

**PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION**

2026-D33

PROVIDER –
Hendrick Medical Center

PROVIDER NUMBER – 45-0229

vs.

MEDICARE CONTRACTOR –
Novitas Solutions Inc.

RECORD HEARING HELD –
February 26, 2026

FISCAL YEAR ENDING – 08/31/2021

CASE NUMBER – 21-1652

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ISSUE STATEMENT:

Whether the Medicare Contractor and the Centers for Medicare and Medicaid Services (“CMS”) properly determined the effective date of Hendrick Medical Center’s (“Hendrick” or the “Provider”) sole community hospital (“SCH”) designation.¹

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board (“Board”) agrees with the Medicare Contractor’s October 20, 2021 reconsideration determination and finds that the proper effective date of the SCH designation is January 13, 2021, as in accordance with 42 C.F.R. § 412.92(b)(2)(i), “[SCH] status is effective as of the date the [Medicare Contractor] receives the complete application,” and this application was completed when Hendrick sent a copy of CMS’ tie-in approval letter to the Medicare Contractor on January 13, 2021.

INTRODUCTION:

Hendrick Medical Center is an acute care hospital located in Abilene, Texas.² The Medicare contractor³ assigned to Hendrick for this appeal is Novitas Solutions, Inc. (“Medicare Contractor”).

Hendrick acquired nearby Abilene Regional Medical Center (later renamed Hendrick Medical Center South) and subsequently applied for SCH designation pursuant to 42 C.F.R. § 412.92(a).⁴ The Medicare Contractor denied the request, indicating that the SCH application was not complete because it lacked CMS approval of the merger.⁵ Hendrick re-submitted its application. The day after resubmission, CMS approved Hendrick’s change of ownership application (i.e., processed the Medicare tie-in).⁶ Soon after, Hendrick forwarded the *tie-in letter* to the Medicare Contractor.⁷ The Medicare Contractor granted SCH status effective as of the date of the *re-submitted application*.⁸

On August 23, 2021, Hendrick requested reconsideration by the Medicare Contractor of the

¹ See Provider’s Final Position Paper at 1 (August 7, 2025).

² Joint Stipulations of Facts (“Stip.”) at ¶ 1 (Feb. 19, 2026).

³ CMS’ payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries (“FIs”) and these functions are now contracted with organizations known as Medicare administrative contractors (“MACs”). The relevant law may refer to FIs and MACs interchangeably, and the Board will use the term “Medicare contractor” to refer to both FIs and MACs, as appropriate and relevant.

⁴ Stip. at ¶¶ 6, 8. Details of the procedural history are more fully set forth below at pp. 4 - 6, in Statement of Facts, B. Hendrick’s Application for SCH Status.

⁵ *Id.* at ¶ 9.

⁶ *Id.* at ¶¶ 12, 13.

⁷ *Id.* at ¶ 14.

⁸ *Id.* at ¶ 15.

effective date of SCH status. On August 30, 2021, Hendrick appealed the effective date of SCH status to the Board.⁹ In both the reconsideration request and the appeal, Hendrick argued that the effective date should be the date of the *original application*, not that of the *re-submitted application*.¹⁰

On October 20, 2021, the Medicare Contractor responded to Hendrick's request for reconsideration, changing the effective date to January 13, 2021, which is the date Hendrick forwarded the *tie-in approval letter* to the Medicare Contractor. Hendrick thereafter supplemented its appeal to the Board to reflect the reconsideration response and a revised amount in controversy.¹¹

Thus, the question before the Board is whether the Medicare Contractor properly determined January 13, 2021 to be the effective date of the Provider's SCH status.¹²

The Board granted the Provider's request for a record hearing on February 26, 2026. Hendrick Medical Center was represented by Emily J. Cook, Esq. of McDermott Will & Schulte LLP. The Medicare Contractor was represented by Charles Moreland, Esq. of Federal Specialized Services.

STATEMENT OF FACTS:

A. Brief Background on Rural Hospitals and Sole Community Hospitals

Medicare pays hospitals for their inpatient operating costs under the Inpatient Prospective Payment System ("IPPS"), using predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount for all hospitals that are paid in accordance with 42 U.S.C. § 1395ww(d), or IPPS (known as "subsection (d) hospitals"), taking into account whether they are located in "urban" or "rural" labor market areas.¹³ These standardized amounts are adjusted by a "wage index" based on the specific geographic area where a hospital is located.¹⁴ The Secretary defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget.

Historically, providers with lower wage indexes have faced staffing challenges when located

⁹ *Id.* at ¶¶ 16, 17.

¹⁰ Individual Appeal Request, Attachment C – Issue Statement at 1.

¹¹ *See* Ex. C-7.

¹² Parties' joint request for record hearing at 1 (Feb. 19, 2026).

¹³ *See* 42 U.S.C. § 1395ww(d)(2)(A)-(D) ("The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge [...] and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region [...] Each such rate shall be determined for hospitals located in urban or rural areas [...]") (the version of 42 U.S.C. § 1395ww effective Dec. 27, 2020 to Mar. 10, 2021 is cited throughout, unless otherwise indicated).

¹⁴ *See* 42 U.S.C. § 1395ww(d)(3)(E) (Adjusting for different area wage levels).

near a CBSA with a higher wage index that could pay higher wages.¹⁵ To address this problem, Congress instituted a system that allows hospitals to be geographically reclassified to a different labor market area.¹⁶ Beginning in 2000, hospitals located in urban areas are permitted to apply for reclassification as rural.¹⁷ One way a hospital can qualify for rural reclassification is by demonstrating it would qualify as an SCH if it were located in a rural area.¹⁸

Hospitals designated as SCHs receive enhanced IPPS payments from CMS compared to standard acute care providers. When the IPPS was established, Congress was concerned about communities with only one hospital, in part because beneficiaries would have no opportunity to choose a less expensive institution and/or competitive cost data for the area was lacking.¹⁹ Thus, in 1983, Congress:

[E]stablished a separate and more generous reimbursement formula for ‘sole community hospital[s],’ which are statutorily defined as ‘hospital[s] that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), [are] the sole source of inpatient hospital services reasonably available to individuals in a geographical area who are entitled to benefits under [Medicare] part A.’²⁰

¹⁵ See *Geisinger Comm. Med. Ctr. v. Sec. of Dept. of HHS*, 794 F.3d 383, 387 (3rd Cir. 2015) (“IPPS may yield inequitable results where, for instance, a rural hospital’s lower wage index does not accurately reflect its labor costs because it competes for the same labor pool as hospitals in a nearby but higher wage-index urban area.”).

¹⁶ See 42 U.S.C. §§ 1395ww(d)(8)(B)(i) (“the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute”) and 1395ww(d)(10) (establishing the Medicare Geographic Classification Review Board).

¹⁷ See 42 C.F.R. § 412.103 (Special treatment: Hospitals located in urban areas that apply for reclassification as rural). *For a historical overview, see* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106-113 § 401(a), 113 Stat. 1501A-321, 1501A-369 (Nov. 29, 1999); 65 Fed. Reg. 47026, 47029-47030 (Aug. 1, 2000). See also 42 U.S.C. § 1395ww(d)(8)(E) (sets forth criteria for a hospital located in an urban area to qualify as rural).

¹⁸ See 42 U.S.C. § 1395ww(d)(8)(E)(ii)(III):

(ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria: [...] (III) The hospital would qualify as rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.

¹⁹ See *AnMed Health v. Becerra*, 628 F. Supp. 3d 219, 222 (D.D.C. 2022) (quoting S. Rep. No. 92-1230, at 188 (1972); H.R. Rep. No. 92-231, at 84 (1971)).

²⁰ *Id.* at 223 (quoting Pub. L. No. 98-21 § 601(e), 97 Stat. 158).

B. Hendrick's Application for SCH Status

On **October 27, 2020**, Hendrick finalized a merger with Abilene Regional Medical Center.²¹ After the merger:

Abilene Medical became a remote location of Hendrick's main campus, operating under the name Hendrick Medical Center South. As a result of this merger, there was no "like hospital" within 35 miles of *either* Hendrick's main campus or Hendrick Medical Center South. Hendrick therefore became eligible for classification as an SCH by being "located more than 35 miles from other like hospitals." 42 C.F.R. § 412.92(a).²²

On **October 28, 2020**, Hendrick submitted an application for SCH designation containing five exhibits:

- A. the Request for Rural Referral Center ("RRC") Classification,
- B. the Bill of Sale reflecting Hendrick's acquisition of Abilene Regional Medical Center;
- C. screen shots of Hendrick's Provider Enrollment, Chain, and Ownership System (PECOS) Medicare Enrollment Application;
- D. illustrations of Hendrick's like-hospital analysis; and
- E. a copy of 42 C.F.R. § 412.92.²³

Hendrick's application was sent to a Provider Audit and Reimbursement Department ("PAR") Lead Auditor in the Reimbursement Department of the Medicare Contractor.²⁴ Exhibit B to the application for SCH designation includes a copy of a CMS-855A Medicare Enrollment Application dated October 28, 2020, with a status of "awaiting processing."²⁵ The CMS-855A Medicare Enrollment Application reflects an effective date of acquisition of October 27, 2020.²⁶ Hendrick states, in the accompanying letter in which it requests classification as an SCH, that it believes "once the merged provider number is approved, the merger will be retroactive to the

²¹ See Stip. at ¶ 6. See also Ex. P-2 at P0011-13 ("Bill of Sale"); Ex. P-2 at P0014-30 ("Submitted Medicare Application") dated Oct. 28, 2020; Ex. P-6 at P0101 ("CMS Medicare Tie in Notice Approval Letter") reflecting a CHOW ["Change of Ownership"] Effective Date of Oct. 27, 2020.

²² Provider's FPP at 6 (emphasis added). Note: CMS and the MAC "would later recognize . . . after the merger, there is no longer any "like hospital" within 35 miles of either Hendrick location." Stip. at ¶ 7. See also Ex. P-7 at P104.

²³ See Stip. at ¶ 8. See also Ex. P-2 with its included exhibits A – E, to which the above letters correspond.

²⁴ See Ex. C-1 at 000002.

²⁵ See Ex. P-2 at P0014 - 0030.

²⁶ *Id.* at P0014.

date of sale, October 27, 2020. As such, we respectfully request that this SCH application is accepted on the date that the MAC receives the application.”²⁷

On **December 4, 2020**, the PARD of the Medicare Contractor advised Hendrick that it would not be making a decision on the October 28, 2020 application as it was not complete, because it lacked documentation of CMS approval of the merger.²⁸ The Medicare Contractor instructed Hendrick that “[t]he SCH designation request may be re-submitted to our office after the approval of the merger is complete.”²⁹

On **December 29, 2020**, CMS sent a letter to Hendrick acknowledging the acquisition between Hendrick Medical Center and Abilene Regional Medical Center.³⁰

On **January 6, 2021**, Hendrick re-submitted an application for SCH designation, again to the Reimbursement Department of the Medicare Contractor.³¹ This application contained – in addition to the original Exhibits A, C, D, and E – an updated Exhibit B and a new Exhibit F.³² Exhibit B included a copy of a CMS-855A Medicare Enrollment Application dated January 6, 2021, with a status of “approved.”³³ Exhibit F was the Medicare Contractor’s December 4, 2020 letter stating, “[t]he SCH designation request may be re-submitted to our office after the approval of the merger is complete.”³⁴

On **January 7, 2021**, the Provider Enrollment Department of the Medicare Contractor sent notification to Hendrick stating, “Novitas Solutions, Inc. has processed the Medicare Tie in Notice approving your change of ownership application.”³⁵ While the tie-in notice is dated January 7, 2021, the parties have recognized January 6 as the date the Medicare Enrollment Application was approved on the CMS Provider Enrollment, Chain, and Ownership System (“PECOS”).³⁶ A tie-in notice is the official confirmation issued by the Regional Office (“RO”) as part of the Medicare Change of Ownership (“CHOW”) process that links the seller’s existing provider transaction access number (“PTAN”) to the buyer’s new PTAN. Until a Medicare administrative contractor receives this tie-in/approval notice, payments will continue to be issued to the old owner. Here, the tie-in notice provided certain Medicare enrollment information, including the CHOW Effective Date of October 27, 2020.³⁷

On **January 13, 2021**, Hendrick emailed a copy of the January 7 tie-in notice to the Reimbursement Department of the Medicare Contractor.³⁸ Although this email is referenced in

²⁷ *Id.* at P0005.

²⁸ *See* Stip. at ¶ 9. *See also* Ex. P-3 at P0048.

²⁹ *See* Stip. at ¶ 9. *See also* Ex. P-3 at P0048.

³⁰ *See* Ex. C-4.

³¹ *See* Stip. at ¶ 12. *See also* Ex. P-5.

³² *See* Ex. P-5.

³³ *See* Stip. at ¶ 11-12. *See also* Ex. P-5 at P0065 - 0081.

³⁴ Ex. P-5 at P0100.

³⁵ Stip. at ¶ 13. *See also* Ex. P-6.

³⁶ *See* Ex. P-8 at P0107 (Reconsideration Request).

³⁷ *See* Ex. P-6.

³⁸ *See* Stip. at ¶ 14. *See also* Ex. P-10 at P0316.

the October 20, 2021 letter from the Medicare Contractor (see below), the email itself is not contained in the record.

On **March 3, 2021**, the PARD of the Medicare Contractor notified Hendrick that SCH status was granted and would be effective January 6, 2021.³⁹ On **August 23, 2021**, Hendrick submitted a request for reconsideration of this determination.⁴⁰ Hendrick argued that October 28, 2020 should be the effective date of SCH status as this is when they submitted “both a request for SCH designation and a CMS-855A application with supporting documentation proving Hendrick’s consummated acquisition of Abilene Medical (which resulted in there being no like hospital within 35 miles).”⁴¹

On **August 30, 2021**, Hendrick appealed the March 3, 2021 SCH status determination to the Board. In its appeal, Hendrick again argued that October 28, 2020 should be the effective date of SCH status as this is when they submitted a complete application.⁴²

On **October 20, 2021**, the Medicare Contractor upheld the March 3, 2021 SCH status determination.⁴³ The Medicare Contractor stated that the Medicare Contractor and CMS had determined the date the complete application was received was January 13, 2021, not October 28, 2020. Specifically:

In addition, it was pointed out by CMS Central Office, that the effective date of 01/06/2021 stated on the previous approval letter dated 03/03/2021 is incorrect. According to CMS CO, the effective date should be 01/13/2021, because it is the date the Provider emailed a copy of the tie-in approval letter to the Novitas Reimbursement area, making that the date the MAC received all the required supporting documentation. Therefore, the effective date of the SCH status will be changed to 01/13/2021.⁴⁴

On **October 29, 2021**, Hendrick supplemented its appeal to the Board to reflect the reconsideration response and a revised amount in controversy based on the additional time between the original application and the revised effective date.⁴⁵

³⁹ See Stip. at ¶ 15. See also Ex. P-7.

⁴⁰ See Stip. at ¶ 16. See also Ex. P-8.

⁴¹ Stip. at ¶ 16.

⁴² Individual Appeal Request, Attachment C – Issue Statement at 1 (Aug. 30, 2021).

⁴³ See Stip. at ¶ 18. See also Ex. P-10.

⁴⁴ Ex. P-10 at P0316.

⁴⁵ See Individual Appeal Request, Supplement to Appeal (Oct. 29, 2021).

STATEMENT OF RELEVANT LAW:***A. Sole Community Hospital (“SCH”) Defined***

The statute 42 U.S.C. § 1395ww(d)(5)(D)(iii) defines an SCH as 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 a 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) of this title as in effect on September 30, 1997.

The corresponding regulations at 42 C.F.R. § 412.92(a) (2020) set the criteria for a hospital to be considered an SCH:

(a) Criteria for classification as a sole community hospital. CMS classifies a hospital as 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 MAC 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.

(2) The hospital is located between 15 and 25 miles from other like hospitals but 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.

(3) Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

(4) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, combined data from the main campus and its remote location(s) are required to demonstrate that the criteria specified in paragraphs (a)(1)(i) and (ii) of this section are met. For the mileage and rural location criteria in paragraph (a) of this section and the mileage, accessibility, and travel time criteria specified in paragraphs (a)(1) through (3) of this section, the hospital must demonstrate that the main campus and its remote location(s) each independently satisfy those requirements.⁴⁶

B. SCH Application Process

At the time of Hendrick's Original Application for SCH status, 42 C.F.R. § 412.92(b) (2020) set forth the classification procedures for its application and its effective date:

(1) Request for classification as sole community hospital.

⁴⁶ 42 C.F.R. § 412.92(a) (2020) is the version of the regulation in effect at the time of the Original Application for SCH status and is the version cited unless otherwise indicated.

- (i) The hospital must make its request to the MAC.
- (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) [this provision concerns an applicant who cannot obtain information required in (ii), above]
- (iv) The MAC reviews the request and send the request, with its recommendation, to CMS.
- (v) CMS reviews the request and the MAC's recommendation and forward its approval or disapproval to the MAC.

(2) Effective dates of classification.

- (i) For applications received on or before September 30, 2018, sole community hospital status is effective 30 days after the date of CMS' written notification of approval, except as provided in paragraph (b)(2)(v) of this section. **For applications received on or after October 1, 2018, sole community hospital status is effective as of the date the MAC receives the complete application,** except as provided in paragraph (b)(2)(v) of this section.
- (ii) [concerns effective dates when a court or the PRRB

reverses a CMS denial of SCH status]

(iii) [concerns terminating retroactive SCH designation]

(iv) For applications received on or before September 30, 2018, a hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after 30 days after the date of CMS' approval of the classification. **For applications received on or after October 1, 2018, a hospital classified as a sole community hospital receives a payment adjustment, as described in paragraph (d) of this section, effective with discharges occurring on or after the date the MAC receives the complete application.**

(v) If a hospital that is classified as an MDH under § 412.108 applies for classification as a sole community hospital because its status under the MDH program expires with the expiration of the MDH program, and that hospital's sole community hospital status is approved, the effective date of approval of sole community hospital status is the day following the expiration date of the MDH program if the hospital—

(A) Applies for classification as a sole community hospital prior to 30 days before the expiration of the MDH program; and

(B) Requests that sole community hospital status be effective with the expiration of the MDH program.⁴⁷

C. Additional Guidance

When establishing the criteria, the Secretary discussed what constitutes a “complete” application for SCH status:

A complete application includes a request and all supporting documentation needed to demonstrate that the hospital meets criteria for SCH status as of the date of application, which includes documentation of rural reclassification in the case of a geographically urban hospital. We stated in the proposed rule that for an application to be complete, all criteria must be met as of the

⁴⁷ (Bold and underline emphasis added).

date CMS receives the SCH application, but, similar to above, we are clarifying in this final rule and revising this preamble discussion to reflect that **all criteria must be met as of the date the MAC receives the SCH application**, because the MAC, and not CMS, receives SCH applications.

After consideration of the public comments we received, we are finalizing our proposed changes to § 412.92(b)(2)(i) and (b)(2)(iv), with modification, so that for applications received on or after October 1, 2018, the effective date for SCH classification and for the payment adjustment is the date that the MAC, rather than CMS, receives the complete SCH application.⁴⁸

Section 2810 of the Provider Reimbursement Manual Part 1 (“PRM 15-1”) provides guidance on approval of SCH classification:

C. Approval of SCH Classification.—The contractor reviews the documentation submitted by the requesting hospital. If the request is incomplete, the contractor contacts the hospital to obtain additional information. Once all the necessary data have been obtained, the contractor forwards the completed package to the appropriate CMS Regional Office with its recommendation for further action.

The CMS Regional Office makes the final determination on the hospital’s request and responds in writing to the contractor. The hospital receives notification of the decision from its contractor. For applications received on or before September 30, 2018, SCH status becomes effective for discharges occurring 30 days after the date of CMS approval except as provided in 42 CFR 412.92(b)(2)(v). **For applications received on or after October 1, 2018, SCH status is effective as of the date the MAC receives the complete application**, except as provided in 42 CFR 412.92(b)(2)(v). **There are no retroactive effective dates on SCH designations** other than requests granted by a court order or PRRB decision.

Once a hospital has been designated as an SCH, it retains that classification indefinitely unless there is a change in the circumstances under which the classification was approved

⁴⁸ 83 Fed. Reg. 41144, 41430-31 (Aug. 17, 2018) (emphasis added) (*available at* Ex. C-8).

suggesting a need for reevaluation or the hospital requests its SCH classification be cancelled.⁴⁹

D. Burden of Proof and Standard of Review

A Board decision must include findings of fact and conclusions of law that “the provider carried its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that the provider is entitled to relief on the merits of the matter at issue.”⁵⁰ Additionally, “[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the [Medicare contractor] and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole.”⁵¹ In *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 230 (1938), the U.S. Supreme Court held, “[s]ubstantial evidence is more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.”⁵² Accordingly, in an appeal before the Board, a provider must prove by a preponderance of substantial, relevant evidence that it is entitled to the relief sought. And, while the provider has the burden of proof, the Medicare contractor must “[e]nsure that the evidence it considered in making its determination . . . is included in the record.”⁵³ Further, the “Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.”⁵⁴

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

Pursuant to 42 C.F.R. § 412.92(b), the date the Medicare Contractor received the *complete application* is the date Hendrick’s SCH status is effective.⁵⁵ To be *complete*, the application must include “all supporting documentation needed to demonstrate that the hospital meets criteria for SCH status as of the date of application.”⁵⁶ To be clear, the criteria relevant for the instant case is:

⁴⁹ PRM 15-1 § 2810 (2018) (emphasis added).

⁵⁰ 42 C.F.R. § 405.1871(a)(3).

⁵¹ 42 U.S.C. § 1395oo(d). This statutory provision further confirms that: “[t]he Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.” *See also* 42 C.F.R. § 405.1869(a).

⁵² *See also Pomona Valley Hosp. Med. Ctr. v. Becerra*, 82 F.4th 1252, 1258-59 (D.C. Cir. 2023).

⁵³ 42 C.F.R. § 405.1853(a)(3).

⁵⁴ 42 C.F.R. § 405.1867.

⁵⁵ *See* 83 Fed. Reg. at 41430. “[B]ecause the MAC receives SCH applications and not CMS, we are clarifying in this final rule that under our policy, as finalized below, ***the effective date is the date that the MAC receives the complete application.*** We have revised our finalized regulatory text and this preamble throughout to reflect that the MAC, and not CMS, receives the SCH application. ***A complete application includes a request and all supporting documentation*** needed to demonstrate that the hospital meets criteria for SCH status ***as of the date of application....***” (emphasis added).

⁵⁶ *Id.*

[To be] located more than 35 miles from other like hospitals, or [...] located in a rural area (as defined in § 412.64) and [...] is located between 25 and 35 miles from other like hospitals and [...] 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.⁵⁷

1. The Original Application

Hendrick argues that the original application submitted on October 28, 2020 was complete with “everything needed to demonstrate that it was eligible for SCH status” because it included “a CMS-855A [Medicare Enrollment] Application containing documentation demonstrating that it had completed its acquisition of Abilene Medical.”⁵⁸ As discussed above in Section C (“Additional Guidance”) of the Statement of Relevant Law, comments in the Federal Register included with the 2019 Final Rule read that:

A complete application includes a request and all supporting documentation needed to demonstrate that the hospital meets criteria for SCH status as of the date of application . . .⁵⁹

The record does not show any dispute over criteria other than the merger approval letter.⁶⁰ In fact, the five exhibits Hendrick submitted with the original application included evidence of its rural reclassification, geographical distance from other hospitals, and a “like hospital” analysis.⁶¹ The Medicare Contractor refers to the effective date of the merger as “the only issue in this appeal.”⁶² It does not dispute that after the merger there is no “like hospital” within 35 miles of Hendrick.⁶³ Accordingly, the Board finds it unnecessary to evaluate the adequacy of any other criteria.

The Medicare Contractor maintains that the application was not complete when it was originally submitted, because, at that time, the CMS-855A Medicare Enrollment Application was pending review at the Centers for Medicare Regional Office (“CM RO”).⁶⁴ The Medicare Contractor asserts that “[s]ince the approval of the Provider’s merger was not complete at that time, the application for their SCH approval was returned to the provider on 12/04/2020.”⁶⁵

Hendrick argues that it is unlawful to “interpret[] a merger-based SCH application to be

⁵⁷ 42 C.F.R. § 412.92(a).

⁵⁸ Provider’s FPP at 4.

⁵⁹ 83 Fed. Reg. at 41430.

⁶⁰ See, e.g., Stip. at ¶¶ 8, 9.

⁶¹ See Ex. P-2.

⁶² Medicare Contractor’s Final Position Paper (“Medicare Contractor’s FPP”) at 5 (Sept. 4, 2025).

⁶³ See Stip. at ¶ 7.

⁶⁴ See Medicare Contractor’s FPP at 5.

⁶⁵ *Id.*

‘complete’ only when it includes documentation that the agency has approved the underlying merger....”⁶⁶ Hendrick suggests that the Board should decline to follow this policy. Its reasons are threefold.

First, Hendrick contends the interpretation of what constitutes a complete SCH application based on merger compared to SCH applications is less favorable than what constitutes a complete SCH application based on rural reclassification.⁶⁷ In each of those scenarios, the hospital’s eligibility for SCH is based on an underlying legal status.⁶⁸ In the case of a rural reclassification the effective date is the date the hospital submits the combined applications.⁶⁹ By contrast, in the case of a merger the hospital “must not only *file* a CMS-855A application simultaneously with the SCH application, but must submit documentation demonstrating CMS’s *approval* of the CMS-855A application,” both dates which come well after the date of the underlying merger.⁷⁰ Hendrick suggests that there will be a substantial “time difference between the effective date of the merger . . . and the effective date of SCH status.”⁷¹

Second, Hendrick argues that CMS adopted the FY 2019 final rule to minimize payment disadvantages and to eliminate the time lag “between the effective date of a rural reclassification and the effective date of SCH status.”⁷² However, Hendrick says the same time lag problems exist for a merger-based SCH application.⁷³

Third, Hendrick suggests that the policy defining a complete application was not lawfully implemented, as it was not promulgated through notice-and-comment rulemaking.⁷⁴ Hendrick, citing *Allina Health Servs. v. Price*, states that the Medicare statute requires notice-and-comment rulemaking “for any (1) ‘rule, requirement, or other statement of policy’ that (2) ‘establishes or changes’ (3) a ‘substantive legal standard’ that (4) governs ‘payment for services.’”⁷⁵ In sum, Hendrick argues that CMS’ merger-approval-documentation policy specifies a requirement that establishes a standard for a complete application that is distinct from the definition in 42 C.F.R. § 412.92(b)(2)(i).⁷⁶ Hendrick argues the merger-approval-documentation policy is a substantive standard.⁷⁷ Since the merger-approval-documentation ties SCH status to a complete application, Hendrick asserts it governs payment for services.⁷⁸

The Medicare Contractor’s position is that the CMS-855A application was pending at the CM

⁶⁶ Provider’s FPP at 22.

⁶⁷ *Id.*

⁶⁸ *Id.* at 23.

⁶⁹ *Id.* at 23-24. *See also* 42 C.F.R. § 412.103 and 83 Fed. Reg. at 41430.

⁷⁰ *Id.* at 24 (emphasis in original).

⁷¹ *Id.*

⁷² *Id.* at 26 (citing 83 Fed. Reg. at 41430).

⁷³ *Id.* at 27.

⁷⁴ *Id.* at 28-29.

⁷⁵ Provider’s FPP at 28 citing *Allina Health Servs. v. Price*, 863 F.3d 937, 943 (D.C. Cir. 2017), *aff’d sub nom. Azar v. Allina Health Servs.*, 139 S.Ct. 1804 (2019) (quoting 42 U.S.C. § 1395hh(a)(2)).

⁷⁶ *Id.* at 28-29.

⁷⁷ *Id.* at 29.

⁷⁸ *Id.*

RO for review as of the date of the SCH request, so the approval of the merger was not complete.⁷⁹

While the October 28, 2020 original application included a bill of sale, it included a PECOS report showing that the Medicare 855-A Medicare Enrollment Application was *pending*.⁸⁰ The Board finds that the supporting documentation required for a complete application included CMS approval of the merger; therefore, the original application was not complete. The Medicare Contractor did not address Hendrick's arguments with respect to the time lag and notice-and-comment rulemaking.

The Board acknowledges that time lag problems may exist for a merger-based SCH application. In fact, the Secretary later addressed this problem in the 2023 rulemaking. However, the Board is bound by the regulations that were in place at the time of Hendrick's application and must "afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS."⁸¹ The Board, therefore, cannot "decline to give effect to the merger-approval-documentation policy [in favor of the later] definition of a 'complete application' that CMS set forth in the preamble to the FY 2019 final rule,"⁸² as requested by Hendrick.

With regard to "the merger-approval-documentation policy," Hendrick is arguing that the "complete application" requirements of 42 C.F.R. § 412.92(b)(2)(i) do not require documentation of an approved merger. The FY 2019 IPPS Final Rule stated that "[a] complete application includes a request and *all supporting documentation* needed to demonstrate that the hospital meets criteria for SCH status as of the date of application."⁸³ The preamble goes on to state, "for an application to be complete, all criteria must be met as of the date" the Medicare administrative contractor receives the application.⁸⁴ Later revisions to the regulation did call out merger approval as one example of what is required for a complete application, but this is not a modification.⁸⁵ The Board finds that the definition of a complete application was not modified and was lawfully implemented.

2. The Re-Submitted Application

Hendrick argues that even if the Board finds the original application was not complete, it should find that Hendrick submitted a complete application before January 13, 2021.⁸⁶ The Board found that the original application was not complete because it did not include CMS approval of the

⁷⁹ See Medicare Contractor's FPP at 5.

⁸⁰ See Ex. P-2 at P0014-30.

⁸¹ 42 C.F.R. § 405.1867.

⁸² Provider's PPP at 30.

⁸³ 83 Fed. Reg. at 41430(emphasis added).

⁸⁴ *Id.* Note that the preamble clarifies "that all criteria must be met as of the date the MAC receives the SCH application, because the MAC, and not CMS, receives SCH applications."

⁸⁵ See 88 Fed. Reg. 58640, 59038 (Aug. 28, 2023), stating, "We note that *we did not propose to modify any SCH classification requirements or what constitutes a "complete application."* The SCH application must, therefore, include all required documentation that would constitute a "complete application" including documentation of the hospital's merger approval." (emphasis added).

⁸⁶ See Provider's FPP at 19.

merger. CMS's PECOS system indicates that CMS had approved Hendricks' CMS-855A application on January 6, 2021,⁸⁷ *and a representative from the Provider Enrollment department of the Medicare Contractor sent Hendrick notification of the tie-in notice approval of change of ownership on January 7, 2021.*⁸⁸

On January 13, 2021, Hendrick forwarded the tie-in approval letter that it received on January 7, 2021 to the staff of the PARD at the Medicare Contractor that was processing its SCH status request, thereby completing its SCH application. The email itself is not contained in the record, consequently, the Board is without knowledge of to whom the email was addressed, whether it contained specific details, or the context in general. The official response to Hendrick's August 23, 2021 request for reconsideration ("response") of the denial of the original application indicates:

[I]t was pointed out by CMS Central Office, that the effective date of 01/06/2021 stated on the previous approval letter dated 03/03/2021 is incorrect. *According to CMS CO, the effective date should be 01/13/2021, because it is the date the Provider emailed a copy of the tie-in approval letter to the Novitas Reimbursement area,* making that the date the MAC received all the required supporting documentation. Therefore, the effective date of the SCH status will be changed to 01/13/2021.⁸⁹

The response indicates the original application was not complete because "[the Medicare Contractor] did not have the *tie-in approval letter* as part of the complete package to prove that the hospitals were merged, which would make them eligible for SCH status by not having another like hospital within 35 miles of them."⁹⁰

Therefore, the Board finds that the re-submitted application was not complete until Hendrick sent the tie-in notice to the Medicare Contractor on January 13, 2021. The submission of the tie-in notice completed the incomplete package that Hendrick had sent on January 6, 2021.

3. The 2023 Rulemaking Does Not Apply

Hendrick has argued that the FY 2024 final rule impacting the effective date for merger-based SCH applications should be retroactively applied to Hendrick.⁹¹

⁸⁷ See Ex. P-5 at P0065-081 (reflecting an approved Medicare Enrollment Record, dated 01/06/2021). The Board also notes Stip. at ¶ 11 ("CMS's PECOS system indicated that CMS had updated Hendrick's Medicare enrollment records to reflect its merger with Abilene Medical, reflecting that CMS had approved Hendrick's CMS-855A application").

⁸⁸ Stip. at ¶ 13; *see also* Ex. P-6.

⁸⁹ Ex. P-10 (emphasis added).

⁹⁰ Ex. P-10 at P0316 and Ex. C-7 at 000022 (emphasis added) (same document).

⁹¹ Provider's FPP at 30.

Nearly three years after Hendrick submitted the October 28, 2020 SCH application, CMS amended 42 C.F.R. § 412.92(b) in the Final Rule effective October 1, 2023, changing the effective date for SCH applications that depend on a merger. Specifically, the Secretary added 42 C.F.R. § 412.92(b)(2)(vi), which reads:

(vi) ***For applications received on or after October 1, 2023***, where eligibility for sole community hospital classification is dependent on the hospital's merger with another hospital, sole community hospital status is effective as of the effective date of the approved merger if, and only if, the date that the Medicare administrative contractor (MAC) receives the complete application is within 90 days of CMS' written notification to the hospital of the approval of the merger.⁹²

When updating the regulation, the Secretary recognized that “[f]or some hospitals, eligibility for SCH classification may depend on the hospital's merger with a nearby ‘like hospital’ as defined in § 412.92(c)(2) and meeting other criteria at § 412.92(a). The merger allows the two hospitals involved to operate under a single provider agreement.”⁹³

The Secretary also describes a similar scenario to the instant case, “where the applicant hospital was not eligible for SCH classification due to its proximity to a nearby like hospital. When the applicant hospital subsequently merges with the nearby like hospital, it is *potentially eligible* for SCH classification.”⁹⁴

In reference to such a scenario, the Secretary indicated:

If an SCH application is approved, **under current policy**, the effective date of the SCH classification is the date the MAC receives the complete application. In situations where SCH classification is contingent on a merger, **a hospital is not considered to have submitted a complete application to the MAC unless the application contains the notification that the merger was approved**.⁹⁵

In the preamble to the 2023 Final Rule, the Secretary specifically acknowledged the issue presented in this appeal when the current [pre-2023] policy's approval criteria and effective dates were applied:

We have heard concerns that in these situations the time difference between the effective date of the hospital merger, which may be retroactive, and the effective date of the SCH status, which is

⁹² (Bold and italics emphasis added).

⁹³ 88 Fed. Reg. at 59038 (footnotes omitted).

⁹⁴ *Id.* (italics emphasis added).

⁹⁵ *Id.* (Bold and underline emphasis added).

based on the date the complete application is received by the MAC, including the merger approval, may be problematic for hospitals because they cannot benefit from the special payment protections that are afforded to SCHs until the effective date of the SCH classification.⁹⁶

As a result of the 2023 Final Rule, for applications received on or after October 1, 2023, SCH status is “effective as of the effective date of the approved merger if the MAC receives the complete application within 90 days of CMS’ written notification to the hospital of the approval of the merger.”⁹⁷ The Secretary notes that this timeframe “provide[s] sufficient time for a hospital to submit a complete SCH application, while addressing the concerns, as previously discussed, that merger approval may be delayed for reasons beyond a hospital’s control.”⁹⁸ The Secretary did not modify any SCH classification requirements or what constitutes a “complete application” for SCH classification, which still requires documentation of the hospital’s merger approval.⁹⁹ The Secretary reiterated that this requirement conformed with their previous policy, stating:

[W]e **continue** to believe that our **current approach in determining the effective date for SCH classification where the SCH application is contingent on a hospital merger** is reasonable.¹⁰⁰

Some commenters requested that CMS apply this new provision retroactively or to “similar situations for which the parties have preserved appeal rights over the effective date determination for an SCH approval.”¹⁰¹ However, the Secretary specifically rejected the request, stating:

We appreciate the commenters’ ideas and suggestions. However, we do not agree that we should apply our proposed changes retroactively. The IPPS is a prospective system and, we generally make changes to IPPS regulations effective prospectively based on the date of discharge or the start of a cost reporting period within a certain Federal fiscal year. Under that approach, we believe that applying this change for a merger that already took place may constitute retroactive rulemaking—and would be a departure from

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *See id.* (“The SCH application must, therefore, include all required documentation that would constitute a “complete application” including documentation of the hospital’s merger approval.”)

¹⁰⁰ *Id.* (Bold and underline emphasis added).

¹⁰¹ “Comments On the Hospital Inpatient Prospective Payment Systems...” Hall Render Killian Heath & Lyman (June 7, 2023) at 2, available at <https://www.regulations.gov/comment/CMS-2023-0057-1897> (last accessed Sept. 25, 2026). *See also* “RE: CMS-1785-P, Medicare Program...” Ohio Hospital Association (June 9, 2023) at 17, available at <https://www.regulations.gov/comment/CMS-2023-0057-2949> (last accessed Sept. 25, 2026), stating “we ask that CMS also apply this proposal for those SCHs who were seeking their status during the COVID-19 pandemic and were impacted by this time difference.”

our usual practice in IPPS—regardless of whether there’s a pending administrative appeal. We believe that following our usual approach and adopting the new effective date policies for SCH and rural reclassification applications where SCH eligibility is dependent on a hospital merger that are received on or after October 1, 2023 will allow for the most equitable application among all IPPS providers seeking to qualify for SCH classification and rural reclassification (as applicable).¹⁰²

The Secretary also responded to requests for clarification on what constitutes a “complete application” for SCH reclassification.¹⁰³ The Secretary reiterated that this definition had not changed, and directed the commenters to Chapter 28 of the PRM, § 2810.B for guidance, stating:

In addition to the documentation list in the PRM, for an SCH application where eligibility for SCH classification is dependent on a hospital merger, that documentation **must include confirmation that the merger has been approved by CMS** (for example, a CMS tie-in notice recognizing the two CCNs as merged).¹⁰⁴

The 2023 revised regulation does not apply because CMS received both applications *before* October 1, 2023. Although Hendrick claims compliance with the new regulations, it was not eligible for SCH status at the time the applications were submitted, as its hospital merger was not yet approved.

In summary, both the original SCH application submitted on October 28, 2020, and the second application submitted on January 6, 2021, were required to be complete and include evidence that, *as of that date*, there were no like hospitals within 35 miles of Hendrick. The parties have agreed that Hendrick did not receive the notification of Medicare tie-in notice approving the change of ownership application until January 7, 2021.¹⁰⁵ Therefore, as of October 28, 2020 and January 6, 2021, Hendrick *had not* received CMS approval of their merger with Abilene Regional Medical Center. As a result, ***at the time the Medicare Contractor received the original and re-submitted SCH applications***, there remained two “like hospitals” with unique provider numbers within 35 miles of each other. CMS did not approve the merger until **January 7, 2021**.¹⁰⁶ Regardless of CMS’ approval of the merger, the regulations establish SCH eligibility based on the date a complete application is received by the Medicare Contractor from Hendrick,

¹⁰² 88 Fed. Reg. at 59039.

¹⁰³ See e.g., “RE: CMS-1785-P, Medicare Program...” Ohio Hospital Association (June 9, 2023) at 17, available at <https://www.regulations.gov/comment/CMS-2023-0057-2949> (last accessed Sept. 26, 2026), stating “We also ask that in finalizing the proposal, the agency clarifies its current policy of ‘complete’ applications in accordance to the regulation for cases contingent on a merger.”

¹⁰⁴ 88 Fed. Reg. at 59039 (bold and underline emphasis added).

¹⁰⁵ Stip. at ¶ 13.

¹⁰⁶ *Id.*

which is unaffected by a retroactive effective date of a merger or provider number acquisition.¹⁰⁷ Hendrick has not proven by a preponderance of substantial, relevant evidence that it is entitled to the relief sought.

Based on the foregoing, the Board finds that Hendrick was not an SCH until **January 13, 2021**, as this was the date the completed application was received.

DECISION:

After considering Medicare law and regulations, the arguments presented, and the evidence admitted,¹⁰⁸ the Board agrees with the Medicare Contractor's October 20, 2021 reconsideration determination and finds that the proper effective date of the SCH designation is January 13, 2021, as in accordance with 42 C.F.R. § 412.92(b)(2)(i), "[SCH] status is effective as of the date the [Medicare Contractor] receives the complete application," and this application was completed when Hendrick sent a copy of CMS' tie-in approval letter to the Medicare Contractor on January 13, 2021.

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FOR THE BOARD:

9/29/2026

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Chair

Signed by: KEVIN D. SMITH -A

¹⁰⁷ See also PRM 15-1, § 2810(C) ("For applications received on or after October 1, 2018, SCH status is effective as of the date the MAC receives the complete application . . . There are no retroactive effective dates on SCH designations other than requests granted by a court order or PRRB decision.").

¹⁰⁸ Any arguments or evidence, whether or not specifically referenced or discussed herein, were considered by the Board in the deliberations of this appeal.