PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON-THE-RECORD
2003-D49

PROVIDER –
Iroquois Memorial Hospital
Watseka, Illinois

Provider No. 14-0167

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
AdminaStar Federal, Inc,

DATE OF HEARING-
June 18, 2003

CASE NO. 02-1970

INDEX

ISSUE:

Is the Provider entitled to status as a Medicare Dependent Hospital ("MDH") for the period of October 1, 2001 through January 14, 2002?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Iroquois Memorial Hospital ("Provider") is an acute care hospital facility located in Watseka, Illinois. On January 11, 2002, the Provider requested MDH designation to be effective with the start of its cost reporting period beginning October 1, 2001.[1] After reviewing the Provider's request pursuant to the requirements set forth under 42 C.F.R. § 412.108, AdminaStar Federal, Inc. ("Intermediary") denied the Provider's request, stating that the hospital facility was not eligible for MDH status because it became a sole community provider on January 14, 2002.[2] The Intermediary's denial letter further stated that, pursuant to the August 1, 2001 Federal Register, the time frame for the effective date of MDH status was changed to 30 days from the date of the intermediary's approval. Since the Provider's request for MDH status was dated January 11, 2002, and the Provider was approved for sole community hospital status on January 14, 2002, it was not possible for the MDH effective date to have been prior to the sole community hospital effective date.

Upon receipt of the Intermediary's denial letter on or about July 19, 2002, the Provider timely filed an appeal with the Provider Reimbursement Review Board ("Board") and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1841. The Provider was represented by Keith D. Barber, Esquire, of Hall, Render, Killian, Heath & Lyman. The Intermediary's representative was James Grimes, Esquire, of the Blue Cross Blue Shield Association. The estimated amount of Medicare reimbursement in controversy is $175,000.

In order to assist the Board in deciding the issue in dispute, the parties submitted the following joint stipulations for inclusion in the record:

1. Counsel for Iroquois Memorial Hospital and the Intermediary desire to enter into a joint stipulation of facts in the matter of the Hospital's appeals of the Intermediary's denial of Medicare Dependent Hospital Status from October 1, 2001 to January 14, 2002 as reflected in the appeal and Position Papers filed in PRRB Case No. 02-1970.

2. The undersigned counsel for the Hospital and the Intermediary stipulate that, as reflected in the Position Papers submitted by the parties, there are no material facts in dispute and that dispute is solely one of proper interpretation of statute, regulation and program guidance.

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[1] See Provider's Exhibit P-1.
[2] See Provider's Exhibit P-2.

3. The undersigned counsel further stipulate that the attached statute 42 U.S.C. § 1395ww(d)(5) and regulation 42 C.F.R. § 412.108, in addition to other exhibits and citations reflected in the Position Papers submitted by the parties, reflects the controlling statute and regulation on this issue.

4. The undersigned counsel further stipulate that the legal, as opposed to factual nature of the dispute, establishes that a live hearing before the Board will not serve to further develop the facts or issues in this case and that an on record review by the Board is consented to by both parties.

PROVIDER'S CONTENTIONS:

The question of law before the Board is whether the Provider may qualify for MDH status for a portion of its cost reporting period until it is no longer eligible because of its sole community hospital classification. The MDH law in question is found at 42 U.S.C § 1395ww (d)(5)(G).[3] This statute mandates that hospitals shall receive MDH payments "for any cost reporting period beginning on or after April 1, 1990, and before October 1, 1994, or discharges occurring on or after October 1, 1997, and before October 1, 2006." In determining the amount of these payments, the amount shall be based on "discharges occurring during any subsequent cost reporting period (or portion thereof)." The Provider contends that the statutory language is explicit in emphasizing the beginning of the cost reporting period as to when MDH status begins, and that the allowance of such status can be for a portion of the period. Accordingly, the statutory provisions are directly on point and dispositive of the question at issue. It is undisputed that, except for the requirement that the hospital not be classified as a sole community hospital, which did not occur until January 14, 2002, the Provider met all of the statutory requirements for MDH payment for the period of October 1, 2001 to January 14, 2002.

With respect to the relevant regulation at 42 C.F.R. §412.108,[4] the Provider argues that the regulatory provisions provide even greater emphasis that MDH status commences at the beginning of the cost reporting period as follows:

> "[F]or cost reporting periods . . . beginning on or after October 1, 1997 and ending before October 1, 2006, a hospital is classified as a Medicare-dependent, small rural hospital if it is located in a rural area . . . and meets all of the following conditions:
>
> (i) The hospital has fewer than 100 beds . . .
>
> (ii) The hospital is not classified as a sole community hospital . . .

[3] See Provider's Exhibit P-3.
[4] See Provider's Exhibit P-4.

(iii) [The hospital meets the 60 percent Medicare discharges standard].

42 C.F.R. § 412.108(a)(1).

The Provider notes that the Intermediary emphasizes the language at 42 C.F.R. §412.108(b)(4), which states, "a determination of MDH status . . . is effective 30 days after the date the fiscal intermediary provides written notice to the hospital." The Provider asserts that the provision quoted by the Intermediary must be read in a manner to make it consistent with the above quoted provisions of the statute and regulation which indicate when payment for MDH status will commence. The provision cited by the Intermediary is not a basis to deny MDH status to a hospital for a period where it indisputably qualifies.

The Provider contends that the Intermediary improperly applied the Federal Register provision of August 1, 2001, which makes MDH status effective 30 days from intermediary approval.[5] The Provider insists that the statement reflects only when payments will start and not when MDH status is recognized. To be consistent with the statute and other provisions of the same Federal Register, it is the beginning date of the cost-reporting year that is the starting point for MDH status.

The Provider further argues that the Centers for Medicare and Medicaid Services ("CMS") improperly set a deadline after the deadline had passed. On December 20, 2001, CMS published Program Transmittal A-01-144[6] which advised that a hospital "may request MDH status at any time" and recognized that "some hospitals may be disadvantaged by the timing of the approval of their MDH status and the beginning of their cost reporting period." The Program Transmittal further advised that approval of MDH status for hospitals with cost reporting periods beginning on or after April 1, 2001 and before January 1, 2002, shall be effective as of the date of the beginning of the hospital's cost reporting period, if the hospital submitted a request to its fiscal intermediary prior to October 1, 2001." The Provider points out that, while the guideline was issued on December 1, 2001, its instructions state that the hospital must have applied for MDH status by October 1, 2001 to receive this treatment. Accordingly, CMS notified hospitals of the deadline nearly 12 weeks after the deadline. The Provider asserts that it submitted its application as quickly as practical after receiving notice in late December, 2001. The Provider does not believe that CMS and the Intermediary should be allowed to entrap it in this retroactively applied deadline.

In summary, the Provider argues that the Intermediary's denial of MDH status for the time period between the start of the cost reporting period and its designation as a sole community hospital was clearly arbitrary and capricious, and results in the under-reimbursement of services under Medicare Part A. The Provider requests that the Board reverse the Intermediary's determination.

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[5] See Provider's Exhibit P-5.
[6] See Provider's Exhibit P-6.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly denied the Provider's request for MDH status in accordance with the regulatory provisions of 42 C.F.R. § 412.108 et seq.[7] In order to qualify for special treatment as a MDH facility, the Provider had to meet all of the following criteria under 42 C.F.R. § 412.108(a):[8]

> (1) The hospital must be located in a rural area (as defined in §412.63(b);
> (2) The hospital has 100 or fewer beds as defined in § 412.105(b) during the cost reporting period;
> (3) The hospital is not also classified as a sole community hospital under § 412.92; and
> (4) At least 60 percent of the hospital's inpatient days or discharges were attributable to individuals receiving Medicare Part A benefits during the hospital's cost reporting period. . . .

With respect to the classification procedures set forth under 42 C.F.R § 412.108(b), sub-paragraph (4) states that: [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. . . ."[9]

The Intermediary points out that the Provider sought SCH classification by letter dated December 6, 2001, which CMS granted by letter postmarked December 14, 2001.[10] CMS' letter advised that SCH status was effective for all discharges and associated payments adjustments 30 days after its notification. In a letter dated January 15, 2002, the Intermediary notified the Provider that the effective date for SCH status was January 14, 2002.[11]

Based on the facts presented and the application of the regulatory provisions, the Intermediary asserts that the Provider did not meet the qualifications for MDH status. Pursuant to the regulatory provisions, MDH status and the payment adjustment that accrues become effective 30 days after the written notification to the provider. At that time, the hospital will attain MDH status and PPS payments will be adjusted for discharges that occur on or after that date. Applying the regulation to the instant case, it is clear that the Provider's application for MDH status was dated January 11, 2002.[12] The regulation at 42 C.F.R. § 412.108(a)(1)(ii) states that a MDH cannot also be classified as a SCH. In this case, the Provider qualified as a SCH effective January 14, 2002. If the Provider were approved for MDH status, it would be effective 30 days after the approval, February 10, 2002, at which point the Provider would already be classified as

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[7] See Intermediary's Exhibit I-2.
[8] See Intermediary's Exhibit I-5.
[9] Id.
[10] See Intermediary's Exhibit I-6.
[11] See Intermediary's Exhibit I-7.
[12] See Intermediary's Exhibit I-1.

a SCH. As a result, the Provider did not meet the qualifications for MDH status as set forth under the governing regulations.

The Intermediary contends that its position is further supported by the timeframes established in the Final Rule concerning MDH classification published in the Federal Register on August 1, 2001, which states:

> Therefore, hospitals are free to request MDH status at any time. We also are revising the time provided for fiscal intermediaries to make their determination, from 180 days to 90 days. We believe this will provide sufficient time for review while being responsive to the commenter's concern that the process not be too lengthy. Similar to the approval period for SCH's as described above, MDH status and the associated payment adjustment are effective 30 days after written notification to the MDH. (Emphasis added.)[13]

The Intermediary also notes that CMS issued a Program Memorandum on December 20, 2001 to clarify the instructions published in the August 1, 2001, Final Rule.[14] The Intermediary cites the following excerpts from the Program Memorandum to emphasize the appropriateness of its determination:

> In the final rule, we indicated that a hospital may request MDH status at any time, and that the intermediary will make its determination and notify the hospital within 90 days from the date it receives the hospital's request and all of the required documentation. If the request is approved, MDH status and the associated payment adjustments are effective 30 days after the date of written notification of approval from the intermediary to the hospital. (Emphasis added.)
>
> We did not address situations where a hospital could not have known of this timetable sufficiently in advance to submit a request in time to attain approval prior to its first cost reporting period beginning on or after April 1, 2001. We recognized that some hospitals may be disadvantaged by the timing of the approval of their MDH status and the beginning of their cost reporting period. Therefore, approval of MDH status for hospitals with cost reporting periods beginning on or after April 1, 2001 and before January 1, 2002, shall be effective as of the date of the beginning of the hospital's cost reporting period, if the hospital submitted a request to its fiscal intermediary prior to October 2, 2001. (Emphasis added). For hospitals whose first cost reporting period begins on or after January 1, 2002, the timetable described in the August 1, 2001 Final Rule will

[13] See Intermediary's Exhibit I-3.
[14] See Intermediary's Exhibit I-5.

> provide sufficient time to make the determination effective for the beginning of the cost reporting period. . . .
>
> Example Two: A hospital with a cost reporting period of July 1 through June 30, submits a complete, written request for MDH status that is received by its intermediary on January 2, 2002. The intermediary considers the hospital's three most recently settled cost reporting periods: 7/1/99 – 6/30/00, 7/1/98 – 6/30/99, and 7/1/97 – 6/30/98, and finds the hospital qualifies as a MDH based on at least two of these cost reporting periods. The intermediary provides written notification of approval to the hospital within 90 days of receipt of the request for MDH status. The hospital's MDH status is effective 30 days after the date of written notification of approval. (Emphasis added.)

While the Provider relies on the wording in the Federal Register of August 1, 2001, as support for its position that MDH status must be granted at the start of the cost reporting period, the Intermediary argues that the Provider is taking the wording of certain paragraphs out of context. When read in its entirety, it is clear that the regulation added a new option for hospitals to qualify for MDH status which began with a provider's first cost reporting period that began after April 1, 2001. This new option allows a hospital to base MDH eligibility on two of the three most recently audited cost reports rather than on the cost reporting period that began during fiscal year 1987. The regulatory provision does not state that the MDH status begins only on the first day of the provider's cost reporting period.

The Intermediary notes that the regulatory provisions of 42 C.F.R. §412.108 clearly state that the provider is responsible for requesting MDH status from the Intermediary, and that MDH status is effective 30 days after the date the intermediary provides written notification to the hospital. In the instant case, the Provider was alerted to this provision in the Final Rule published in the Federal Register on August 1, 2001, which was effective on October 1, 2001. The Provider failed to request MDH status prior to the beginning of its cost-reporting period which also began on October 1, 2001. With respect to the Program Memorandum issued by CMS on December 20, 2001, the Intermediary argues that this issuance merely clarified the provisions of 42 C.F.R. § 412.108. The Program Memorandum did not change the wording in the Final Rule issued on August 1, 2001, and did not set a "retroactive deadline."

In summary, the Intermediary insists that the Provider was notified as of August 1, 2001 of its need to request MDH status, and that the implementation date would be 30 days after notification. The Provider failed to take the necessary action until January 11, 2002. While the regulation permitted the Provider to request MDH status at any time, the regulation does state that MDH status begins at the beginning of the cost reporting period. Based on its review of the Provider's request, the Intermediary determined that the Provider could not qualify for MDH status because the hospital had already achieved SCH status. The Intermediary concludes that it properly denied the Provider's request, and the Board should affirm its determination.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and policies, parties' contentions and evidence presented finds and concludes that the Intermediary properly denied the Provider's request for MDH designation in accordance with the regulatory provisions of 42 C.F.R. § 412.108 et seq.

The Board finds that the controlling regulation at 42 C.F.R. § 412.108(b)(4) clearly states that the effective date for MDH status is 30 days after the date the fiscal intermediary provides written notification to the hospital. Since the Provider's application for MDH status was dated January 11, 2002, the earliest date that MDH status could be approved would have been February 10, 2002. One of the criteria to qualify for special treatment as a MDH facility is that the hospital cannot also be classified as a SCH. The record shows that the Provider attained SCH status on January 14, 2002. Therefore, by the time MDH status could have been granted, the Provider did not qualify under the governing regulation.

The regulations at 42 C.F.R. § 412.108 et seq. provide specific policy with respect to the qualification, application and effective date for MDH status. The Board is bound by the governing regulations.

DECISION AND ORDER:

The Provider is not entitled to MDH status for the period of October 1, 2001 through January 14, 2002. The Intermediary's determination is affirmed.

BOARD MEMEBERS PARTICIPATING:

Suzanne Cochran, Esquire (Concurring Opinion)
Gary B. Blodgett, D.D.S.
Martin W. Hoover, Jr., Esquire (Concurring Opinion)
Elaine Crews Powell, C.P.A.

DATE: August 27, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman

Concurring Opinion of Suzanne Cochran and Martin Hoover

We concur that the unambiguous terms of the regulation cut off the Provider's ability to have its determination as a Medicare Dependent Hospital retroactive to the beginning of the cost report period. We question, however, whether the result in this case creates a conflict with the statute in that the timelines established by the new rule in issue here ("the August regulation"[15]) do not permit some providers to qualify for the full period permitted by the statute.

The statute[16] provides that "the term Medicare dependent, . . . means, with respect to any cost reporting period to which (i) applies. . . " and then the criteria are set out. Subsection (i) provides that the MDH designation is "for any cost reporting period beginning on or after April 1, 1990 . . ." Subsection (ii) provides that the amount determined under this clause is –

> (1) for discharges occurring during the 36 month period beginning with the first day of the cost reporting period that begins on or after April 1, 1990. . .
> (2) for discharges occurring during any subsequent cost report period . . .

The old regulation of October 1, 2000 incorporated the MDH extension applicable here. It states at subsection (a):

> For cost reporting periods beginning on or after April 1, 1990 . . . *a hospital is classified* as a [MDH] if. . .[the criteria are met]." (emphasis added).

The language of the statute and the old regulation indicate that the provider is to be classified as an MDH for any cost report period for which it qualifies and that the classification be for the full period.

Subsection (b) of the October, 2000 regulation "Classification procedures" says

> The fiscal intermediary determines whether a hospital meets the criteria in paragraph (a) of this section. *If a hospital disagrees with an intermediary's decision*, it should notify its intermediary and submit documentable evidence that it meets the criteria. (emphasis added)

There are no deadlines stated except that the intermediary must make its determination within 180 days from the date it receives the hospital's request and all other necessary information.

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[15] Provider Exhibit 5.
[16] 42 U.S.C. 1395ww(d)(5)(G)(iv).

Prior to the issuance of the August regulation, the above language seems to clearly indicate that the intermediary was to make a determination *without any input from the provider unless the provider disagrees.* Only then did a provider's obligation arise to submit evidence to show entitlement.

An interim final rule preceded the regulation in issue here. It was published in the Federal Register in June, 2001 and is referenced in the August regulation. The Interim Final rule is the first mention of any application by the provider to initiate the process. It was substantially different from the final rule, however. The Interim Final required the provider to apply within 180 days of the NPR for the cost reporting period in question. The Intermediary then had 180 days to make its determination. Under this process, a determination would have had to be retroactive or a provider could never qualify for MDH. That is, the application process laid out in the interim final rule clearly contemplated that MDH status would be retroactive since an NPR is only issued well after the close of a cost report period.

The August regulation had an effective date of October, 2001. The commentary incorporated by HCFA discusses the issue here specifically; that is, that the timelines create a situation where a provider could not effectively qualify for a period that is provided for under the statute. HCFA's restatement of the comment refers to the qualification process 'already in place' by which the Intermediary "automatically determines, using the cost report information they have. . ." whether the hospital qualifies. The commenter complained that a determination could take 2-4 years and "would not allow hospitals to qualify by the first cost reporting period beginning on or after the April 1, 2001 effective date." The HCFA response does not dispute that the current process is an 'automatic' determination by the intermediary without an application. HCFA responds, though, that it is more appropriate to require hospitals to request MDH status rather than placing this requirement with the Intermediary. The next sentence states "we will further clarify the MDH policy and process (including the change noted) through future program memoranda.

The change referred to is:

- HCFA deleted the language that requests must be made within 180 days of the NPR. The commentary states that they can be made any time and are not limited to the 180 days after the NPR.[17]

- The Intermediary's time for review was reduced from 180 days to 90.

- MDH status and the associated payment adjustment were made effective 30 days after written notification of approval to the provider.

[17] NPRs are issued by the Intermediary based on a cost report filed by the provider. Cost reports are due five months after the close of the fiscal year. NPRs can often take a year or more to be issued. As a practical matter, any request made after the latter part of the provider's fiscal year would be futile under the final rule.

The last provision totally changed the process by cutting off any qualification period prior to the Intermediary determination date plus 30 days. This was the first notice of the process. Even though an application process had been introduced in June, it provided for the application to be filed well after the cost report period in issue and, by implication, made approval retroactive to the entire period for which the provider qualified. The August regulation was effective Oct 1. Since prior to the regulation the process was an automatic determination by the Intermediary retroactive to the beginning of the cost report period, the new process applied only to cost report periods beginning on or after Oct 1, 2001. Providers with an October 1 cost report start date were, therefore, given 60 days to comply with a process that contemplated a minimum of 120 days and, realistically, even longer. [18]

HCFA apparently recognized the gap created by the new rule and in December issued a Program Memorandum (PM) to intermediaries. It noted that some intermediaries began making the MDH payments to hospitals as soon as the January 2001 transmittal came out, thus reinforcing the "automatic determination" process.

The PM provided for retroactive approval to the beginning of the cost report period but only for any provider that had filed an application prior to October 1, 2001, two months earlier than the notice. The justification for the modification to the regulation was that:

> We did not address situations where a hospital could not have known of this timetable sufficiently in advance to submit a request in time to attain approval prior to its first cost period beginning on or after April 1, 2001. We recognize that some hospitals may be disadvantaged by the timing of the approval of their MDH status and the beginning of their cost reporting period.

HCFA's PM is aimed at closing the gap and would have been effective except, by not sending out the PM until December but making the cut off date October, the PM 'fix' still leaves a gap. Whether that gap conflicts with the statute is a matter that is beyond the Board's authority to determine.

Suzanne Cochran, Esq. Martin W. Hoover, Jr., Esq.

[18] The only way a provider could have been assured of qualifying for the full cost report period was to file an application 120 days prior to the beginning of its cost report period . Until August 1, providers had no notice of the thirty day waiting period after approval. It is unrealistic to assume a provider could have filed a request on the day it first received notice. Any provider with a cost report period beginning prior to January 1, 2002 would be disadvantaged assuming 30 days is a sufficient time after receiving notice to file an application: 30 days + 90 + 30.