PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D66

PROVIDER -Holzer Medical Center
Gallipolis, Ohio

Provider No. 36-0054

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
AdminiStar Federal, Inc.

DATE OF HEARING-
June 9, 1998

Cost Reporting Period Ended -
June 30, 1991

CASE NO. 94-0070

INDEX

ISSUE:

Does the Provider meet the criteria for receiving disproportionate share payments based on the application of undisputed facts?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Holzer Medical Center ("Provider") is a not-for-profit, general short term hospital located in Gallipolis, Ohio. The issue presented in this case arises from the Notice of Program Reimbursement ("NPR") issued by Blue Cross and Blue Shield Association/AdminiStar Federal, Inc. ("Intermediary") on April 26, 1993. The NPR covered reimbursement for the fiscal year ended June 30, 1991, and included a determination by the Intermediary that the Provider did not qualify for additional payment as a disproportionate share hospital ("DSH"). The Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The estimated amount of Medicare reimbursement in controversy is approximately $964,500.

In the interest of facilitating the presentation of this issue before the Board as a hearing on the written record, the parties submitted the following joint stipulations:

> WHEREAS, the Provider has appealed from the Intermediary's determination that the Provider is not entitled to disproportionate share payments for the cost reporting period ended June 30, 1991;
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> WHEREAS, the parties agree that the only issue before this Provider Reimbursement Review Board (the "Board") is whether the Provider meets the criteria for receiving disproportionate share payments based on application of undisputed facts;
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> WHEREAS, the resolution of whether the Provider is entitled to disproportionate share payments can be more efficiently and economically resolved through the stipulations set forth below without the necessity of a live hearing on this issue before the Board;
>
> NOW THEREFORE, the Provider and the Intermediary hereby agree and stipulates as follows:
>
> 1. For purposes of the Medicare program, Provider is located in a "rural area" as that term is defined by Section 1886(d)(2)(D) of the Social Security Act (42 U.S.C.
> § 1395ww(d)(2)(D)) and 42 C.F.R. § 412.62(f).

2. Provider operates 269 adult and 30 nursery beds for a total of 299 beds.

3. At all pertinent times, Provider has been and continues to be designated as a "rural referral center" as that term is defined by Section 1886(d)(5)(C)(i) and 42 C.F.R. § 412.96.

4. For fiscal year 1991, Provider had 1,533 patient days for patients who were Medicare beneficiaries entitled to supplemental security income ("SSI") benefits and a total of 20,160 patient days for patients entitled to Part A benefits. This proportion computes to a percentage of 7.6042%.

5. From the June 30, 1991 final cost report at worksheet S-3, Provider had 7,086 patient days for Medicaid beneficiaries. The June 30, 1991 final cost report at Worksheet S-3 also reflects a total of 41,310 patient days for Provider. This proportion of Medicaid patient days to total patient days computes to a percentage of 17.1532%.

6. In determining that the Provider was not entitled to receive disproportionate share payments, the Intermediary applied the 30% threshold for hospitals in a rural area with more than 100 beds. The Intermediary found that the Provider's disproportionate share percentage was 24.7574% (the sum of the two percentages discussed above in paragraphs 4 and 5).

7. The June 30, 1991 final cost report of the Provider indicates revenues from DRG payments in the amount of $11,003,004.00 and revenues from outlier payments for the same period in the amount of $87,629.00, for a total of $11,090,633.00.

8. In determining whether the Provider is entitled to disproportionate share payments, the parties submit that the only issue before the Board is whether the "urban" threshold under Section 1886(d)(5)(F)(v) (42 U.S.C. § 1395ww(d)(5)(F)(v)) should apply to the Provider by virtue of the Provider's designation as a "rural referral center."

9. Should the Board (or the Administrator or a court of final review) find that the Provider is entitled to disproportionate share payments, the parties agree that they will recalculate the disproportionate share percentage to include all inpatient hospital days of service for which a patient was eligible for assistance under a state Medicaid plan, whether or not the hospital actually received payment for those days, pursuant to HCFA Ruling 97-2 (dated February 27, 1997). The Provider acknowledges that such recalculation would not cause the disproportionate share percentage to exceed 30%. The Intermediary further agrees to apply the disproportionate share percentage, as adjusted, as appropriate for "urban" hospitals

pursuant to the final decision in this case.

10. This joint Stipulation and the Exhibits attached hereto shall be considered part of the administrative record of the above-captioned appeal.

PROVIDER CONTENTIONS:

The Provider contends that a 15 percent threshold should be used to determine whether it serves a disproportionate share of low income patients. While it is the Intermediary's position that the Provider is a rural hospital subject to the 30 percent threshold for purposes of the DSH adjustment, it is the Provider's contention that, as a rural referral center, it is considered to be an urban hospital for Medicare reimbursement and, thus, the 15 percent threshold should be applied in making the determination. The Provider argues that it qualifies as a DSH under the statutory provisions of 42 U.S.C. § 1395ww(d)(5)(F)(v), and that the Intermediary's citation of the pertinent statute and regulations does not address the arguments that have been raised in this case.

The Provider believes that it is first important to understand what Congress created and intended by the designation "rural referral center" as provided under 42 U.S.C. § 1395ww(d)(5)(C). With the passage of the Social Security amendments of 1983, the Medicare program underwent significant changes with the implementation of the prospective payment system. As part of those changes, Congress created the rural referral center designation with the following provision:

> The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas). A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center. Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October, 1984, during the first quarter of that period), and the Secretary must make a final determination with respect

> to such appeal within 60 days after the date the appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

42 U.S.C. § 1395ww(d)(5)(C)(i) (emphasis added).

In 1984, the Health Care Financing Administration ("HCFA") promulgated the current regulations at 42 C.F.R. § 412.96 which set forth the criteria for a hospital to receive rural referral center status. Throughout its existence, the Provider notes that the establishment of rural referral center status was to recognize a rural hospital as possessing the characteristics of an urban hospital. Consistent with the status conferred by the original statutory provision, HCFA constantly defended its criteria for defining rural referral centers. In response to commenters to proposed regulations who believed the criteria were too stringent, HCFA typically responded as follows:

> The underlying principle of section 1886(d)(5)(C)(i) of the Act is that the hospitals that wish to be designated as rural referral centers must be able to demonstrate that they resemble typical urban hospitals, not that their geographical location is like an urban location.

50 Fed. Reg. 35646 (Sept. 3, 1985).

For purposes of the Medicare program, the Provider believes it is readily apparent that rural referral centers earned such status by possessing the operational characteristics of urban hospitals and are reimbursed accordingly. In addition to Congress' special recognition of rural referral centers, when the Medicare Prospective Payment System ("PPS") was enacted in 1983, the Secretary of the Department of Health and Human Services ("Secretary") was directed to make certain exceptions and adjustments, including the disproportionate share adjustment, to PPS payments for hospitals as follows:

> The Secretary shall provide for such exemptions from, and exceptions and adjustments to, the limitation established under paragraph (1)(A) as he deems appropriate, including those which he deems necessary to take into account --
>
> * * *
>
> (B) the special needs of psychiatric hospitals and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this subchapter, . . .

42 U.S.C. § 1395ww(a)(2) (emphasis added).

This directive was further expanded under 42 U.S.C. § 1395ww(d)(5)(F)(i) to provide the

following:

> (i) For discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which--
>
> > (I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or
> >
> > (II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this subchapter or State plans approved under subchapter XIX of this chapter) during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such net inpatient care revenues during the period.

42 U.S.C. § 1395ww(d)(5)(F)(i).

Pursuant to the above-stated statutory provisions, the Provider contends that it is a DSH which is defined in the referenced "clause (v)" of the statute as follows:

> (v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds --
>
> (I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,
>
> (II) 30 percent, if a hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital under subparagraph (D),
>
> (III) 40 percent, if the hospital is located in an urban area and has less than 100 beds, or
>
> (IV) 45 percent, if the hospital is located in a rural area and is not described in subclause (II).
>
> A hospital located in a rural area and with 500 or more beds also "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient

> percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.

42 U.S.C. § 1395ww(d)(5)(F)(v).

The Provider argues that the basis for the disproportionate share adjustment relates directly to the operating costs of providers. The premise upon which the disproportionate share legislation is based is that hospitals that serve a higher number of low-income patients incur higher Medicare costs per case. This is because low-income patients are in poorer health, tend to have more complications and secondary diagnoses, and have fewer alternatives available for out-of-hospital care. Further, hospitals which serve a higher number of low-income patients require extra over-head costs and higher staffing ratios which reflect the special need of such personnel as medical social workers, translators, nutritional and health education workers. All of these costs are part of a hospital's operating costs. Thus, if Medicare law treats rural referral centers and urban hospitals the same for purposes of operating costs, the disproportionate share adjustment premised on operating costs must apply equally to rural referral centers and urban hospitals. Accordingly, the Provider concludes that the 15 percent threshold should be applied to determine that the Provider is a disproportionate share hospital.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider does not qualify for an additional payment as a hospital that serves a significantly disproportionate number of low income patients. In support of this position, the Intermediary cites the explicit law and regulations which set forth the qualification criteria as follows:

> (v) In this subparagraph, a hospital "serves a significantly disproportionate number of low income patients" for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds--
>
> (I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,
>
> (II) 30 percent, if the hospital is located in a rural area and has more than 100 beds , or is located in a rural area and is classified as a sole community hospital under subparagraph (D),
>
> (III) 40 percent, if the hospital is located in an urban area and has less than 100 beds, or
>
> (IV) 45 percent, if the hospital is located in a rural area and is not described

in subclause (II).

42 U.S.C. § 1395ww(d)(5)(F)(v).

(c) Criterion for classification. A hospital is classified as a disproportionate share" hospital under any of the following circumstances:

(1) The hospital's disproportionate patient percentage, as determined under paragraph (b)(5) of this section, is at least equal to one of the following:

(i) 15 percent, if the hospital is located in an urban area and has 100 or more beds, or is located in a rural area and has 500 or more beds.

(ii) 30 percent, if the hospital is located in a rural area and either has more than 100 beds and fewer than 500 beds or is classified as a sole community hospital under § 412.92 of this subpart.

(iii) 40 percent, if the hospital is located in an urban area and has fewer than 100 beds.

(iv) 45 percent, if the hospital is located in a rural area and has 100 or fewer than 100 beds.

42 C.F.R. § 412.106(c).

The Intermediary argues that it is undisputed that the Provider is located in a rural area and has over 100 beds. In order to qualify for the disproportionate share adjustment, the Provider must have a disproportionate patient percentage greater than or equal to 30 percent. In the instant case, the Provider's disproportionate patient percentage is 24.7574 percent. The Intermediary notes that a rural hospital that has between 100 and 500 beds must meet the 30 percent threshold to qualify for a DSH adjustment. If the rural hospital does meet that threshold and is a rural referral center, then it is entitled to a DSH adjustment calculated at 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent.

In further support of its position, the Intermediary cites the Federal Register dated April 20, 1990 which includes the following statement:

Section 6003(c) of Public Law 101-239 adds an additional qualifying methodology under section 1886(d)(F)(5)(v) of the Act for certain rural hospitals beginning with discharges occurring on or after April 1, 1990. That is, if a hospital is located in a rural area has more than 100 beds,. . . and has a

> disproportionate patient percentage of at least 30 percent during its cost reporting period, the hospital will qualify for a disproportionate share adjustment.

55 Fed. Reg. 15,153 (Apr. 20, 1990).

This Federal Register goes on to state:

> A hospital located in a rural area and classified as a rural referral center will receive a disproportionate share adjustment that will increase the hospital's DRG revenue by 4 percent plus 60 percent of the difference between its disproportionate patient percentage and 30 percent.

55 Fed. Reg. 15,154 (Apr. 20, 1990).

Finally, the Intermediary notes that the House of Representatives Committee on the Budget Report for OBRA 1989 explained, "Rural referral centers would receive a disproportionate share adjustment based on the same formula as that used for urban hospitals although the threshold for disproportionate share rural hospitals would be retained." (emphasis added.) The Provider did not meet the 30% disproportionate patient percentage for a disproportionate share adjustment.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395ww(a) et seq.	-	Payment to Hospitals for Inpatient Hospital Services
§ 1395ww(d) et seq.	-	Disproportionate Share Adjustment

2. Regulations - 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.62(f)	-	Geographical Classifications
§ 412.96	-	Special Treatment: Referral Centers
§ 412.106 et seq.	-	Special Treatment: Hospitals that Serve a Disproportionate Share of Low Income Patients

3. Other:

50 Fed. Reg. 35,646 (Sept. 3, 1985).

55 Fed. Reg. 15,153 - 15,154 (Apr. 20, 1990).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the controlling law and regulations, the facts of the case, parties' contentions and evidence in the record, finds and concludes that the Intermediary properly determined that the Provider does not qualify for disproportionate share payments under the governing law and regulations.

As set forth in the joint stipulations of the parties, the Provider is a 299-bed rural hospital that also qualifies as a rural referral center under the criteria set forth at 42 C.F.R. § 412.96. During the fiscal year in contention, the Provider's disproportionate patient percentage was 24.7574 percent. In order to qualify for a disproportionate share adjustment, the Provider must meet the qualification criteria established under 42 U.S.C. § 1395ww(d)(5)(F)(v) and the implementing regulations at 42 C.F.R. § 412.106(c). Pursuant to these authoritative directives, a hospital is classified as a disproportionate share hospital if its disproportionate patient percentage is at least equal to one of the following:

(1) 15 percent, if the hospital is located in an urban area and has 100 or more beds, or is located in a rural area and has 500 or more beds.

(2) 30 percent, if the hospital is located in a rural area and has more than 100 beds, or is located in a rural area and is classified as a sole community hospital.

The Board finds that the governing law and regulations at 42 U.S.C. § 1395ww(d)(5)(F)(v) and 42 C.F.R. § 412.106(c) set forth explicit and clear qualification criteria which a provider must meet in order to qualify for a disproportionate share adjustment. As a rural hospital with more than 100 beds and fewer than 500 beds, the Provider needed to attain a disproportionate patient percentage of 30 percent. Since the Provider's disproportionate patient percentage was 24.7574 percent for the cost reporting period in dispute, the Provider did not meet the criteria for receiving disproportionate share payments.

The Board finds that there is nothing in the governing statutory and regulatory provisions which would permit the Provider to be classified as an urban hospital because of its designation as a rural referral center. Irrespective of the reasonableness or fairness of the Provider's contention that the urban threshold of 15 percent should be utilized in determining its qualification for a disproportionate share adjustment, the Board is bound by the explicit qualification criteria set forth under the controlling provisions of the pertinent law and regulations which apply in this case.

DECISION AND ORDER:

The Provider does not meet the criteria for receiving disproportionate share payments based on the application of undisputed facts. The Intermediary's determination is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: June 30, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman