PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D61

PROVIDER –
Iron County Community Hospital

Provider No. 23-3519

vs.

INTERMEDIARY –
United Government Services, LLC
Blue Cross Blue Shield Association

DATE OF HEARING -
October 23, 2002

ESRD Window Closing
August 28, 2000

CASE NO. 01-0627

INDEX

ISSUE:

Was HCFA's (CMS's) determination concerning the exception request under the prospective payment system proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Iron County Community Hospital ("Provider") is a Sole Community Hospital as recognized by the Medicare regulations. The Provider requested an exception to its End Stage Renal Dialysis ("ESRD") payment rate on July 28, 2000. On August 22, 2000, the request was returned to the Provider by its Intermediary for more information. On August 28, 2000 the Intermediary acknowledged that it accepted all of the information. On September 11, 2000, the Intermediary sent the Provider's request to the Center for Medicare and Medicaid Services (CMS) with its recommendation for full approval of the composite rate payment request. On November 22, 2000, CMS denied the request.

The Provider did not agree with the CMS decision and requested a hearing before the Provider Reimbursement Review Board ("Board"). The Provider has met the jurisdictional requirements of the Medicare regulations at 42 C.F.R §§ 405.1835-.405.1841 and 413.180. The amount in contention is an increase in the Prospective Payment Rate from $127.82 to $211.95. The Medicare reimbursement effect is approximately $173,223.

The Provider was represented at the hearing by Ronald Rybar of the Rybar Group. The Intermediary was represented by Bernard Talbert, Esquire, of the Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider points out that there are three elements that a provider must document in order to obtain an exception. The provider must be an isolated facility, it must be essential to the care of ESRD beneficiaries and it must establish that its costs are reasonable and attributable to its status as an Isolated Essential Facility ("IEF").

The Provider contends that it is an isolated facility as it is located in a rural county 177 miles from the nearest Metropolitan Statistical Area ("MSA") in Wisconsin and 418 miles from the nearest MSA in Michigan. It is the only dialysis provider in a county of 1,100 square miles and is acknowledged by Medicare as being a Sole Community Hospital, a qualification that is dependent upon geographical isolation of the facility.

The Provider maintains that it is an essential facility because a significant number of its patients would experience undue hardship in terms of increased costs and time spent in obtaining dialysis if its facility did not exist. Its average patient would incur additional total costs of approximately $19,000 per year if required to travel to the next closet ESRD

facility.[1] The Intermediary witness testified at the hearing that additional travel cost of "$2,500 a year" would be considered to be a hardship for an individual patient.[2]

If the Provider's facility were not available, the average per-treatment commute time to the next closet ESRD facility would increase by one hour and six minutes.[3] Iron County receives approximately 135 inches of snow per year, resulting in icy road conditions on a regular basis during the winter months and a doubling of the commute time.

The average age of the Provider's patient population is 70.14, 50% of the patients are diabetic and 86% suffer from hypertension. The fragile nature of its population in terms of sickness and age accentuates why an undue hardship for its patients would result if the Provider's facility were not available.[4]

The Provider argues that the closest ESRD facility has 100% utilization and therefore could not handle the Provider's patients. The next closest ESRD facility would put its patients beyond any feasible thrice-weekly commute required of ESRD patients.

The Provider has the responsibility to document and establish that its costs are related to its isolated essential facility status. The Provider contends that it meets the staffing requirement of the ESRD regulations, and that its staffing standard of 3.0 full time equivalent (FTE's) employees meets the safety requirements as established by CMS.

The Provider points out that its costs are only slightly higher than most of the providers in its peer group with larger volumes of patients. The CMS Manual HIM 15-1 § 2725.3D states in part: "One factor that may contribute to an IEF higher cost per treatment is a low number of treatments." The peer group comparison indicates that the Provider has a low number of treatments; therefore, it is a logical conclusion that it's higher cost per treatment is its IEF status.

The Provider maintains that it has established through documentation that it meets the three elements of the correlation of cost to IEF status. These elements are productivity[5] staffing mix,[6] and under-utilization.[7] The Provider indicated that three employees are needed to set up and maintain the dialysis machines for each shift.[8] With slightly more than 6 patients per day (low volume), the average number of patient treatments per FTE is significantly below that of the smallest facilities in the country. This low productivity accounted for $53.38 in excess of the Provider's composite rate.

The required staffing mix of the unit to meet CMS standards and provide for patient safety is the second reason cited by the Provider for exceeding the composite rate. The

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1 See Exhibit P-11.
2 See Tr. at 155.
3 See Exhibit P-8.
4 See Provider Position Paper at 5.
5 See Exhibit P-15A.
6 See Exhibit P-15B.
7 See Exhibit P-15C.
8 See Provider Position Paper at 7.

nursing staff to total staff ratio of the Provider was compared to the national standard. The higher nursing cost of the Provider was quantified, based on its low volume and fixed mix of staff. This accounted for $21.60 in excess of the composite rate, directly tied to IEF status via low volume, fixed staff.[9]

The Provider maintains that it met the third element of cost tied to IEF status, under-utilization, as the Provider had 82.5% utilization.[10] The Provider documented that it could not work with fewer stations because, for all of the sample months reviewed in FY 2000, the average number of treatments per day exceeded six. Eight shifts of capacity were always required to serve its patients. Quantification of the amounts in excess of the composite rate with virtually 100% fixed costs and 100% utilization is $37.08.[11]

The Provider contends that CMS's denial would result in the Provider's patients going from its facility, which has a cost per treatment of $210.42, to the next nearest facility, which has a cost per treatment of $271.97. This alone results in cost inefficiency and does not appear to have been taken into account in CMS's determination process.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider has failed to demonstrate that it meets the criteria required by regulation for an adjustment to the its ESRD rate. In order to qualify for an exception, the Provider must first prove that it is an IEF. This requires that it meet the requirements set out in the regulation at 42 C.F.R. § 413.186(a). That regulation states:

> (a) Qualifications. To qualify for an exception to the prospective payment rate based on being an isolated essential facility-
> (1) The facility must be the only supplier of dialysis in its geographical area;
> (2) The facility's patients must be unable to obtain dialysis services elsewhere without substantial additional hardship; and
> (3) The facility's excess costs must be justifiable.

The Intermediary contends that the Provider was not the only supplier of dialysis service in the geographical area. Therefore, it does not meet the qualification criteria set out at 42 C.F.R. § 413.186(a)(1). Furthermore, since the Provider has not submitted documentation to show incremental costs associated with being an IEF, it fails to meet the criteria set forth in paragraph (3) of the addressed regulation.

The Intermediary contends that CMS reviewed the Provider's qualifications as an IEF, including the evidence submitted by the Provider to show that there is no other available dialysis for patients without incurring substantial hardship. The review by CMS indicated that there is alternative dialysis service available to patients in the geographical

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[9] See Exhibit P-15B.
[10] See Provider Position Paper at 6
[11] See Exhibit P-15C

area served by the Provider. Another facility, located in Iron Mountain, Michigan, has available dialysis capacity to serve patients in that geographical area. Therefore, the Provider has not demonstrated that it quantifies as an IEF or that it meets the criteria for a rate exception.

The Intermediary maintains that the Provider failed to demonstrate that it met the criteria for approval of a rate exception request because it has neither documented its incremental treatment cost for delivery of service, nor shown that incremental treatment costs are related to its status as an IEF.

The Intermediary maintains that the Provider failed to show that its incremental costs associated with salary, patient acuity, capacity, overtime, supplies or overhead were attributable to IEF status, and CMS concluded that these costs were in fact not so attributable.

The Intermediary contends that while it did find that the Provider was an isolated facility by virtue of its remoteness to any MSA, it did not find that it is an essential facility. This was based on the findings that other renal dialysis centers exist within reasonable proximity to the Provider and that these facilities have sufficient capacity to handle additional patient load.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the Medicare law, program instructions, parties' contentions and evidence submitted, finds and concludes that the Provider is an Isolated Essential Facility and is entitled to the higher ESRD rate.

The Board finds that the Provider was an isolated, essential facility, and that its costs were related to its isolated and essential status.

The Provider was the only dialysis facility in Iron County, a large rural county of 1100 square miles located 177 miles from the nearest Metropolitan Statistical Area ("MSA"). It was acknowledged by Medicare as being a Sole Community Hospital; no public transportation was available, and heavy snowfall, severely cold temperatures and hazardous driving conditions during the winter months made travel for its frail, elderly patients very difficult.

The Board also finds that the Provider was an essential facility, as the closet alternative renal dialysis center, Dickinson County Health Care Dialysis, was located more than 30 miles from the Provider and did not have available capacity to accommodate all of Iron County Community Hospital's patients.

In addition, the Board agrees that certain of the Provider's patients would experience substantial additional hardship (as addressed in the regulation at 413.186(a)(2)) in terms of increased costs and travel time if they were forced to go elsewhere for their dialysis treatments. The Intermediary witness acknowledged at the hearing that the extra annual

cost of $2,500 and the increase in the average per treatment commute time of one hour six minutes would create additional hardship for the Provider's patients.

The Board finds that the Provider has documented and established that the higher cost was linked to the facility being isolated and essential. The Provider indicated that three employees are needed to set up and maintain the dialysis machines for each shift. With slightly more than 6 patients per day (low volume), the average number of patient treatments per FTE is significantly below that of the smallest facilities in the country. A quantification of that amount was made utilizing ACCH operating statistics and staffing levels. The Board finds that the low volume accounted for $53.38 in excess of the composite rate. In addition, Provider's staffing mix, required to meet CMS standards and patient safety, accounted for $21.60 in excess of the composite rate. The Provider's underutilization accounted for $37.08 in excess of the composite rate.

The Board finds that the next closest facility to which CMS would have the Provider's patients go for ESRD services has a higher cost per treatment than the Provider has requested. The Board concludes it would be illogical to shift the Provider's patients to a higher cost facility. Such a shift would not only mean increased costs to Medicare but would also put the patients at greater risk due to increased travel time and hazardous driving conditions, and it may very well be detrimental to their already compromised health. The Board finds such a result to be contrary to the spirit and the letter of the regulations

DECISION AND ORDER:

The Intermediary's determination that the Provider is not an isolated essential facility and that its costs are not allowable was not proper. CMS's denial of the rate increase is reversed.

BOARD MEMBERS PARTICIPATING:

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

DATE: September 25, 2003

FOR THE BOARD:

Suzanne Cochran
Chairman