**ome urban hospitals that became rural under section 1886(d)(8)(E) of the Act in order to qualify for MDH status had canceled their rural status so that they could instead receive their urban area wage index or reclassify for a**

[45] 71 Fed. Reg. 47869, 48060, 48062 (Aug. 18, 2006).
[46] Ex. P-3.
[47] For example, 42 C.F.R. § 412.108(b)(4) requires an MDH to notify the applicable CMS Regional Office/Medicare contractor when the circumstances under which the hospital was approved for MDH status have changed. 71 Fed. Reg. 47870, 48060 (Aug. 18, 2006).

> **higher wage index under section 1886(d)(10) of the Act for FY 2013.** The commenters further stated that **if the MDH program is extended, such hospital would no longer be qualified for MDH status because the hospital is no longer a rural provider**.
>
> *Response*: Although we understand the commenters' concerns, we believe it would be imprudent for CMS in this FY 2013 final rule to revise existing Medicare regulations and procedural rules around actions that the Congress may take in the future. **If legislation is passed to continue the MDH program, CMS will develop policies and procedures to implement the specific provisions of such legislation**.[48, 49]

Again, since Florida Hospital cancelled its rural status effective January 1, 2013, its MDH status was only effective from October 1, 2012 through December 31, 2012 (the last date on which Florida Hospital held rural status). The Board finds Florida Hospital had to *both* request to be reclassified as rural under § 412.103(b) *and* then reapply for MDH status. Indeed, Florida Hospital's situation fits within Examples 4 and 5 in the March 7, 2013 Notice of Extension:

> *Example 4*: Hospital D was classified as an MDH prior to the September 30, 2012 expiration of the MDH program. **In anticipation of the expiration of the MDH program**, Hospital D requested that its rural classification be cancelled per the regulations at § 412.103(g). Hospital D's rural classification was cancelled effective October 1, 2012. **Hospital D's MDH status will not be automatically reinstated**. In order to reclassify as an MDH, Hospital D must request to be reclassified as rural under § 412.103(b) **and must reapply for MDH status under § 412.108(b)**.
>
> *Example 5*: Hospital E was classified as an MDH prior to the September 30, 2012 expiration of the MDH program. **In anticipation of the expiration of the MDH program**, Hospital E requested that its rural classification be cancelled per the regulations at § 412.103(g). Hospital E's rural classification was **cancelled effective January 1, 2013**. Hospital E's MDH status will be reinstated but only for the period of time during which it met the criteria for MDH status. Since Hospital E cancelled its rural status and was classified as urban effective January 1, 2013, MDH status will only be reinstated effective October 1, 2012 through December 31, 2012 and will be cancelled effective January 1, 2013. In order to reclassify as an MDH, Hospital

[48] 77 Fed. Reg. 53258, 53371 (Aug. 31, 2012). The comment appears to relate to the prior history of Congressional extensions to the MDH program as well as then currently-pending legislative bills that, if enacted, would extend the MDH program. Indeed, ATRA was introduced in the House on July 24, 2012. *See also* S. 2620, 112th Cong. (May 7, 2012).
[49] The Board notes that, while the Provider's cancellation request is ***dated*** August 31, 2012, the CMS Regional Office documents that it did not receive that request until September 11, 2012. *See* Ex. P-4.

> E must request to be reclassified as rural under § 412.103(b) **and must reapply for MDH status under § 412.108(b)**.[50]

To this end, Florida Hospital first requested to have its status changed from urban to rural on January 3, 2013. CMS approved its request for reclassification as rural, effective January 10, 2013. Florida Hospital then had to reapply for MDH status under § 412.108(b), and reestablish that it met the criteria to qualify as an MDH, since there could have been a change in its eligibility since the cancellation (or the last time its eligibility to be classified as an MDH had been reviewed by the Medicare Contractor).[51] Florida Hospital did so on March 19, 2013. On May 7, 2013, the Medicare Contractor approved its MDH status, effective June 6, 2013. The regulation at 42 C.F.R. § 412.108(b)(3)(4) (2013) provides:

> (3) The fiscal intermediary will make its determination and notify the hospital within 90 days from the date that it receives the hospital's request and all of the required documentation.
>
> (4) A determination of MDH status made by the fiscal intermediary is effective 30 days after the date the fiscal intermediary provides written notification to the hospital.

The Board finds CMS correctly limited Florida Hospital's reimbursement from October 1, 2012, through December 31, 2012. The Medicare Contractor timely issued the May 7, 2013 determination (within the 90 days allotted by the regulation) and properly classified Florida Hospital as an MDH effective June 6, 2013 (30 days after providing written notice to the hospital).

The Board finds CMS' policies, as articulated in the Notice of Extension, are reasonable. The regulation at § 412.108(a) provides that a hospital is classified as an MDH if it meets the following conditions: 1) it is located in a rural area; 2) it has 100 or fewer beds; 3) the hospital is not also classified as an SCH; and 4) at least 60 percent of the hospital's inpatient days/discharges were attributable to individuals entitled to Medicare Part A benefits during the hospital's cost reporting period. CMS' policies, as articulated in the Notice of Extension, align with the criteria outlined in the regulation for classification as an MDH and, thus, are reasonable. The Board agrees that CMS' policy, as articulated in the Notice of Extension, that requires that MDHs which had requested a cancellation of their rural classification must again request to be reclassified as rural (one of the criterion to be classified as an MDH) ***and*** then reapply to for MDH status. CMS' policy to require MDHs that requested a cancellation of their rural classification to reapply for MDH status is also reasonable, given that the hospitals voluntarily cancelled their MDH status and requested to go from a rural to an urban classification *and* must re-establish that they meet *all* of the MDH criteria. At that point of cancellation, these hospitals could no longer qualify as an MDH, as they were urban, not rural. To qualify as an MDH, these hospitals would need to again be reclassified as rural, and

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[50] 78 Fed. Reg. at 14692 (bold and italics emphasis added and italics in original).

[51] For example, in order to qualify as an MDH, it needs to demonstrate that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the applicable cost reporting period(s) specified in 42 C.F.R. § 412.108(a)(1)(iv). However, it is unclear from the record what Florida Hospital had to do to reestablish that it met this criterion when it reapplied in March. *See infra* note 52.

only after that is accomplished could they reapply for MDH status to verify they met all of the other remaining MDH criteria.[52]

In addition, Florida Hospital makes the argument that Congress must have intended a seamless transition and extension of the MDH program, as it made the MDH program extension retroactive to October 1, 2012, so that there would be no gap in MDH status.[53] The Board, however, finds no evidence of that intention as it relates to Florida Hospital's situation. The MDH program was set to expire on September 30, 2012. Congress renewed the MDH program retroactively back to October 1, 2012, the beginning of the next federal fiscal year ("FFY"), in order to prevent that *program* from expiring, but did not specifically address how the retroactive renewal impacted prior participants.[54]

Florida Hospital further asserts that "the [Medicare Contractor's] application of a policy prohibiting it from obtaining the uninterrupted reimbursement for MDH status effectively imposes new substantive requirements on the Provider, in violation of the rulemaking procedures at Section 553 of the Administrative Procedures Act" ("APA").[55] Florida Hospital contends that the Medicare Contractor "applied the Notice of Extension in a manner that effectively creates a substantive change to the MDH program requirements."[56] As a result, the Provider believes that CMS and the Medicare Contractor's application of a substantive policy change were implemented without observing the requisite notice and comment rulemaking procedures and, thereby, constitute a violation of APA § 553.[57] The Board finds that the Notice of Extension is not a rule and, thus, does not require notice and comment rulemaking. The Notice of Extension did not propose to make any substantive changes to the policies or methodologies already in effect as a matter of law, but simply applied rate adjustments under the ATRA to these existing policies and methodologies. Thus, the Notice of Extension is an interpretive rule, general statement of policy, and/or rule of agency procedure or practice, which are not subject to notice and comment rulemaking[58] (and, to the extent

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[52] Significantly, CMS' May 7, 2013 determination to grant Florida Hospital's March 19, 2013 request to be reclassified as an MDH is based on more than just the information included in Florida Hospital's March 19, 2013 request as demonstrated by the fact that 12 different "source" documents are listed in the workpaper attached to the May 7, 2013 determination. Exhibit P-1 at 2. For example, in reviewing whether Florida Hospital met the 60 percent criterion at 42 C.F.R. § 412.108(a)(1)(iv), the workpaper identified the following documents as "references" for this finding:

Utilization Data.xls
Provider MDH Status Request Letter.pdf
Attachment 2_Notification to CMS_19.xlsx
100118 PSR.docx
CR 8214.pdf

Id. at 3. As part of this appeal, the Board did not review, nor did the Provider ask the Board to review or confirm, that it met the 60 percent criterion (whether prospectively or retrospectively). To this end, the record does not contain all of the documents listed above. Rather, it appears that the Provider has asked the Board to find either: (1) this review was unnecessary and it should have been deemed to have continuously met the MDH criteria; or (2) the May 7, 2013 can and should be retroactively applied to an earlier date. The Board declines in each instance.

[53] Provider's FPP at 10.

[54] The MDH program has been extended a number of times throughout the years in this manner by Congress.

[55] *Id.* at 15.

[56] *Id*. at 17.

[57] *Id*.

[58] The Notice of Extension says as much: "The policies being publicized in this notice do not constitute agency rulemaking. Rather, the Congress, in the ATRA, has already required that the agency make these changes, and we are simply notifying the public of the extension of the changes to the payment adjustment for low-volume hospitals

it were found not to be an interpretive rule, there would be good cause to waive the notice and comment requirements[59]). Although the Board is not bound by interpretive rules and general statements of policy, it affords great weight to interpretive rules, general statements of policy and rules of agency organization, procedure, or practice established by CMS. Further, the Board confers great weight to the Medicare Contractor's interpretation in the Notice of Extension and concludes that the Medicare Contractor properly classified Florida Hospital as an MDH effective June 6, 2013.

Florida Hospital argues in the alternative that, if the Board decides against instructing the Medicare Contractor to issue a determination finding that it is qualified to receive the uninterrupted MDH payments from October 1, 2012, through October 1, 2013, the Board should instruct the Medicare Contractor to issue a determination that its MDH effective date was March 19, 2013, the date the Medicare Contractor received the Florida Hospital's complete MDH application.[60] However, the Board finds there is no regulatory basis for Florida Hospital's proposed effective date of March 19, 2013. A determination of MDH status made by the Medicare Contractor necessarily includes a review of whether Florida Hospital met all of the qualifications to be an MDH (including whether it met the 60 percent criterion)[61] and, per 42 C.F.R. § 412.108(b)(4), is effective 30 days after the date the Medicare Contractor provides written notification to the hospital of that determination. The Board finds the Medicare Contractor provided written notice to the hospital on May 7, 2013. Thus, consistent with § 412.108(b)(4), the effective date of Florida Hospital's MDH status is properly June 6, 2013.

Florida Hospital also requests, if the Board decides against instructing the Medicare Contractor to issue a determination finding that it is qualified to receive the uninterrupted MDH payments from October 1, 2012, through October 1, 2013, that its MDH status only be denied for the nine days it was not classified as rural.[62] However, the Board again finds no basis in the statute, regulations, or Notice of Extension for this request.

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and the MDH program for an additional year effective October 1, 2012. As this notice merely informs the public of these extensions, it is not a rule and does not require any notice and comment rulemaking. To the extent any of the policies articulated in this notice constitute interpretations of the Congress's requirements or procedures that will be used to implement the Congress's directive; they are interpretive rules, general statements of policy, and rules of agency procedure or practice, which are not subject to notice and comment rulemaking or a delayed effective date." 78 Fed. Reg. at 14692.

[59] In this regard, the Notice of Extensions states: "[T]o the extent that notice and comment rulemaking or a delay in effective date or both would otherwise apply, we find good cause to waive such requirements. Specifically, we find it unnecessary to undertake notice and comment rulemaking in this instance as this notice does not propose to make any substantive changes to the policies or methodologies already in effect as a matter of law, but simply applies rate adjustments under the ATRA to these existing policies and methodologies. As the changes outlined in this notice have already taken effect, it would also be impracticable to undertake notice and comment rulemaking. For these reasons, we also find that a waiver of any delay in effective date, if it were otherwise applicable, is necessary to comply with the requirements of the ATRA. Therefore, we find good cause to waive notice and comment procedures as well as any delay in effective date, if such procedures or delays are required at all." *Id.*

[60] *Id*. at 14.

[61] *See supra* note 52.

[62] *Id.* at 18.

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board concludes that the Medicare Contractor properly classified Florida Hospital as an MDH, effective June 6, 2013.

Board Members Participating:

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For the Board:

5/5/2023

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV