PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

2014-D7

PROVIDER –
Deborah Heart and Lung Center
Browns Mills, New Jersey

Provider No.: 31-0031

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Novitas Solutions, Inc.

DATE OF HEARING-
July 2, 2013

Cost Reporting Period Ended -
December 31, 2011

CASE NO.: 12-0144

INDEX

ISSUE:

Whether CMS improperly denied the Provider's request to be reclassified as a rural hospital.[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established under Title XVIII of the Social Security Act ("Act") to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42. U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & 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[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant accounting period and the portion of those costs allocated to the Medicare Program.[4] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[5] A provider dissatisfied with the intermediary'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.[6]

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[7] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8] The statutory provisions addressing the IPPS are located in 42 U.S.C. § 1395ww(d) and they contain a number of provisions that adjust payment based on hospital-specific factors.[9]

Under Medicare law, the location of a hospital can affect its payment methodology as well as whether the facility qualifies for special treatment both for operating and for capital payments. Whether a facility is situated in an urban or a rural area will, for example, affect payments based on the wage index values and Federal standardized amounts specific to the area. Similarly, the

---

[1] Transcript ("Tr.") at 6.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42C.F.R. §§ 413.20, 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835.
[7] *See* 42 U.S.C. §§ 1395ww(d); 42 C.F.R. Part 412.
[8] *See id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).

percentage increase in payments made to a hospital that treats a disproportionate share of low-income patients is based, in part, on its urban/rural status, as is a hospital's qualification as a sole community hospital ("SCH"), rural referral center ("RRC"), critical access hospital ("CAH"), or other special category of facility.[10]

42 U.S.C. § 1395ww (d)(2)(D) provides several key definitions. First, it defines an "urban area" as an area within a Metropolitan Statistical Area ("MSA") as defined by the Office of Management and Budget ("OMB"). It also defines a "large urban area, with respect to any fiscal year, as "an urban area which the Secretary determines ... has a population of more than 1,000,000 (as determined . . . based on the most recent available population data published by the Bureau of the Census)." Finally, it defines the term "rural area" as "any area outside such an area or similar area [*i.e.*, outside of a large urban area or other urban area]."

Several statutory provisions in 42 U.S.C. § 1395ww(d) provide procedures under which a hospital can apply for reclassification from one geographic area to another. For example, § 1395ww(d)(8)(B) specifies that, under certain conditions, the Secretary shall treat a hospital in a rural county adjacent to one or more urban areas as being located in the urban area to which the greatest number of workers in the county commute. In addition, § 1395ww(d)(10) establishes the Medicare Geographic Classification Review Board ("MGCRB") and a process under which a hospital may request the MGCRB to reclassify it for purposes of the standardized amount or the wage index if it meets certain criteria established by the Secretary.

Section 401(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA")[11] amended 42 U.S.C. § 1395ww(d)(8) by adding a new paragraph (E) and directed the Secretary to treat any subsection (d) hospital located in an urban area as being located in the rural area of the State in which the hospital is located if the hospital files an application (in the form and manner determined by the Secretary) and meets one of the following criteria:

- The hospital is located in a rural census tract of an MSA (as determined under the most recent modification of the Goldsmith modification, originally published in the **Federal Register** on February 27, 1992 (57 Fed. Reg. 6725));
- The hospital is located in an area designated by any law or regulation of the State as a rural area (or is designated by the State as a rural hospital);
- The hospital would qualify as a rural, regional or national referral center, or as a sole community hospital if the hospital were located in a rural area; or
- The hospital meets such other criteria as the Secretary may specify. [12]

[10] 65 Fed.Reg. 47026, 47029 (August 1, 2000) (excerpts included as Provider P-16).
[11] Pub. L. No. 106-113, Appendix F, 113 Stat.1501A-321, 1501A-369 (1999).
[12] 42 U.S.C. 1395ww(d)(8)(E)(ii).

The preamble to the final rule published on August 1, 2000 ("August 2000 Final Rule")[13] provides the following background on the Goldsmith Modification that is used in the first criterion:

> The Goldsmith Modification, one of the qualifying criteria, evolved from an outreach grant program sponsored by the Office of Rural Health Policy of the Health Resources and Services Administration (HRSA). The program's purpose was to establish an operational definition of rural populations lacking easy geographic access to health services. Using 1980 Census Bureau data, Dr. Harold F. Goldsmith and his associates created a methodology for identification of census tracts that were located within a large metropolitan county of at least 1,225 square miles but were so isolated from the metropolitan core by distance or physical features as to be more rural than urban in character. The most important criterion to identify these census tracts is the comparatively few residents in these areas, less than 15 percent of the labor force, who commute to work in the metropolitan core and suburbs. . . . The amendments made by section 401 of Public Law 106-113 enable a hospital located in one of these areas to be treated as if it were situated in the rural area of the State in which it is located.[14]

The preamble to the August 2000 Final Rule also provides the following information on the effect of being reclassified as rural under 42 U.S.C. § 1395(d)(8)(E) (*i.e.*, § 1886(d)(8)(E) of the Act):

> A hospital that is reclassified as rural under section 1886(d)(8)(E), as added by section 401(a) of Public Law 106-113, is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act), including standardized amount ([42 C.F.R.] §§ 412.60 *et seq.*), wage index (§ 412.63), and disproportionate share calculations (§ 412.106) as of the effective date of the reclassification.[15]

CMS promulgated the following regulatory provision at 42 C.F.R. § 412.103 to reflect the statute:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural.**
>
> (a) *General criteria.* A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may

[13] 65 Fed. Reg. 47026 (Aug. 1, 2000).
[14] 65 Fed. Reg. at 47029.
[15] *Id.* at 47030.

be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:

(1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural-Urban Commuting Area Codes, as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration . . . .

(2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

(3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.

(4) For any period after September 30, 2004 and before October 1, 2006, a CAH in a county that, in FY 2004, was not part of a MSA as defined by the Office of Management and Budget, but as of FY 2005 was included as part of an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement in § 485.610(b) of this chapter if it meets any of the requirements in paragraphs (a)(1), (a)(2), or (a)(3) of this section.

(5) For any period after September 30, 2009, and before October 1, 2011, a CAH in a county that, in FY 2009, was not part of an MSA as defined by the Office of Management, but, as of FY 2010, was included as part of an MSA as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on November 20, 2008, may be reclassified as being located in a rural area for purposes of meeting the rural location requirement in § 485.610(b) of this chapter if it meets any of the requirements under paragraph (a)(1), (a)(2), or (a)(3) of this section.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Deborah Heart and Lung Center ("Provider") is an 89 bed not-for-profit hospital located in Browns Mills, New Jersey. Novitas Solutions, Inc. is the Provider's designated intermediary ("Intermediary").

On July 18, 2011, the Provider submitted an application to CMS requesting reclassification as a rural hospital under 42 C.F.R. § 412.103(a)(1). In its application, the Provider cited to certain facts as supporting its qualification under the regulations to be reclassified as a rural hospital.[16] In particular, the Provider represented that "[p]er the most recent version of the Goldsmith Modification, and per the Rural-Urban Commuting Area Codes, as determined by the Office of Rural Health Policy, [the Provider] is located in a rural census tract of Burlington County, [New Jersey]."[17] Additionally, the Provider noted that the census tract in which it is located "has a primary RUCA code of 4 which is considered rural."[18]

On August 9, 2011, the CMS Regional Office for Region II issued a letter denying the Provider's request for reclassification from an urban hospital to a rural hospital. Specifically, in denying the application, the agency asserted that 42 U.S.C. § 1395ww(d)(8)(E) is not applicable to New Jersey hospitals "[b]ecause the statute allows for reclassification to the rural area of the State in which the hospital is located, and there is no rural area in the State of New Jersey, the statute is not applicable to New Jersey hospitals."[19]

On January 25, 2012 the Provider timely appealed the CMS determination to the Board.[20] The Provider was represented by Felicia Y. Sze, Esq., of Hooper, Lundy & Bookman, P.C. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of the Blue Cross and Blue Shield Association.

STIPULATION OF FACTS:

The Provider and the Intermediary stipulated to certain facts, including the following pertinent facts:

3. The Provider is located in a Metropolitan Statistical Area, as defined by the Office of Management and Budget.

4. The Provider is located in census tract 340057022.05.

5. The most recent version of the Goldsmith Modification, the Rural-Urban Commuting Area ("RUCA") codes, classifies certain census tracts in a Metropolitan Statistical Area as rural, based on the assignment of a code from 1-10.

6. The Office of Rural Health Policy of the Health Resources and Services Administration considers census tracts with RUCA codes of 4, 5, 6, 7, 8, 9, or 10 as rural.

---

[16] Provider Exhibit P-1.
[17] *Id.*
[18] *Id.*
[19] Provider Exhibit P-2.
[20] Provider Exhibit P-3.

7. Census tract 340057022.05 is assigned a RUCA code of 4.[21]

PROVIDER'S CONTENTIONS:

The Provider contends that Congress established the reclassification process under 42 U.S.C. § 1395ww(d)(8)(E) to provide aid to hospitals that were rural in nature, despite their location in a MSA. By reclassification as a rural hospital, a hospital is treated as if it is located in a rural area, thereby becoming eligible to participate in programs targeting rural hospitals, such as the Medicare Dependent Hospital program. As a part of the process of being reclassified, a hospital reclassified as a rural hospital pursuant to § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 does not actually become geographically reassigned to a specific rural area of a state. There is no dispute that the Provider meets the criteria for reclassification under § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 based on its location in a rural census tract.[22]

The Provider explains that, notwithstanding its location in a rural census tract, CMS incorrectly interprets the mandate in § 1395ww(d)(8)(E) that it "treat [a qualifying hospital] as being located *in the rural area…of the State* in which the hospital is located"[23] to mean that a hospital located in an all-urban state such as New Jersey is ineligible for reclassification under § 1395ww(d)(8)(E). CMS' denial improperly limits the scope of reclassification under § 1395ww(d)(8)(E) or 42 C.F.R. § 412.103 in a manner contrary to the text of the laws, the legislative history of the laws, and the policy furthered by the reclassification process.[24]

The Provider argues that CMS improperly denied its application for reclassification because the statute does not require the existence of a "rural area" in a State as a condition precedent to reclassification. The plain language of 42 U.S.C. § 1395ww(d)(8)(E) prohibits CMS from imposing additional conditions for reclassification.[25] Neither the statute nor the regulations require that a hospital be located in a state with a rural area to be eligible for reclassification. The use of the phrase "treat[ed] as being located in the rural area…of the State" simply means that the qualifying hospital will be treated as if it were in a rural area. As the reclassification creates the fiction of placing the hospital in a rural area, there is no need for an actual rural area in the state.[26]

The Provider asserts that its interpretation of § 1886(d)(8)(E) is supported by the legislative history and the purpose underlying the reclassification process. The Provider argues that Congress enacted § 1395ww(d)(8)(E) in BBRA to provide increased flexibility to rural hospitals, many of which were struggling after the implementation of the Balanced Budget Act of 1997 ("BBA"). Congress sought to allow hospitals located in rural areas within an MSA to be eligible for programs for rural hospitals. The legislative history demonstrates that Congress' intent in enacting § 1395ww(d)(8)(E) was to provide assistance for those hospitals, such as the Provider, which are located in areas of a MSA that are more rural in character. Nowhere in the legislative

---

[21] Provider Exhibit P-28 at 1 (Joint Stipulation dated June 28, 2013).
[22] Provider's Final Position Paper at 13.
[23] (Emphasis added.)
[24] Provider's Final Position Paper at 2.
[25] Provider's Post-Hearing Brief at 7, 13.
[26] Provider's Final Position Paper at 2.

history is there any suggestion that Congress intended to treat hospitals in all-urban states differently from hospitals in states with rural areas.[27]

Likewise, the Provider argues that CMS' reclassification denial conflicts with 42 C.F.R. § 412.103(a). In this regard, the Provider asserts that this regulation only requires it submit an application demonstrating that it meets one of five enunciated criteria and it is "undisputed" that it meets the first criterion that it be located in a rural census tract of an MSA as determined under the most recent version of the Goldsmith Modification.[28] The Provider highlights testimony of the Intermediary's representative at the hearing who stated: "After my brief review [of § 412.103(a), specifically, and the rest of § 412.103, generally], I do not see anything relating to" whether the regulation is not applicable to states that are comprised solely of MSAs.[29]

Finally, the Provider argues that the Intermediary's evidence and arguments related to extraneous facts about the Provider and Burlington County, as well as New Jersey in general, are irrelevant. Pursuant to the statute and the regulation, the only relevant factor applicable to the Provider's qualification is the RUCA classification system. In this regard, the Provider notes that the RUCA classification system does not consider such factors as population density, the proximity of other hospitals to the Provider, the Provider's competition with these other hospitals, or the geographic residence of the Provider's patients. The Provider contends that the Intermediary seeks to supersede the RUCA classification system with such arguments. This directly contradicts § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103, the statute and regulation that established the criteria by which reclassification would be permitted. [30]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that nothing in the statute or implementing regulation changes the fundamental requirement that the hospital seeking reclassification as a rural hospital must be located in a rural portion of the state or outside an MSA. In addition, nothing in the statute or regulation relieves the hospital from demonstrating that it is entitled to reclassification on the basis of factors Congress identified as justifying the reclassification provision, *i.e.*, that the hospital is the "only available medical facility capable of serving the health care needs of a rural community's Medicare population," experiencing "low volume, few resources," and identified as having the most "trouble" in adapting to the BBA.[31] Moreover, the hospital must be isolated by distance or geography from large urban areas.[32] Finally, nothing in the statute precludes the agency from taking these factors into account when evaluating a provider's application for reclassification as a rural hospital. [33]

The Intermediary states that the statutory definition of "rural" governs in this appeal. It notes that 42 USC § 1395ww(d)(2)(D) clearly defines "rural" as follows:

---

[27] Provider's Final Position Paper at 3.
[28] Provider's Post-Hearing Brief at 12.
[29] *Id*, at 13 (citing to Intermediary's witness testimony, Tr. at 172:14-173:5).
[30] Provider's Post-Hearing Brief at 19.
[31] *See* H.R. 106-436 at 35 (Nov. 2, 1999) (excerpts included at Provider Exhibit P-11).
[32] *See* 65 Fed. Reg. at 47029.
[33] Intermediary's Final Position Paper at 1-2.

> [T]he term "rural area" means any area outside such an area or similar area [*i.e.*, an urban area].

The Intermediary points out that the term "urban area" means an area within an MSA and, therefore, as a threshold matter, to be a rural area within the meaning of the statute, the area must be outside an urban area or outside an MSA. Further, the Intermediary points out that a rule of statutory construction requires that, where a statute defines a term in its definitional section, such definition controls the meaning of the term wherever it appears in the statute. In light of this rule, the definition of rural must be read consistently as "outside an urban area." The Intermediary concludes that this rule – and the resulting conclusion- supports the agency's view that the statute does not apply to a state where there is not a rural area meeting the statutory definition of rural. Accordingly, the Provider cannot qualify for reclassification because it is not located in a rural area as defined by the applicable federal statute.[34]

The Intermediary goes on to argue that the Provider has not met its burden to show that it qualifies as a "rural" hospital. None of the factors cited by the Congress in enacting "flexibility" in reclassifying hospitals as "rural" applies to the Provider. It does not fall within the purpose of the Act, namely to afford relief to hospitals that are "so isolated from the metropolitan core by distance or physical features as to be more rural than urban in character."[35]

In support of this "burden of proof" argument, the Intermediary maintains that the Provider has shown no facts to contradict or disprove the urban nature of New Jersey. The Intermediary notes that, with a population of 8,864,590, New Jersey ranks as the ninth most populous state and the most densely populated state. In this regard, New Jersey has over 1,185 persons per square mile and lies mostly within the sprawling metropolitan areas of New York City and Philadelphia. The Provider can show no set of facts to demonstrate that New Jersey is a rural state.[36]

Additionally, Burlington County, where the Provider is located, is the site of a robust economy and lacks the characteristics of an isolated, rural area. The Intermediary also notes that the Provider cannot claim that it is the "only available medical facility capable of serving the health care needs of a rural community's Medicare population." There are a total of 36 hospitals within 35 miles of the Provider. Lastly, the statistics show that the Provider draws patients from a broad geographic area – not just Burlington County, the ostensibly rural area it is alleged to solely serve. In this regard, the most recent available UB 92 data for 2006 shows that a majority of the Provider's patients come from outside Burlington County and from all across the State of New Jersey.[37]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Provider has satisfied the criteria for reclassification as a rural hospital under § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103. CMS

---

[34] Intermediary's Final Position Paper at 3.
[35] Intermediary's Final Position Paper at 3-4.
[36] Intermediary's Final Position Paper at 4.
[37] Intermediary's Final Position Paper at 4-7.

improperly denied the Provider's application for reclassification because neither Section § 1395ww(d)(8)(E) nor 42 C.F.R. § 412.103 require the existence of a "rural area" in a state as a condition precedent to reclassification.

The Board finds that the Provider qualifies for reclassification as a rural hospital by its location in a rural census tract of an MSA. Pursuant to both § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103, a prospective payment hospital is eligible to be treated as a rural hospital if it is located in a rural census tract of an MSA, as determined by the most recent version of the Goldsmith Modification. As acknowledged in 42 C.F.R. § 412.103 and the parties' Joint Stipulation, the most recent version of the Goldsmith Modification is defined by the RUCA codes, as determined by the HRSA Office of Rural Health Policy. CMS and the HRSA Office of Rural Policy consider all census tracts with RUCA codes from 4 – 10 as rural.[38] The Provider is located in a rural RUCA census tract because it is located in a RUCA census tract assigned with a code of 4.[39] Accordingly, the Provider has demonstrated that it is located eligible for reclassification as a rural hospital.

The Board finds that § 1395ww(d)(8)(E) does not require the existence of an actual "rural area" in a state as a condition precedent to reclassification. In § 1395ww(d)(8)(E), Congress stated that, if a hospital meets one of the specified criteria, the Secretary "shall treat" such hospital "as being located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located." The whole phrase that begins with "as being" describes the characteristic that is to be attributed to the qualifying hospital, namely that it is "located in the rural area (as defined in paragraph (2)(D)) of the State in which the hospital is located." That phrase does not specify any condition precedent.[40] As conceded by the Intermediary's witness, nowhere in the statute did Congress forbid hospitals in states with no rural areas from reclassification.[41]

---

[38] Joint Stipulation at ¶ 6.

[39] Joint Stipulation at ¶ 7.

[40] The fact that the article "the" in front of the term "rural area" followed by a reference to the definition of that term does not in and of itself create an implied condition precedent. 42 U.S.C. § 1395ww (d)(2)(D) defined this term as "any area outside such an area or similar area [*i.e.*, outside of a large urban area or other urban area]." Thus, the term "rural area" as used in the statute appears to be a collective term encompassing "any area" in a state outside of an urban area and, as such, there can only be one "rural area" for a state even though portions of such designated area may not be contiguous. Accordingly, in specifying that the Secretary "shall treat" a qualifying hospital "as being located in the rural area," the statute is merely creating a fiction by attributing a characteristic to the qualifying hospital (*i.e.*, "being located in the rural area") even though that hospital does not in fact have that characteristic (*i.e.*, is not actually located in the rural area). Indeed, through the operation of 42 C.F.R. § 412.102, CMS treats this fiction as fact because this regulation provides a process for "reclassification [of a qualifying urban hospital] as rural" and, as explained in the Federal Register, this reclassification is for purposes of reimbursement under 42 U.S.C. § 1395ww(d) for IPPS and under 42 U.S.C. § 1395k for the hospital outpatient prospective payment system. *See, e.g.*, 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000); 65 Fed. Reg. 67798, 67817 (Nov. 13, 2000); 66 Fed. Reg. 39828 (Aug. 1, 2001) ("A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act . . . is treated as rural for all purposes of payment under the Medicare inpatient hospital prospective payment system (section 1886(d) of the Act) . . . .").

[41] Tr. at 174-175 (witness stating he was "not aware of any specific mention" in statute denying eligibility for reclassification to hospitals in state that are solely comprised of MSAs).

The first criterion listed in the controlling statute is that a hospital be located in a rural census tract, as determined under the most recent Goldsmith Modification.[42] Because the Provider met the first criterion, it, *ipso facto*, qualified for reclassification.

The Board agrees with the Provider that Congress' decision to use the most recent Goldsmith Modification, *i.e.*, the RUCA codes, to define rural areas was a perfectly rational way to identify rural areas within MSAs. Because there are 3,000 counties in the United States, but approximately 8,000 census tracts, Congress reasonably chose to use a sub-county definition to identify rural areas that may be hidden within MSAs. The RUCA classification system is also able to identify degrees of how rural an individual census tract is (from 1 through 10 with additional subclassifications), while the MSA system simply tags an entire county as metropolitan or not metropolitan.

Congress considered various methods of defining which hospitals should be eligible to be treated as rural hospitals for Medicare reimbursement. Congress chose a sub-county definition of rural within metropolitan areas. CMS, through its regulatory authority, specified that RUCA codes of four and above would be defined as rural for the purposes of reclassifying census tracts.[43] It is only this explicit definition of "rural" that gives the concept of "rural" any meaning and, more specifically, it is by virtue of CMS adopting RUCA Level 4 as the starting point for identify rural census tracts that the Provider's census tract qualifies as rural. CMS' attempt to limit the Provider's ability to reclassify as a rural hospital, solely because it is located in an MSA of a state solely comprised of MSAs, contravenes Congress' and its own regulatory determination to rely on RUCA codes to define and identify rural areas within MSAs.

The Board finds that the legislative history of § 1395ww(d)(8)(E) demonstrates Congress' intent to broadly permit hospitals to reclassify as rural and shows no intent to bar New Jersey hospitals from reclassification. In fact, the legislative history reflects Congress' intent to grant greater flexibility to hospitals in rural census tracts in MSAs.[44] The following statements are excerpts from the House Committee on Ways and Means Report on the BBRA and they illustrate this intent:

- The impact of the policy changes made by the BBA on rural health care providers has been of particular concern to the Committee…The bill seeks to address this concern by including provisions in Title IV that are designed to help rural providers, and the beneficiaries they serve, make the transition to the post-BBA environment. Included are provisions extending the Medicare Dependent

---

[42] 42 U.S.C. § 1395ww(d)(8)(E)(ii)(I).

[43] More specifically, the Secretary promulgated 42 C.F.R. § 412.103(a)(1) to defer to the HRSA Office of Rural Health Policy in setting the line for determining "rural" on the Goldsmith Modification: "The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural-Urban Commuting Area [RUCA] codes, as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration, which is available via the ORHP Web site at: *http://www.ruralhealth.hrsa.gov* . . . ." *See* 70 Fed. Reg. 47278, 47447 (August 12, 2005) (excerpt included at Provider Exhibit P-27).

[44] Moreover, in 42 U.S.C. § 1395ww(d)(8)(E)(ii)(IV), Congress built in additional flexibility by giving authority to the Secretary to create other criteria by which a hospital could be reclassified as rural.

Hospital Program, *several sections allowing for greater flexibility in the geographic and categorical designations of rural health facilities...*[45]

- This provision would require the Secretary to establish a process for hospitals located in urban Metropolitan Statistical Areas (MSAs) to apply *to be treated as rural hospitals*, supplement the federal criteria used to designate rural providers, allow for state designation as a rural provider, and permit urban hospitals to be designated as sole community hospitals.[46]

- This provision would permit additional flexibility for hospitals to reclassify *for purposes of becoming rural hospitals* so that they may participate in Medicare as critical access or sole community hospitals.[47]

The Senate Committee on Finance also produced a report on the Senate version of the BBRA. The following statements are excerpts from that report and illustrate the Senate's intent:

- This provision would permit a hospital that is considered to be in an urban area or large urban area, for the purposes of PPS reimbursement using the existing definition, to be treated *as a hospital in a rural area* if classified as such by either of two alternative definitions. The Secretary is directed to set up a waiver process within 180 days of enactment of this legislation whereby hospitals currently treated as urban or large urban *would be treated as rural if located in a rural area within a metropolitan county* as defined by the most recent update of the Goldsmith Modification or as determined by the census tract definition adopted by the Office of Rural Health Policy....[48]

- Because MSAs are based on county boundaries, some cover large geographic areas that include rural areas. *For purposes of Medicare reimbursements and policies, this provision would allow hospitals and providers to be considered rural if they are located in MSAs, if they meet certain other definitions of rural.* The provision would allow these providers to participate in programs aimed at expanding access in rural areas.[49]

The Conference Report reconciling the House and Senate versions of the BBRA discussed the adoption of the House version of § 1395ww(d)(8)(E). In particular, the report includes the following explanation of this statutory provision:

H.R. 3075, as passed

Instructs the Secretary to treat certain urban hospitals as rural hospitals no later than 60 days after their application for such

---

[45] H.R. Rep. No. 106-436, at 35 (1999) (emphasis added) (excerpt included at Provider Exhibit P-11).
[46] *Id.* at 66 (emphasis added).
[47] *Id.* (emphasis added).
[48] S. Rep. No. 106-199, at 27 (1999) (emphasis added) (excerpts included at Provider Exhibit P-12).
[49] *Id.* (emphasis added).

> *treatment if the hospitals: (1) are located in a rural census tract of a Metropolitan Statistical Area (as determined by the Goldsmith Modification published in the Federal Register on February 27, 1992....*
>
> Provides that a hospital in an urban area *may apply* to the Secretary *to be treated as if the hospital were located in a rural area of the State* in which the hospital is located. Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and referral centers. . . ..[50]

The Board also reviewed the regulation that implemented 42 U.S.C. § 1395ww(d)(8)(E). The implementing regulation is located at 42 C.F.R. § 412.103. Subsection (a) provides the "General criteria" for an urban hospital to "be reclassified as a rural hospital." Subsection B provides the "Application requirements" for a hospital to request this reclassification. Subsection (c) addresses "CMS review" of the application which is completed within 60 days of the filing date. Subsection (d) addresses the "Effective date of reclassification." Finally, subsections (e), (f), and (g) address the "Withdrawal of [an] application," the "Duration of classification," and "Cancellation of classification." Nowhere in the regulation did the Secretary forbid hospitals in states with no rural areas from reclassification. Rather, the regulation specifies that, when a hospital applicant qualifies under one of the specified criteria, it, *ipso facto*, qualifies for reclassification as of the filing date of the written application for such reclassification:

> (a) *General criteria.* A prospective payment hospital that is located in an urban area . . . may be classified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification . . . , which is available via the ORHP Web site at: *http://www.ruralhealth.hrsa.gov* . . . .
>
> (b) *Application requirements*—. . . .
>
> (2) *Contents of application.* An application is complete if it contains an explanation of how the hospital meets the condition that constitutes the basis of the request for reclassification set forth in paragraph (a) of this section, including data and documentation necessary to support the request. . . .
>
> (d) *Effective dates of reclassification.* (1) Except as specified in paragraph (d)(2) of this section, CMS **will consider** a hospital that

[50] H.R. Conf. Rep. No. 106-479, at 887-888 (1999) (emphasis added) (excerpts included at Provider Exhibit P-14).

> satisfies any of the criteria set forth in paragraph (a) of this section as being located in the rural area of the State in which the hospital is located as of that filing date.
>
> (2) If a hospital's complete application is received in CMS by September 1, 2000, and satisfies any of the criteria set forth in paragraph (a) of this section, CMS will consider the filing date to be January 1, 2000.[51]

In addition, the Board finds that CMS' statements in the Federal Register have been consistent with the Board's interpretation that § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103 permit urban hospitals meeting certain criteria to be treated as rural hospitals. The following are examples of some of these statements:

- Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals *will now be able to be designated a rural hospital* and become eligible to be designated a critical access hospital.[52]

- Section 401 of the BBRA 1999 adds section 1886(d)(8)(E) to the Act to *permit reclassification of certain urban hospitals as rural hospitals*. Section 401 adds section 1833(t)(13) to the Act to provide that a hospital *being treated as a rural hospital* under 1886(d)(8)(E) also *be treated as a rural hospital* under the hospital outpatient PPS.[53]

- A hospital that is reclassified as rural under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106-113, is *treated as rural* for all purposes of payment under the Medicare hospital inpatient prospective payment system...[54]

- Under section 1886(d)(8)(E) of the Act, as added by section 401 of the BBRA 1999, if a hospital submits an application and meets certain criteria, the Secretary *treats the hospital as being located in a rural area* for purposes of section 1886(d) of the Act.[55]

- A hospital granted redesignation under section 1886(d)(8)(E) of the Act is therefore *treated as a rural hospital*...[56]

---

[51] *See also supra* note 40.
[52] 65 Fed. Reg. at 47089 (emphasis added).
[53] 65 Fed. Reg. at 18439 (April 7, 2000) (emphasis added) (excerpt included at Provider Exhibit P-15).
[54] 65 Fed. Reg. at 47030 (emphasis added).
[55] 65 Fed. Reg. at 67817 (November 13, 2000) (excerpt included at Provider Exhibit P-18).
[56] 67 Fed. Reg. at 50028 (August 1, 2002) (excerpt included at Provider Exhibit P-20).

- The regulations at § 412.103(a)(3) provide for a *hospital located in an urban area to be reclassified as a rural hospital...*[57]

The Board agrees with the Provider that CMS' actions following the adoption of 42 C.F.R. § 412.103 also support the interpretation that § 1395ww(d)(8)(E) permits urban hospitals meeting certain criteria to be treated as rural hospitals. In 2001, CMS sought to clarify the distinction between the processes of geographically reclassifying a hospital from one area to another under the MGCRB process for redesignation and reclassifying a hospital from an urban hospital to a rural hospital under 42 U.S.C. § 1395ww(d)(8)(E). In this regard, CMS states the following:

> Under section 1886(d)(8)€ of the Act . . . a hospital located in an urban area may file an application to be treated as being located in a rural area for purposes of payment under section 1886(d)(of the Act. The issue here is whether a hospital that has been reclassified from an urban area to a rural area under section 1886(d)(8)(E) of the Act should be permitted to subsequently be reclassified under the MGCRB process from the rural area to another area. As discussed below, we believe that, for purposes of the MGCRB process, *it is appropriate to distinguish between hospitals that are reclassified as rural under section 1886(d)(8)(E) of the Act and hospitals that are geographically rural.* . . .
>
> The statutory language of section 1886(d)(8)(E) of the Act directs the Secretary to treat qualifying hospitals, for purposes of section 1886(d) of the Act, "as being located in the rural area . . . of the State in which the hospital is located." Section 1886(d) of the Act encompasses the hospital wage index and the standardized amount. Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).
>
> . . . .
>
> We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) is entirely voluntary. Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify.[58]

---

[57] 69 Fed. Reg. at 49055 (August 11, 2004) (excerpt included at Provider Exhibit P-21).
[58] 65 Fed. Reg. at 47088-47089 (emphasis added).

In order "to clarify the distinction between hospital reclassification from urban to rural and the geographic reclassification (or redesignation) of an urban area to rural,"[59] CMS revised the title of 42 C.F.R. § 412.102 to "Hospitals located in areas that are reclassified from urban to rural as a result of redesignation" to contrast it from 42 C.F.R. § 412.103 which is entitled "Hospitals located in urban areas and that apply for reclassification as rural." CMS' distinction between these two procedures supports the view that reclassification from urban to rural under § 1395ww(d)(8)(E) does not require reclassification to an actual rural area in a state. The stark contrast between the approaches between true reclassification from one area to another specific area through the MGCRB versus the treatment of a hospital as if it is rural demonstrates that a reclassification under § 412.103 does not involve an actual geographic reassignment. Accordingly, there need not be a specific, actually designated rural area for a hospital to be treated as rural for purposes of § 412.103(a).[60]

Finally, the Board finds that the Intermediary's arguments with respect to the population and population density of New Jersey and Burlington County, the proximity of other hospitals to the Provider, the Provider's competition with these other hospitals and the geographic residence of the Provider's patients are not relevant in this appeal.[61] The RUCA classification system does not consider these factors.[62] In addition these factors are not mentioned anywhere in § 1395ww(d)(8)(E), nor are they addressed anywhere in the regulations at 42 C.F.R. § 412.103.

Based on the foregoing, the Board concludes that CMS improperly denied the Provider's application for reclassification.[63]

---

[59] 65 Fed. Reg. 47026, 47031 (Aug. 1, 2000)

[60] Similarly, the Board recognizes that, on August 11, 2004, CMS promulgated the regulations at 42 C.F.R. § 412.64(h)(4)-(5) to address how the rural floor of the wage index for purposes of 42 U.S.C. § 1395(d)(3)(E) applies to certain "all-urban States" such as New Jersey. *See* 69 Fed. Reg. 48916, 49109-4911, 49242-49243 (Aug. 11, 2004). As there was no rural floor established for such "all-urban States," CMS calculated an "imputed" rural floor for these States. *See id.* at 49110 (applying it for three FFYs); 78 Fed. Reg. 50496, 50589-50590, 50965 (Aug. 19, 2013) (showing extensions through FFY 2013). CMS adopted the imputed rural floor essentially to ensure that hospitals in "all-urban States" were treated similarly to those located in other states that had rural floors. *See* 69 Fed. Reg. at 49110-49111. Similar to CMS' avoidance of disparate treatment of hospitals located in all-urban states for purposes of the rural floor wage index provisions, the Board's interpretation of 42 U.S.C. § 1395ww(d)(8)(E) would interpret and apply it in manner that avoids any disparate treatment and is consistent with Congressional intent to provide greater flexibility.

[61] Further, Intermediary concedes that this case solely focuses on the denial reason stated by CMS which was based solely on an interpretation of the controlling statute. *See* Tr. at 182-187; Provider Exhibit P-2.

[62] Again, the Board notes that CMS adopted the range of RUCA codes 4 to 10 as rural. *See supra* note 43.

[63] The Board notes that the sole explanation that the CMS Regional Office for Region II gave for denying the Provider's applications is the following statement:

> Because the statute [*i.e.*, 42 U.S.C. § 1395ww(d)(8)(E)] allows for reclassification to the rural area of the State in which the hospital is located, and there is no rural area in the State of New Jersey, the statute is not applicable to New Jersey hospitals. We are therefore denying the hospital's request for reclassification from urban to rural.

The Board declined to give any weight to CMS' interpretation because: (1) no explanation was provided in the denial letter for this interpretation; (2) no explanation for this interpretation could be identified in the agency's final rules or other written guidance; and (3) the Board review of the controlling statute and regulation and the related statutory and regulatory history shows that neither § 1395ww(d)(8)(E) nor 42 C.F.R. § 412.103 require the existence of an actual "rural area" in a state as a condition precedent to reclassification.

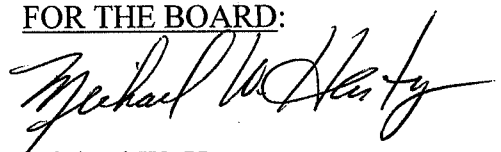
DECISION AND ORDER:

The Board finds that CMS improperly denied the Provider's application for reclassification because the Provider satisfied the criteria for reclassification as a rural hospital under 42 U.S.C. § 1395ww(d)(8)(E) and 42 C.F.R. § 412.103. Therefore, the Provider's reclassification is effective July 18, 2011, the date it submitted its application for reclassification.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: APR 15 2014