PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2013-D5

PROVIDER –
Maine Coast Memorial Hospital
Ellsworth, Maine

Provider No.: 20-0050

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
NHIC, Corp. c/o National Government
Services, Inc.

DATE OF HEARING –
November 15, 2011

Cost Reporting Period Ended –
June 30, 2009

CASE NO: 11-0570

INDEX

ISSUE:

Was Maine Coast Memorial Hospital's request to be designated as a Sole Community Hospital properly denied?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due to a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare and Medicaid Services ("CMS," formerly the Health Care Financing Administration ("HCFA")) is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulations and under interpretive guidelines published by CMS.[2]

Cost reports are required from providers on an annual basis with reporting periods based on the provider's fiscal year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs to be allocated to the Medicare program.[3] The MAC reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[4] A provider dissatisfied with the MAC's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[5]

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Inpatient Prospective Payment System ("IPPS").[6] PPS provides Medicare payment for hospital inpatient operating and capital-related costs at predetermined, specific rates for each hospital discharge. IPPS allows special treatment for facilities who qualify as "Sole Community Hospitals" (SCHs). The statutory definition of an SCH is as follows:

> (iii) for purposes of this subchapter, the term "sole community hospital" means any hospital –
> (I) that the Secretary determines is located more than 35 road miles from another hospital,

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[1] FIs and MACs are hereinafter referred to as MACs.

[2] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

[3] *See* 42 C.F.R. § 413.20.

[4] 42 C.F.R. § 405.1803.

[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1839.

[6] *See* 42 U.S.C. § 1395ww(d).

> (II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in the geographic area who are entitled to benefits under part A, or
> (III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1395i-4(i)(1) as in effect on September 20, 1997.[7]

42 C.F.R. § 412.92 (2009)[8] sets forth the special treatment for SCHs and establishes the criteria that must be met in order for a hospital to be classified as a SCH. CMS adjusts the PPS rates for SCHs to accommodate their special operating circumstances (*e.g.*, isolated location, weather/travel conditions, unavailability of other hospitals). In particular, § 412.92(a)(1) establishes the following criteria that the Provider in this case must meet to obtain SCH status:

> (a) *Criteria for classification as a sole community hospital.* CMS classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in § 412.64) and meets one of the following conditions:
> (1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:
> (i) No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area;
> (ii) The hospital has fewer than 50 beds and the intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital; or
> (iii) Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.[9]

Further, § 412.92(b) specifies what information a provider applicant needs to submit to a MAC in order to determine whether the provider applicant meets this SCH criteria. The information required is as follows:

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[7] 42 U.S.C. § 1395ww(d)(5)(D)(iii).
[8] All citations to the C.F.R. are to the edition dated October 1, 2009 unless specified otherwise.
[9] (Emphasis in original).

> (b) *Classification procedures*—(1) *Request for classification as sole community hospital.* (i) The hospital must make its request to its fiscal intermediary.
> (ii) If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:
> (A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital draws inpatients) for all inpatient discharges to document the boundaries of its service area.
> (B) The hospital must provide patient origin data from all other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.
> (iii)(A) If the hospital is unable to obtain the information required under paragraph (b)(1)(ii)(A) of this section concerning the residences of Medicare beneficiaries who were inpatients in other hospitals located within a 35 mile radius of the hospital or, if larger, within the hospital's service area, the hospital may request that CMS provide this information.
> (B) If a hospital obtains the information as requested under paragraph (b)(1)(iii)(A) of this section, that information is used by both the intermediary and CMS in making the determination of the residences of Medicare beneficiaries under paragraphs (b)(1)(iii) and (b)(1)(iv) of this section, regardless of any other information concerning the residences of Medicare beneficiaries submitted by the hospital.[10]

Significantly, §§ 412.92(a)(1)(i) and 412.92 (b)(1)(ii)(B) each set forth a fraction that represents what will hereinafter be referred to as the "'no more than 25 percent' test":

Language for the fraction in § 412.92(a)(1)(i) or the "Subsection (a) Fraction"	"No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger, within its service area."
Language for the fraction in § 412.92(b)(1)(ii)(B) or the "Subsection (b) Fraction"	"[N]o more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care."

[10] (Emphasis in original.)

The language used to described the fraction in § 412.92(a)(1)(i) is almost the same as that used to describe the same fraction in § 412.92 (b)(1)(ii)(B). In order to distinguish between them, the fraction described in § 412.92(a)(1)(i) will be hereinafter referred to as the "Subsection (a) Fraction" and the fraction stated in § 412.92(b)(1)(ii)(B) will be hereinafter referred to as the "Subsection (b) Fraction."

The terms "miles," "like hospital," and "service area" as used within § 412.92 are defined in subsection (c) as follows:

> (c) *Terminology.* As used in this section—
> (1) The term *miles* means the shortest distance in miles measured over improved roads. An improved road for this purpose is any road that is maintained by a local, State, or Federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital.
> (2) The term *like hospital* means a hospital furnishing short-term, acute care. Effective with cost reporting periods beginning on or after October 1, 2002, for purposes of a hospital seeking sole community hospital designation, CMS will not consider the nearby hospital to be a like hospital if the total inpatient days attributable to units of the nearby hospital that provides a level of care characteristic of the level of care payable under the acute care hospital inpatient prospective payment system are less than or equal to 8 percent of the similarly calculated total inpatient days of the hospital seeking sole community hospital designation.
> (3) The term *service area* means the area from which a hospital draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for classification as a sole community hospital.[11]

The Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2810 further clarifies the process of qualifying for classification as an SCH. The issue in this case involves whether the Provider met the criteria to be classified as a SCH.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Maine Coast Memorial Hospital ("Provider") is a 48-bed nonprofit, Medicare Dependent Hospital located in rural Ellsworth, Hancock County, Maine. On June 28, 2010, the Provider submitted an application to be classified as an SCH based upon documentation from the Provider's cost report for the fiscal year ending ("FYE") June 30, 2009.[12] In its application, the Provider claimed that it qualified as an SCH because it met the following criteria specified in 42 C.F.R. § 412.92(a): (1) the hospital "is located in a rural area"; (2) "[t]he hospital is located between 25 and 35 miles from other like hospitals"; and (3) "no more than 25 percent of the

[11] (Emphasis in original.)
[12] Provider Exhibit P-1.

Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital."[13]

Following its review of the Provider's SCH application, NHIC, Corp. C/O National Government Services, Inc. ("MAC") determined under its interpretation of the applicable regulation that: (1) for purposes of the Subsection (a) and Subsection (b) Fractions, the denominator consists of those Medicare beneficiaries who reside in the Provider's service area and were admitted as inpatients to either the Provider or another "like hospital" located within a 35-mile radius of the Provider; and (2) more than 25% of these Medicare beneficiaries were admitted to the other "like hospitals" located within a 35-mile radius of the Provider.[14] Based on these calculations, the MAC determined that the Provider failed the "no more than 25 percent" and, thereby, denied the Provider's SCH application.

The parties have stipulated to the following facts:[15]

1. The Provider is a 48 bed nonprofit, short term acute care rural community hospital located at 50 Union Street, Ellsworth, Maine, 04605.
2. The following hospitals [are] located within a 35-mile radius of the Provider.
    a. Eastern Maine Medical Center ("EMMC") is an acute care hospital located 27.6 miles from the Provider. EMMC is a "like hospital" as defined by Medicare regulations at 42 C.F.R. § 412.92(c)(2).
    b. Saint Joseph Hospital ("SJH") is an acute care hospital located 27.6 miles from the Provider. SJH is a "like hospital" as defined by Medicare regulations at 42 C.F.R. § 412.92(c)(2).
    c. Blue Hill Memorial Hospital ("BHMH") is a critical access hospital located 14.5 miles from the Provider. BHMH is not a "like hospital" as defined by Medicare regulations at 42 C.F.R. § 412.92(c)(2).
    d. Mount Desert Island Hospital ("MDIH") is a critical access hospital located 20.7 miles from the Provider. MDIH is not a "like hospital" as defined by Medicare regulations at 42 C.F.R. § 412.92(c)(2).

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[13] In addition, pursuant to 42 C.F.R. § 412.92(a)(1)(ii), hospital applicants with fewer than 50 beds such as the Provider can have certain admissions covered by the Subsection (a) Fraction excluded if "the intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the community hospital." As reflected in the Stipulation ¶¶ 7 and 8 (Provider Exhibit P-6), the MAC and Provider have agreed that certain specified admissions qualify under § 412.92(a)(1)(ii) and, thus, are excluded from the "no more than 25 percent" test. As a result, this aspect of the subsection (a) SCH criteria is not being reviewed by the Board. *See also* PRM 15-1 § 2810(B)(3)(d) (providing an example of § 412.92(a)(1)(ii)).

[14] Provider Exhibit P-3 at 27.

[15] Provider Exhibit P-6 (Stipulation).

e. The Acadia Hospital ("AH") is a psychiatric hospital located 28.1 miles from the Provider, AH is not a "like hospital" as defined by Medicare regulations at 42 C.F.R. § 412.92(c)(2).
f. Dorothea Dix Psychiatric Center ("DDPC") is a psychiatric hospital located 28.1 miles from the Provider. DDPC is not a "like hospital" as defined by Medicare regulations at 42 C.F.R. § 412.92(c)(2).

3. The Provider is located between 25 and 35 miles from two (2) other "like hospitals," as that term is defined by Medicare regulations at 42 C.F.R. § 412.92(c)(2). These hospitals are EMMC and SJH.
4. The Provider's service area, as defined by Medicare regulations at 42 C.F.R. § 412.92(c)(3), consists of seventeen (17) towns, as follows: Bar Harbor, Ellsworth, Franklin, Gouldsboro, Tremont, Trenton, Orland, Southwest Harbor, Sullivan, Surry, Milbridge, Steuben, Winter Harbor, Cherryfield, Harrington, Hancock, and Lamoine.
5. Following its review of the Provider's Sole Community Hospital ("SCH") application documentation, the MAC determined that, during the time period relevant to the present appeal, there were 1184 discharges for Medicare beneficiaries residing in the Provider's service area and hospitalized for inpatient care at the Provider.
6. Following its review of the Provider's SCH application documentation, the MAC determined that, during the time period relevant to the present appeal, there were the following numbers of discharges for Medicare beneficiaries residing in the Provider's service area that were hospitalized for inpatient care at all other hospitals with 35-miles of the Provider:

	"Like Hospitals"	CAHs	Psych
EMMC	643	-	-
SJH	69	-	-
BHMH	-	55	-
MDH	-	445	-
AH	-	-	22
DDPC	-	-	8
Totals	712	500	30

7. Following its review of the Provider's SCH application documentation, the MAC determined that 247 of the Medicare beneficiaries identified above were admitted to EMMC due to the unavailability of necessary specialty services at the Provider, and

the MAC agreed to exclude these Medicare beneficiaries from the calculation.

8. Following its review of the Provider's SCH application documentation, the MAC determined that 6 of the Medicare beneficiaries identified above were admitted to SJH due to the unavailability of necessary specialty services at the Provider, and the MAC agreed to exclude these Medicare beneficiaries from the calculation.
9. Following its review of the Provider's SCH application documentation, the MAC determined that 459 of the Medicare beneficiaries identified above were admitted to other "like hospitals" for care. The 459 Medicare beneficiaries consist of 396 patients at EMMC and 63 patients at SJH.
10. The Provider and MAC agree that the numerator of the fraction described in 42 C.F.R. § 412.92(a)(i) and (a)(ii) and 42 C.F.R. § 412.92 (b)(1)(ii)(B) is 459 (Medicare beneficiaries residing in the Provider's service area and hospitalized for inpatient care at other "like hospitals" for care).
11. The Provider contends that the denominator of the fraction described in 42 C.F.R. § 412.92 (a)(i) and (a)(ii) and 42 C.F.R. § 412.92 (b)(1)(ii)(B) is 2173. According to the Provider, this number represents the number of "Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care," and includes 1184 Medicare beneficiaries at the Provider, 396 at EMMC, 63 at SJH, 445 at MDIH, 55 at BHMH, 22 at AH, and 8 at DDPC.
12. The MAC contends that the denominator of the fraction described in 42 C.F.R. § 412.92 (a)(i) and (a)(ii) and 42 C.F.R. § 412.92 (b)(1)(ii)(B) is 1643. According to the MAC, this number represents the number of "Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care," and includes 1184 Medicare beneficiaries at the Provider, and 459 Medicare beneficiaries at "like hospitals" (396 at EMMC and 63 at SJH).

A review of Stipulations ¶¶ 11 and 12 shows that the dispute revolves around whether the Medicare discharges from the psychiatric hospitals and CAHs (445 at MDIH, 55 at BHMH, 22 at AH, and 8 at DDPC) should be included in the denominator of the Subsection (a) and Subsection (b) Fractions. The parties agree on the numerator of each of these fractions but disagree regarding the calculation of the denominator.

The Provider was represented by William H. Stiles, Esq. of Verrill Dana, LLP. The MAC was represented by Bernard M. Talbert, Esq. of the BlueCross BlueShield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the denominator of the "no more than 25 percent" test should be 2173 Medicare discharges, consisting of the Medicare beneficiaries from the Provider's service area that were admitted to and discharged from the Provider, other "like" hospitals as well as all other hospitals within a 35-mile radius of the Provider.[16] Accordingly, the Provider argues that it satisfied the "no more than 25 percent" test set forth in § 412.92(b)(1)(ii)(B) because no more than 25 percent (459/2173 or 21.12 percent) of the Medicare patients at issue "were admitted to other like hospitals for care."[17]

The Provider contends that the plain language of § 412.92(b)(1)(ii)(B) defines the denominator of the Subsection (b) Fraction as "all . . . the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care."[18] The Provider argues that the plain language of the regulation binds the Board under the generally accepted rules of statutory construction.[19]

The Provider believes that the requirement in § 412.92(b)(1)(ii)(B) that "[t]he hospital must provide patient origin data from *all other hospitals* located within a 35-mile radius of it . . ."[20] as the means "to document" the Subsection (b) Fraction further supports its interpretation that the Medicare discharge data for both "like" hospitals and all other hospitals is required to be in the denominator of that fraction.[21] The Provider asserts that, if the numerator and denominator both only included "like hospital" data, the regulation would have only required "like hospital" data be submitted.[22]

The Provider also contends that, contrary to the MAC's interpretation, the applicable regulation does not contain a "competition" or "market share" test under which the Provider would be required to admit at least 75% of the Medicare beneficiaries who reside in its service area and who are admitted as inpatients to the Provider or another "like hospital" located within a 35-mile radius of the Provider.[23] The plain language of the regulation does not contain any discussion of 75 percent. The Provider points out that the only references to 75 percent in the SCH regulations are: (1) in the definition of the Provider's service area;[24] and (2) the determination of prospective payment rates for inpatient operating costs for SCHs.[25] The Provider characterizes the Subsection (b) Fraction as a test to ensure that the applicant does not lose more than 25% of the Medicare beneficiaries to "other like hospitals"[26] (as opposed to "all other hospitals"). The Provider states "[s]imply put, if less than 25% of these Medicare beneficiaries are admitted to 'other like hospitals,' the Provider has satisfied the test set forth in the regulation."[27]

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[16] *Id.* at ¶ 11.
[17] *See id.* at ¶¶ 10-11; Provider's Final Position Paper at 8.
[18] Provider's Final Position Paper at 6, 10, 15.
[19] *Id.* at 8-13, 15.
[20] (Emphasis added.)
[21] *See id.* at 9-12.
[22] Provider's Post Hearing Brief at 6.
[23] *See id.* at 6-7.
[24] *See* 42 C.F.R. § 412.92(c)(3).
[25] *See* 42 C.F.R. § 412.92(d)(2)(i).
[26] There is no dispute that the CAHs and Psychiatric hospitals at issue are not "like hospitals." *See* Provider Exhibit P-6 at ¶¶ 2-3.
[27] Provider's Post Hearing Brief at 6.

Finally, the Provider contends that the process described in 42 C.F.R. § 412.92(a)(1)(ii) and PRM 15-1 § 2180(B)(3)(d) to net out certain Medicare beneficiaries from the Subsection (b) Fraction does not support the MAC's position. The Provider asserts that it simply followed the PRM instruction that: "these cases are removed from both the out-of-area services and the total services . . . ."[28] The Provider argues that this instruction shows that CMS was aware of the need to net certain patients from both parts of the fraction. The Provider believes CMS would have specified non-like hospitals (*e.g.*, CAHs and psychiatric hospitals) also be excluded from the denominator if this had been their intention.[29]

MAC 'S CONTENTIONS:

The MAC contends that the statutory definition of SCH in 42 U.S.C. § 1395ww(d)(5)(D)(iii) cedes a great deal of discretion to the Secretary and includes the critical factor of "absence of other like hospitals." The MAC argues that the plain meaning of the statute requires that any analysis has to be based on "like" hospitals rather than all hospitals (both like and unlike).

In support of this position, the MAC points to several policy statements made in the preamble to the final rule published on August 1, 2001 ("August 2001 Final Rule") that purported it was, "discussing and clarifying many of the rules and policies governing SCHs because of the legislative changes that have occurred in recent years" and contained "a detailed discussion of these policies."[30]

The MAC believes it is clear that the purpose for "no more than 25 percent" test is to measure competition or market share. In the regard, CMS discusses the concept of competition in making SCH classification determinations in the preamble to the August 2001 Final Rule:

> Fourth, we believe it is reasonable to examine a hospital's competitors within a 35-mile radius. Most competing hospitals will not be at the outer limit of the 35-mile radius, and, if these hospitals are not truly competitors, the discharge data will bear out that fact. Also, we examine a hospital's service area based on discharges within zip code areas, and, often, this will exceed a 35-mile radius. Therefore, we believe the 35-mile radius is reasonable.[31]

The MAC argues that the preamble's reference to competitors makes obvious that the concept of competition forms the basis for the "no more than 25 percent" test. As a result, the Subsection (a) and Subsection (b) Fractions used for this test are designed to measure market share or, more specifically, how many patients an SCH applicant draws in relation to other competing "like" hospitals. To this end, the MAC refers to the "no more than 25 percent" test as a market share

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[28] PRM 15-1 § 2810(B)(3)(d).
[29] The Provider notes that CAHs were specifically deemed not to be "like hospitals" in 66 Fed. Reg. 39828, 39876 (Aug. 1, 2001). Provider's Final Position Paper at 14.
[30] 66 Fed. Reg. 39828, 39872 (Aug. 1, 2001).
[31] *Id.* at 39876.

test.[32]

Further, the MAC asserts that the Provider is wrong in arguing that inpatient admissions from hospitals that are not "like hospitals" should be considered or used in the "no more than 25 percent" test. The MAC argues that inpatient admissions from two CAHs should not be added into the denominator of either fraction, citing the following language from the preamble to the August 2001 Final Rule:

> Eighth, we do not consider CAHs like hospitals to be SCHs. CAHs are generally smaller with a very limited length of stay, while SCHs operate as full-service acute-care hospitals.[33]

The MAC also asserts that even if the preamble language is disregarded, there is no ostensible reason why the CAH patients in the Provider's service area could not have used the Provider. The reverse is not true, however. The fact that the 500 patients who chose to use the nearby CAHs instead of the Provider further dilutes the Provider's market share.[34] The MAC argues that if Medicare CAH discharges are entirely excluded (as it argues they should be) or entirely included in both the numerator and denominator of the test, the Provider fails the "no more than 25 percent" test.[35] The only way the Provider can pass the "no more than 25 percent" test is by excluding the 500 CAH patients from the numerator and including them in the denominator. The MAC believes that this method as proposed by the Provider is twisted thinking. The MAC believes that the CAH patients should be totally factored out of the fraction used for the "no more than 25 percent" test.[36]

The MAC believes that the PRM would have provided an example including discharges from both like and unlike hospitals if CMS intended that they were to be included in the denominator and not the numerator.[37] That did not happen. Therefore, the MAC concludes the comparison must be contained exclusively within "like" hospitals using a market share or competitor-based analysis.[38]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions, and the evidence presented. Set forth below are the Boards findings and conclusions.

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[32] *See* Intermediary's Final Position Paper at 7-8.
[33] 66 Fed. Reg. at 39876. The MAC points out that this Preamble clarification is a "liberalization" of the plain meaning of a "like" hospital which works to the benefit of the Provider because 42 C.F.R. § 412.92(a)(1) specifies that a provider applicant cannot be classified as an SCH if a "like" hospital is located less than 25 miles from the provider applicant. In the present case, two CAHs were located within 15 miles of the Provider and would have quashed the Provider's request based simply on the fact that these hospitals were too close to the Provider. *See*: Intermediary's Final Position Paper at 8.
[34] *Id.*
[35] *Id. at* 9.
[36] *Id.*
[37] *See generally* PRM 15-1 § 2810.
[38] *See* Intermediary's Final Position Paper at 10.

The Board first will analyze whether the statute or regulations with which the Board is bound to comply answers the question in this case.[39] The relevant statute states:

> (iii) for purposes of this subchapter, the term *"sole community hospital" means any hospital* –
> (I) that the Secretary determines is located more than 35 road miles from another hospital,
> (II) that, *by reason of factors such as* the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (in accordance with standards promulgated by the Secretary), location, weather conditions, travel conditions, or *absence of other like hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in the geographic area who are entitled to benefits under part A*, or . . .[40]

The Board finds that, while the statute does not answer the question before the Board, the statute does specify that the "absence of other like hospitals" is a factor as well as gives the Secretary discretion on how to interpret and apply this factor. Therefore, the Board must look to regulations and policy to determine how the Secretary has interpreted and applied this factor.

The Provider maintains that the plain language of the regulation at 42 C.F.R. § 412.92 specifies that Medicare inpatient admissions to all hospitals (both like and unlike) within a 35-mile radius of the Provider must be included in the denominator of the Subsection (b) Fraction and that this plain language binds the Board. The Board disagrees with the Provider's position.

As previously noted, both the Subsection (a) and Subsection (b) Fractions state the "no more than 25 percent" test, and the language that each uses to describe that test is almost identical. The Board finds the Subsection (b) Fraction is a restatement or paraphrase of the Subsection (a) Fraction and to resolve the question of how to interpret and apply the "no more than 25 percent" test, the Board focuses first on the Subsection (a) Fraction.

The Board finds that § 412.92(a) as its title suggests establishes the "Criteria for classification as a sole community hospital" that the Provider in this case must meet in order to obtain classification as a SCH. Specifically, § 412.92(a) states in pertinent part:

> (a) *Criteria for classification as a sole community hospital.* CMS classifies a hospital as a sole community hospital if . . . it is located in a rural area (as defined in § 412.64) and meets one of the following conditions:
> (1) The hospital is located between 25 and 35 miles from other like hospitals and meets one of the following criteria:
> (i) . . . no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are

[39] 42 C.F.R. § 405.1867.
[40] 42 U.S.C. § 1395ww(d)(5)(D)(iii) (emphasis added).

> admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger,[41] within its service area.

The language in § 412.92(a)(1)(i) criteria sets forth the Subsection (a) Fraction with the following language pertinent to the Provider: "no more than 25 percent of Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals." The Board finds that, when this language is read in isolation, there is ambiguity regarding what the denominator of the Subsection (a) Fraction is comprised. Specifically, reading this criteria in isolation, the numerator for the Subsection (a) Fraction would be "Medicare beneficiaries who become hospital inpatients in the hospital's service area" and "are admitted to other like hospitals located within a 35-mile radius of the hospital" while the denominator would be "Medicare beneficiaries who become hospital inpatients in the hospital's service area." On its face, the language for the denominator could be interpreted several different ways, depending in part on whether the phrase "in the hospital's service area" modifies "Medicare beneficiaries" or "hospital inpatients."

As a result, the Board must look elsewhere within § 412.92 for guidance on the scope of the "no more than 25 percent" test. Similar to the statute's use of the phrase "absence of other like hospitals," § 412.92 uses the phrase "other like hospitals." The Board notes that the use of this phrase in the statute and as well as subsection (a) and subsection (a)(1)(i) in § 412.92 confirms that the provider applicant is a "like" hospital and suggests that the "no more than 25 percent" test may be a market test for comparison of "like" hospitals (*i.e.*, for comparison of the hospital applicant to "other like hospitals" to the extent they are not absent). The definition of "like hospital" in §412.92(c)(2) is supportive of this interpretation as the identification of "like hospitals" includes a case-by-case process to exclude certain hospitals that are not similar to the provider applicant and, thus, presumably not a competitor of the provider applicant. However, this does not resolve the ambiguity in the § 412.92 (a)(1)(i) language for the "no more than 25 percent" test.

The SCH regulations at 42 C.F.R §412.92(b) specify "Classification procedures" including what information needs to be submitted for a MAC to process the application and determine whether the Provider met the criteria for classification as an SCH. In particular, 42 C.F.R. § 412.92(b)(1)(ii) describes in two clauses the information that a provider is required to submit where clause (A) requests certain admissions data pertaining the hospital applicant and clause (B) request certain admissions data on "all other hospitals":

> (b) *Classification procedures*—(1) *Request for classification as sole community hospital. . . .*
> (ii) If a hospital is seeking sole community hospital classification under paragraph (a)(1)(i) or (a)(1)(ii) of this section, the hospital must include the following information with its request:
> (A) The hospital must provide patient origin data (for example, the number of patients from each zip code from which the hospital

[41] The Board notes that the Provider's service area is not larger than a 35-mile radius of the Provider. *See* Provider's Final Position Paper at 9, fn 2.

> draws inpatients) for all inpatient discharges to document the boundaries of its service area.
> (B) The hospital must provide patient origin data from all other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care.[42]

Significantly, §412.92(b)(1)(ii)(B) also sets forth the Subsection (b) Fraction using the following language pertinent to the Provider: "no more than 25 percent of either all of the population or the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care were admitted to other like hospitals for care." The numerator of the Subsection (b) Fraction would be "the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care" and "admitted to other like hospitals for care" while the denominator would be simply "the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care."[43]

As the Subsection (b) Fraction restates or paraphrases the Subsection (a) Fraction, the Board looks to the language of the Subsection (b) Fraction to determine whether it clarifies the Subsection (a) Fraction for purposes of the "no more than 25 percent" test. In this regard, the Board concludes that placement of the phrase "in the hospital's service area" in the Subsection (b) Fraction's confirms that, for purposes of the Subsection (a) Fraction, the phrase "in the hospital's service area" modifies "Medicare beneficiaries."[44] As a result, for purposes of

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[42] (Emphasis in original).

[43] The Board also disagrees with the Provider's construction of 42 C.F.R. § 412.92(b)(1)(ii)(B). The Provider asserts that the denominator of the Subsection (b) Fraction is the following language from § 412.92(b)(1)(ii)(B): "all . . . the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care…" *See, e.g.*, Provider's Post Hearing Brief at 5. It is unclear whether the Provider is taking the word "all" from the earlier phrase "all other hospitals" where it is used as an adjective or from the phrase "all of the population" where it is used as a noun. The following is § 412.92(b)(1)(ii)(B) with text italicized to show where these occurrence of "all" as well as the remainder of the Provider's excerpt appear:

> (B) The hospital must provide patient origin data from *all* other hospitals located within a 35 mile radius of it or, if larger, within its service area, to document that no more than 25 percent of either *all* of the population or *the Medicare beneficiaries residing in the hospital's service area and hospitalized for inpatient care* were admitted to other like hospitals for care.

(Emphasis added.) However, the Board finds that neither occurrence of the term "all" can modify or refer to "the Medicare beneficiaries." The first occurrence of "all" in the phrase "all other hospitals" is too remote and the Provider's excerpt would change "all" from being an adjective into a noun where the word "of" is implied (*i.e.*, "all . . . [of] the Medicare beneficiaries"). Moreover, the meaning of "all other hospitals" is not synonymous with "the Medicare beneficiaries." The denominator as represented by the phrase "the Medicare beneficiaries" clearly must include the provider applicant's admissions data; however, the § 412.92(b)(1)(ii)(B) request for admissions data on "all other hospitals" does not include the provider applicant and, thus, would only be a subset of the total admissions data ultimately included in the denominator.

The second occurrence of "all" in the phrase "all of the population" is surrounded by the terms "either . . . or." The "either . . . or" placement effectively isolates that phrase to make it clear that "all" does not modify "the Medicare beneficiaries."

[44] This finding is also consistent with earlier iterations of the "no more than 25 percent" test in 42 C.F.R. § 412.92(a)(1). For example, in the 1985 edition of the C.F.R., the "no more than 25 percent" test was located in 42

the Subsection (a) Fraction, the denominator restated using the § 412.92(a)(1)(ii) language becomes "Medicare beneficiaries [in the service area] who become hospital inpatients." The restated denominator for the Subsection (a) Fraction confirms that the denominator's ambiguity exists in the term "hospital inpatients." In particular, it is unclear whether the term "hospital inpatients" is limited to Medicare beneficiaries who reside in the service area and are admitted as inpatients only to "like" hospitals (as opposed to both like and unlike) and whether these hospitals must be located within the larger of the 35-mile radius of the hospital applicant or the hospital applicant's service area (as opposed to anywhere in the United States).

In reviewing the remainder of § 412.92(b)(1)(ii)(B), the Board finds that it is inconclusive in resolving the ambiguity in the term "hospital inpatients." The Board agrees with the Provider that § 412.92(b)(1)(ii)(B) requires the Provider to submit with its application admissions data from all other hospitals (both like and unlike) located *within a 35-mile radius* of the Provider. Further, the Board agrees with the Provider that the admissions data is being submitted for use with (*i.e.*, "to document") the "no more than 25 percent" test and that the limitation of the admissions data to other hospitals located within the 35 mile radius suggests that the test's denominator as applied to the Provider would not include any admissions data from hospitals located *outside* this 35-mile radius. Notwithstanding, the Board finds that this does not mean that the denominator must necessarily include *all* of the § 412.92(b)(1)(ii)(B) admissions data from all hospitals (both like and unlike) located within the 35-mile radius as advocated by the Provider. For example, the definition of "like hospital" in § 412.92(c)(2) excludes certain otherwise "like" hospitals on a case-by-case basis. While the admissions data required to be submitted under § 412.92(b)(1)(ii)(B) would include admissions data on any hospitals that otherwise is excluded under the definition of "like" hospital, it is unclear from the face of § 412.92(a)(1)(i), and in particular the Subsection (a) Fraction, how the admissions data on these excluded hospitals, if any, would be used in the "no more than 25 percent" test. Indeed, this case-by-case exclusion process illustrates why, under the MAC's interpretation, CMS would want hospital applicants to submit the admissions data for all hospitals within the 35-mile radius as part of the SCH application packet even though the admissions data for some of these hospitals might ultimately be excluded from use within the "no more than 25 percent" test.[45] The Board notes that, in analyzing the remainder of § 412.92 (b)(1)(ii)(B), the Board refers back to § 412.92(a)(1)(i) and the Subsection (a) Fraction rather than to § 412.92(b)(1)(ii)(B) and the Subsection (b) Fraction because § 412.92(b)(1)(ii)(B) does not specify, in the first instance, the criteria or formula for determining whether the Provider can obtain SCH status. Rather, § 412.92(b)(1)(ii)(B) paraphrases the Subsection (a) Fraction for "no more than 25 percent" test

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C.F.R. § 412.92(a)(2)(i) and stated in pertinent part: "no more than 25 percent of the Medicare beneficiaries in the hospital's service area are admitted to other like hospitals for care."

[45] Moreover, as noted by the Provider, PRM 15-1 § 2810(B)(3)(d) which is derived from the 42 C.F.R. § 412.92(a)(1)(ii) clarifies the regulatory process of excluding certain specialty admissions from both the numerator and denominator of the "no more than 25 percent" test. *See supra* notes 28 and 29 and accompanying test. *See also* 53 Fed. Reg. at 38510-38513, 38530-38531 (amending 42 C.F.R. § 412.92(b) to add § 412.92(b)(1)(ii)(B) as it exists in the 2009 edition of the C.F.R.). This manual section conflicts with the Provider's position that the regulation requires all Medicare beneficiaries in the service area who are admitted as an inpatient to any hospital ("like" or "unlike") located in a 35-mile radius of the Provider be included in the denominator. Further, it illustrates another circumstance in which not all of the admissions data required to be submitted by a provider applicant in § 412.92(b)(1)(ii)(B) would be used in the "no more than 25 percent" test. Indeed, as noted in *supra note* 13, the Intermediary has applied this PRM section to the Provider and, thereby, excluded certain admissions from both the numerator and denominator of the "no more than 25 percent" test as applied to the Provider.

(*i.e.*, the criteria or formula that is found in § 412.92(a)(1)(i)). Further, it is clear that § 412.92(b)(1)(ii)(B) was never meant to reflect the full universe of data (*i.e.*, "document" in full the data) to be included in the denominator of the "no more than 25 percent" test because the denominator clearly includes certain admissions data from the provider applicant and that data is requested in clause (A) (as opposed to clause (B)) of § 412.92(b)(1)(ii).

Based on the above analysis and findings, the Board concludes that § 412.92 is ambiguous about whether all of the admissions data specified in § 412.92(b)(1)(ii)(B) must be used in the "no more than 25 percent" test.

Having found that the statute and the regulation are ambiguous as to the question at issue, the Board examined CMS policy as reflected in the preambles to proposed and final rules. First, the Board reviewed the preambles to the proposed and final rules which put in place the regulatory language at issue. CMS promulgated the language in controversy (except the 50-mile limit subsequently was reduced to 35-miles) as part of the final rule published on September 30, 1988 ("September 1988 Final Rule").[46] In the preamble to the September 1988 Final Rule, CMS clarified its policy for the "no more than 25 percent" test with the following discussion:

> Comment: One commenter pointed out an inconsistency between an SCH criterion as presented in the regulatory text and as discussed in preamble language. That is, the regulatory text a[t] § 412.92(a)(2)(i) states that we will measure whether more than 25 percent of the residents who become inpatients or 25 percent of the Medicare inpatients within a hospital's service area are admitted to other like hospitals for care. However, the preamble of the May 27, 1988 proposed rule states that this requirement can be satisfied if the hospital submits patient origin data from all other hospitals located within the larger of its service area or a 50-mile radius. The commenter noted that the regulatory test would require a hospital to identify every person within its service area or the 50-mile radius who was admitted to any hospital for treatment. Under the preamble language, a hospital seeking SCH status would have to show only that it admitted 75 percent of all inpatients admitted to any hospital located within the larger of its service area or a 50-mile radius. The commenter also asked about what assistance is available from HCFA if neighboring hospitals are uncooperative in providing data on admissions to their facilities.
>
> Response: We agree with the commenter that the language is confusing. We also recognize the difficulty of identifying every resident or Medicare beneficiary who became an inpatient during a particular period of time. Therefore, we are revising §412.92(a)(2)(i) to clarify that *a hospital seeking SCH status must show that* during the cost reporting period ending before it files for SCH status, *it admitted at least* 75 percent of all the hospitalized

[46] 53 Fed. Reg. 38476 (Sept. 30, 1988).

> residents or *75 percent of all the Medicare beneficiaries who were admitted to any like hospital located within the larger of the requesting hospital's service area or a 50-mile radius.*
>
> We also recognize that there are instances in which a hospital may experience difficulty in collecting the data to show the percentage of patients it admits from its service area. . . . We are therefore offering to assist hospitals in making available data from Medicare's central office records. Hospitals seeking this assistance should address their request to their intermediary .
>
> The hospital must furnish its full name, address and Medicare provider number and state that it is requesting patient origin data so that it may qualify as an SCH. *The hospital must furnish a complete listing of zip codes within its service area and it must provide the full name, address and, if available, the Medicare provider number of every other hospital located within the larger of its service area or a 50-mile radius. . . .*
>
> After the intermediary verifies the information furnished and forwards the hospital's request to HCFA's central office, *HCFA* will respond as rapidly as possible and *will provide a count by zip code of the number of Medicare discharges from each of the identified hospitals* for the one year period representing the requesting hospital's most recently completed cost reporting period. . . .
>
> Hospitals should be aware that if they fail to achieve SCH status based on HCFA-furnished data on Medicare patient origin, they may not substitute other patient origin data for the same time period to *demonstrate that the hospital seeking SCH status admitted at least 75 percent of all Medicare beneficiaries who were admitted to this hospital and all like hospitals within its service area or, if larger, a 50-mile radius.*[47]

The Board finds the September 1988 Final Rule which implemented the language in controversy clarified that, of the admissions data specified in 42 C.F.R. § 412.92(b)(1)(ii)(B), only the admissions data that pertains to the hospital applicant and other "like" hospitals located within the larger of a 35-mile radius of the hospital applicant or the hospital applicant's service area would be included in the denominator of the "no more than 25 percent" test. In limiting the denominator to inpatient admissions to "like" hospitals, CMS created a denominator based on homogenous units (*i.e.*, "like" hospitals), thereby allowing CMS to interchangeably describe this test as either losing "no more than 25 percent" of the market[48] or keeping "at least 75 percent" of the market (*i.e.*, allowed CMS to describe the test from two perspectives – the glass one-quarter

[47] *Id.* at 38511-38512 (emphasis added).
[48] 42 C.F.R. §412.92(a)(1).

empty or the glass three-quarters full).[49] Finally, the above excerpt demonstrates CMS's expectation as reflected in § 412.92(b)(1)(ii)(A) and (B) that inpatient admissions data will be gathered for the hospital applicant as well as "every other hospital" located within the larger of a 35-mile radius (previously a 50-mile radius) of the hospital applicant or the hospital applicant's service area, even though only the inpatient admissions data relating to the provider applicant and "like" hospitals is relevant to the "no more than 25 percent" test.

The Board finds subsequent final rules through the years reaffirmed CMS' interpretation of the "no more than 25 percent" test and further describe it as a "market share test" and a comparison with "like" hospitals. Examples include:

1. An excerpt from the final rule published on September 1, 1989.—

> As clarified in the September 30, 1988 final rule (53 FR 38510), a hospital located between 25 and 50 miles of a like hospital may qualify as an SCH if, during the cost reporting period ending before it applies for SCH status, it admitted at least 75 percent of all the hospitalized residents or 75 percent of all the Medicare beneficiaries who were admitted to any like hospital located within the larger of the requesting hospital's service area or a 50 mile radius. . . .
>
> We have concluded from our analysis of the Systemetrics data that *the current market share test* is inappropriate for hospitals that are located more than 35 miles from a like hospital. . . .
>
> Therefore, effective October 1, 1989, we proposed to modify our SCH criteria as set forth at §412.92(a)(1) and (2) by eliminating the market share test for hospital located more than 35 miles from a like hospital.[50]

2. Another excerpt from the final rule published on September 1, 1989.—

> Although we are not accepting any of the commenter's specific suggestions at this time, we have concluded that the geographic area considered in the market share test is too broad. *Under current policy*, a hospital may qualify as an SCH if it admitted at least 75 percent of all the hospitalized residents or 75 percent of all the Medicare beneficiaries who were admitted to any like hospitals located within the larger of the requesting hospital's service area or a 50-mile radius. Consistent with our decision to eliminate *the market share test* for hospitals located more than 35 miles from a like hospital, we are narrowing the geographic area to take into account admissions to like hospitals located within the larger of the

[49] *See* PRM 15-1 § 2810(B)(3)(d) (providing an example showing the resulting percentage as 76.2 percent).
[50] 54 Fed. Reg. 36452, 36481 (Sept. 1, 1989) (emphasis added).

requesting hospital's service area or a 35-mile radius. To implement this policy, we are revising § 412.92(a)(2)(i) and (b)(1)(ii)(B).[51]

3. Excerpt from the final rule published on August 1, 2001.—

Comment: Several commenters were concerned with the following issues related to the qualifying criteria for sole community hospitals: . . . (4) including competing hospitals within a 35-mile radius of the requesting hospital as opposed to a 35-road-mile distance; . . . (8) CAHs as like hospitals; . . .

Response: . . . Fourth, we believe it is reasonable to examine a hospital's competitors within a 35-mile radius. Most competing hospitals will not be at the outer limit of the 35-mile radius, and, if these hospitals are not truly competitors, the discharge data will bear out that fact. Also, we examine a hospital's service area based on discharges within zip code areas, and, often, this will exceed a 35-mile radius. Therefore, we believe the 35-mile radius is reasonable. . . .

Eighth, we do not consider CAHs like hospitals to be SCHs. CAHs are generally smaller with a very limited length of stay, while SCHs operate as full-service acute care hospitals.[52]

4. Excerpt from the final rule published on August 1, 2002.—

We believe that limiting eligibility for SCH status to hospitals without SCH like hospitals in their service area is a way to identify those hospitals that truly are the sole source of short-term acute-care inpatient services in the community. A limited-service, specialty hospital, by definition, would not offer an alternate source of care in the community for most inpatient services and, therefore, we believe, should not be considered a "like" hospital with the effect of negating SCH status of a hospital that is the sole source of short-term acute care inpatient service in the community. Therefore, in the May 9, 2002 proposed rule, we proposed to amend the definition of SCH like hospitals under §412.92(c)(2), effective with cost reporting periods beginning on or after October 1, 2002, to exclude any hospital that provides no more than a very small percent of the services furnished by the SCH. We believe the percentage of overlapping services between the SCH and the limited service facility should be sufficiently small so that we can

[51] *Id* at 36482 (emphasis added).
[52] 66 Fed. Reg. 39828, 39876 (Aug. 1, 2001) (emphasis in original).

> ensure that only hospitals that truly are the sole source of short-term acute care in their community qualify for SCH status.[53]

The Board finds that these same final rules are absent of comparisons of "like" hospital data to total hospital (like and unlike) data. Accordingly, the Board has rejected the Provider's proposed interpretation of the "no more than 25 percent" test and agrees with the MAC's interpretation that the "no more than 25 percent" test is a market share test.

In conclusion, the Board finds that the statute and regulation have ambiguity as to whether the denominator of the "no more than 25 percent" test should include the admissions data from only "like" hospitals or all hospitals (both like and unlike). The Board finds that the MAC's position that, of the admissions data required to be submitted in 42 C.F.R. § 412.92(b)(1)(ii)(B), only the admissions data from "like" hospitals located with a 35-mile radius of the Provider should be included in the denominator of the "no more than 25 percent test" is a reasonable interpretation of the relevant statute and regulations and is consistent with CMS' policy statements published in the Federal Register.

DECISION AND ORDER:

The Board finds that the MAC's position that, of the admissions data required to be submitted in 42 C.F.R. § 412.92(b)(1)(ii)(B), only the admissions data pertaining to the "like" hospitals located with a 35-mile radius of the Provider should be included in the denominator of the "no more than 25 percent" test as stated in 42 C.F.R. §§ 412.92(a)(1)(ii) and 412.92(b)(1)(ii)(B) is a reasonable interpretation of the relevant statute and regulations and is consistent with CMS' policy statements published in the Federal Register. The MAC's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

Michael W. Harty
Chairman

DATE: FEB 21 2013

[53] 67 Fed. Reg. 49982, 50054 (Aug. 1, 2002).