PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

96-D37

PROVIDER -
Howard Young Medical Center
Woodruff, Wisconsin

Provider No. 52-0091

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of Wisconsin

DATE OF HEARING-
October 12, 1995

Cost Reporting Period Ended -
March 31, 1991

CASE NO. 93-0145

INDEX

Page No.

Issue.......... 2

Statement of the Case and Procedural History.......... 2

Provider's Contentions.......... 4

Intermediary's Contentions.......... 8

Citation of Law, Regulations & Program Instructions.......... 10

Findings of Fact, Conclusions of Law and Discussion.......... 11

Decision and Order.......... 12

ISSUE:

Was the Intermediary's denial of sole community status under 42 C.F.R. § 412.92 proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Prior to the commencement of the hearing, the parties entered into a stipulation.[1] The provisions of that stipulation are outlined at the end of this section.

The Howard Young Medical Center ("Provider") is located in Woodruff, Wisconsin, a non-metropolitan statistical area. The Provider submitted an initial request for classification as an Sole Community Hospital ("SCH") on March 17, 1992, based upon its March 31, 1991 year-end cost report.[2] Additional information was submitted to Blue Cross and Blue Shield United of Wisconsin ("Intermediary") on March 23, 1992 and May 21, 1992.[3]

On June 17, 1992, the Intermediary concluded that the Provider successfully satisfied and documented the SCH status requirements and recommended that the Health Care Financing Administration ("HCFA") grant the Provider SCH status.[4] Shortly thereafter, the Provider became aware of the fact that HCFA was considering redefining the Provider's service area. Specifically, HCFA was planning to exclude the Boulder Junction and Lake Tomahawk areas, while including Eagle River in the Provider's service area. In response, the Provider submitted additional information to the Intermediary, explaining the rationale behind the Provider's definition of its service area on July 1, 1992; on July 16, 1992, it submitted further information regarding the "masked" zip codes included in the Provider's service area.[5]

On July 23, 1992, the Intermediary again recommended that HCFA grant the Provider SCH status.[6] On August 2, 1992, HCFA denied the Provider's request for SCH status, claiming that the Provider did not meet all of the requirements under 42 C.F.R. § 412.92 and PRM § 2810.[7]

---

1 Tr. 8-9.

2 Provider exhibit 1.

3 Provider exhibits 2 and 3.

4 Provider exhibit 4.

5 Provider exhibits 5 and 6.

6 Provider exhibit 7.

7 Provider exhibit 8.

The Provider filed a Notice of Appeal and Request for Hearing with the Provider Reimbursement Review Board ("Board") on November 2, 1992,[8] pursuant to 42 C.F.R. § 405.1835-.1841 and has met the jurisdictional requirements of those regulations.

On March 18, 1993, the Provider requested reconsideration of HCFA's denial from the Intermediary, submitting an alternative service area calculation that complied with HCFA's manual provisions mandating use of the lowest number of zip code areas.[9] On May 3, 1993, the Intermediary denied the request for reconsideration.[10]

The Provider is represented by Don Miller, Esquire and David Snow, Esquire of the law firm of Von Briesen & Purtell, S.C.. The Intermediary's representative is Bernard M. Talbert, Esquire of the Blue Cross and Blue Shield Association.

Additional Information

The Provider is located in Woodruff, a popular summer and winter vacation area in northern Wisconsin. Approximately 20% of the Provider's discharges come from people who are vacationing in the Provider's service area.[11]

Other hospitals within a 35 mile radius of the Provider are Sacred Heart-St. Mary's Hospital in Rhinelander, Wisconsin, which is 26 miles from the Provider, and Eagle River Memorial Hospital in Eagle River, Wisconsin, which is located 26.6 miles from the Provider.

The Provider's request for SCH status defined its service area based on zip code discharge data supplied by the Wisconsin Hospital Association. To select the zip code areas constituting its service area, the Provider identified which zip code areas most utilized the Provider, based upon the percentage of discharges from the Provider to total discharges of patients from that zip code area. The Provider then ranked the zip code areas from which it drew at least 75% of its discharges during the test period. The area defined as "the Lakeland Service Area," accounted for approximately 76% of the Provider's discharges. The Provider then tested all discharges of patients originating from this area for discharges from like hospitals within a 35-mile radius. Therefore, less than 25% of the inpatients discharged from the Lakeland Service Area are discharged from other like hospitals within a 35-mile radius.

---

[8] Provider exhibit 9.

[9] Provider exhibit 10.

[10] Provider exhibit 11.

[11] The Provider and HCFA agree that patients who are vacationing in the Provider's service area should not be counted in determining the Provider's SCH classification.

The Intermediary recommended to HCFA that it should grant the Provider's request for classification as a sole community hospital. Contrary to that recommendation, HCFA denied the request. According to HCFA, the absolute number of discharges, not the percentage of discharges, must serve as the basis for computing the Provider's service area. This resulted in a redefined service area in which the provider did not meet the 75% market share test.

Stipulation:

During the hearing before the Board, the parties stipulated to the following:

> Point [1,] is the following 10 zip codes make up an acceptable service area pursuant to the Provider Reimbursement Manual, Part 1, HCFA 15-1 § 2810.A.2 and 42 C.F.R. § 412.92(c)(3). These zip codes are . . . 54568, 54548, 54547, 54521, 54531, 54558, 54545, 54552, and 54512. . . . We [HCFA] have dropped off 54501 and have added 54512.
>
> Point 2, . . . is that the Provider has demonstrated that for the fiscal year [at issue] . . . less than 25 percent of the Medicare discharges are out of the hospitals in Rhinelander, Eagle River, and Tomahawk. . . . [f]rom that factual conclusion, [and] the standard in . . . [42 C.F.R. §] 412.92 . . . would be sufficient to qualify the Provider as a sole community hospital.
>
> The Provider has agreed to point 1 without waiving any argument that a different service area can be identified pursuant to Medicare statute and regulations. The Intermediary has agreed to point 2 without waving any objection concerning the admissibility of Provider's [new exhibits defining its service area].
>
> The latest submissions by the provider demonstrate that [the Provider] has defined an appropriate service area in accordance with HCFA's instructions and also demonstrate that we meet the market share test, based on Medicare patient discharges for [the] 1991 fiscal year, from that service area. [I]f the ultimate decision [of the Board] is that the exhibits are . . . admissible [and] relevant, then the hospital has demonstrated that qualifies for sole community hospital status for [the] fiscal year [at issue.]

Tr. at 8-11.

PROVIDER'S CONTENTIONS:

The Provider contends that it meets all the requirements for obtaining sole community status as set forth in the regulations at 42 C.F.R. § 412.92(a)(1). Moreover, it is undisputed that the Provider meets the first two requirements because it is located in a rural area and no hospital

is located within 25 miles. Further, it meets the regulatory requirement of 42 C.F.R. § 412.92(a)(1)(I), because 18.16% of its inpatients from its service area become inpatients at hospitals located within 35 miles. Finally and contrary to HCFA's initial contentions, the Provider's definition of its service area satisfies the regulatory criteria.

The Provider contends that the evidence supporting the definition of its service area satisfies the requirements of 42 C.F.R. § 412.92(c)(3). Specifically, the Provider has defined a service area from which it drew 75% of its inpatients during the most recent 12-month cost reporting period that ended prior to its application for SCH status in March 1992. The regulations contain no other requirements for determining a hospital's service area. HCFA concedes that the service area offered by the Provider prior to the hearing, meets the "lowest number of zip codes" requirement set out in the manual.[12] Further, neither the regulations nor the manual address situations where multiple service area calculations result in conflicting determinations of SCH status.

With respect to the "market share" test set out at 42 C.F.R. § 412.92(a)(1)(I), an SCH applicant must show that in the relevant time frame, it draws 75% of the patients, or all Medicare patients, who were discharged either from the applicant hospital or other like hospitals located within 35 miles of the applicant hospital, but within the defined service area. The Provider contends that it demonstrated that for the 12 months that comprise its 1991 cost year, 75.44% of the Medicare beneficiaries from the defined service area were discharged from the provider, and less than 10% were discharged from other like hospitals.[13]

The Provider contends that it is not disputed by HCFA that all other SCH criteria were met.[14]

The Provider contends that the statute and regulations governing Board proceedings require the Board to consider the OHCI data and the alternative service area and market share analysis that it submitted to HCFA prior to the hearing. The Provider claims that this evidence is relevant to the question of whether it qualified for SCH status effective 30 days after the date that HCFA denied its original application.[15] 42 U.S.C. § 1395oo(d) states that Board decisions are based on the record which "shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board . . . [and that it has] the power to affirm, modify or reverse a final determination . . . and to make any

---

[12] Tr. At 149-150 and stipulation of counsel at tr. 8-11.

[13] Provider exhibit 25 and tr. at 47.

[14] See tr. at 36-37 and Intermediary exhibit 1, wherein HCFA concedes that the provider met the criteria of 42 C.F.R. § 412.92(a)(1).

[15] See tr. at 5 and 7 wherein the Board admitted this evidence into the record but did not rule on its relevancy.

other revisions on matters covered by the cost report . . . even though such matters were not covered by such considered by the Intermediary in making a final determination." Id. Pursuant to the regulations at 42 C.F.R. § 412.92(e)(3)(iii) a denial of SCH status is subject to Board review. Further, § 405.1869 of those regulations mirrors the statute and states that the Board has the power to affirm, modify or reverse a determination "even though such matters were not considered in the intermediary's determination." Id. Therefore, HCFA's assertion that the Board may not consider this evidence is contrary to the law. Accordingly, the regulations require that the Board consider this evidence, which HCFA concedes demonstrates the Provider meets all SCH criteria.[16]

The Provider asserts that if the Board rejects HCFA's position regarding this evidence and the Board reaches its conclusion by virtue of HCFA's stipulation, the provider claims that it qualifies for SCH status as of September 24, 1992.[17] This is the case because the regulations at 42 C.F.R. § 412.92(b)(2)(ii)(B) specifically provide that SCH status is effective 30 days after HCFA's original written notification of denial, in the event a court or the Board confers status upon the Provider.[18]

The Provider alternatively argues that the basis of HCFA's original denial was erroneous because it was contrary to law. The service area defined by HCFA was arbitrary and capricious. Further, it ignores the practical realities of the Provider's geographic and market circumstances. In contrast, the Provider claims that the area defined by it is a reasonable interpretation of the regulations, creates a coherent and compact service area, and incorporates the realities of its market area.

HCFA denied the Provider's SCH application, determining that other like hospitals located within 35 miles discharged more than 25% of the patients from HCFA's defined service area and thus failed to meet the market share test required by 42 C.F.R. § 412.92(a)(1)(I). The Provider asserts however, that the testimony at the hearing conclusively showed that the application was assessed in a manner that was contrary to the law. The service area devised by HCFA accounted for 75% of the discharges, but the Provider claims that it did not comply with the other two requirements set out in the manual instructions. For example, the manual instructions require (1) that a service area be defined by the lowest number of contiguous zip codes from which 75% of the patients are drawn, and (2) that the service area must consist of contiguous areas. HCFA Pub. 15-1 §§ 2810A.2.c and 2810B.3.a. The provider claims that the manual instructions clearly require

---

[16] See the Provider's October 11, 1995 memorandum of law supporting the admissibility of Provider exhibits 22, 23, 24, and 25.

[17] See tr. at 8-11.

[18] Intermediary exhibit 3.

that the defined service area be "contiguous", therefore prohibiting skipping over a town that lies between other towns included in the service area. That section goes on to state that a zip code area should not be included in the service area unless any intervening zip code areas are also included. For example, "if town A is located between towns B and C, the service area of the hospital could not include both towns B and C but not town A." HCFA Pub. 15-1 § 2810.(B)(3)(a). HCFA's service area included some towns and arbitrarily excluded others.

At the hearing the witness for HCFA acknowledged several flaws in HCFA's analysis of the Provider's service area and reaffirmed the viability of the contiguous requirement.[19] Moreover, both the Provider and HCFA are equally bound by the manual instruction's contiguity requirement. The provider's witness equally testified concerning the errors of the defined service area. A number of towns were excluded from HCFA's analysis but contained within the defined service area.[20]

The Provider contends that its definition of its service area reflects the practical realities of its service area and is therefore, consistent with the intent of Congress. The major problem with HCFA's defined area is that it included a zip code with a low population base that may never be included in any hospital's service area. For example, using HCFA's method, a zip code area from which a provider receives 75 out of 1800 discharges (4% of the total discharges) could be included in a Provider's service area while excluding a zip code much closer to a Provider from which there are 74 out of 75 discharges (98% of total discharges).

The Provider also contends that HCFA's market share methodology applied in this case is inconsistent with long standing relevant factors because it did not include variables such as physician admitting practices, availability of public transportation, travel time and others that influence a patient's decision to obtain care at a particular hospital. See Intermediary Letter 78-17, Medicare & Medicaid Guide (CCH) Transfer Binder ¶ 28,972, 9696 (April 1978). See also Itasca Memorial Hospital v. Sullivan, Report and Recommendation of McNulty, U.S. Magistrate, U.S.D.C. Minn. Third Division, No. 5-88-0195, August 7, 1989 ("Itasca") and Graham Hospital Association v. Heckler, 739 F.2d 285 (1984) (("Graham"). The Provider avers that physician admitting patterns of two hospitals included in HCFA's defined area prove that those facilities in fact operate in separate service areas.[21]

The Provider contends that the service area defined by it creates a coherent configuration while HCFA's is a sprawling abstract area. The map of the service area defined by HCFA clearly shows a service area that zigs and zags around several zip code areas, ignoring

---

[19] See tr. at 147-149 and a contrary assertion by the Intermediary in its position paper at 8. For further discussion of errors discussed by HCFA's witness see tr. 153-158.

[20] See tr. 63-66.

[21] Provider exhibits 17, 18, 19 and 20.

obvious traffic patterns and the reality of commuting for hospital care. This is due to the fact that HCFA used only the absolute number of discharges for its definition. The Provider claims that a similar factual situation arose in the Itasca case, wherein the court commented that "[t]he determination of a hospital's service area is, essentially a practical evaluation. The service area is the area from which a hospital draws or expects to draw its patients." The court, when discussing the hospital's service areas, noted that only a small number of the patients were drawn from the unpopulated areas included by HCFA, and areas in which it was reasonable to conclude a patient draw for this particular facility, were excluded. The court also stated that it was reasonable to conclude that patients would travel shorter distances to be treated and therefore were not properly included in the facility's service area. Id.

The Provider also argues that the process of defining a hospital's service area is similar to defining legislative districts. Further, that population is the controlling criterion in legislative apportionment controversies. Reynolds v. Simms, 377 U.S. 533, 537 (1964). The Provider cites a series of cases for the proposition that legislative district configurations must not be "crazy quilts." See Baker v. Carr, 369 U.S. 186 (1962) and Well v. Rockefeller, 311 F.Supp. 48, 57 (1970), aff'd 398 U.S. 901 (1970). See also Karcher v. Daggett, 462 U.S. 725, 755 (1983). The Provider avers that just as a state legislative apportionment scheme must be rational, so must the service area for SCH status be so defined.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider's establishment of its service area does not meet the requirements of PRM 15-1, Section 2810A(2)(c).

The Provider claims that they meet the criteria of a sole community hospital as set forth in 42 C.F.R. § 412.92(a)(1). This section states:

> 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.

Id.

According to HCFA, when determining the hospital's service area as it applies to the above regulation, the number of discharges, not the percentage of discharges must be used as the basis for computation. The relevant zip codes should be listed in order of the absolute amount of Provider discharges rather than in order of the percentage of discharges. This is pursuant to PRM 2810(A)(2)(c) which states:

> A hospital's service area is the area from which the hospital draws at least 75 percent of its inpatients during the most recently completed cost reporting period ending before it files for sole community status. A hospital may define its service area as the lowest number of contiguous zip codes from which the hospital draws at least 75 percent of its inpatients.

Id.

To base the service area on those zip codes which most heavily utilize the Provider on a percentage basis skews the statistics and does not apply the regulation as it was intended.

The Provider also contends that the primary reason it does not meet the 25% rule under HCFA's method is the inclusion of Rhinelander in the Provider's service area. However, it should be noted that even if the Rhinelander zip code was removed from the calculation, the Provider would still only service approximately 71% of inpatients in the service area and still would not meet the criteria of a sole community provider.

Also, with regard to the service area, the Provider states that HCFA violated PRM-1 § 2810 B.3.a. by not applying the "contiguous" zip code principle. The Random House College Dictionary defines contiguous as "1. touching; in contact; 2. in close proximity without actually touching; near." All of the zip codes included in the HCFA calculation touch at least one other zip code that is included in the service area.

The Provider also contends that HCFA violated this principle by excluding the Harshaw and Lake Tomahawk zip codes, 54529 and 54539 respectively. It should be noted that these two zip codes did not satisfy the service area requirement of 75 percent.

Finally, it should be noted that the above-mentioned method of establishing the "service area" is based on the September 30, 1988 Federal Register, Vol. 53, No. 190, pp. 38510 through 38511. It states that: [t]he lowest number of zip codes accounting for at least 75 percent of its inpatients would then constitute it service area. Id.

The same language is included in HCFA Pub. 15-1, Section 2810(A)(2)(c) except that contiguity of zip code areas is no longer a requirement for establishing the hospital's service area.

The Intermediary contends that there is no provision for including vacation discharges in the sole community status computation. The zip code data which was obtained from the Wisconsin Hospital Association was based on 2253 discharges, and the hospital's total discharges as reported were 2764. The difference of 511 represent vacation discharges. These discharges are from patients who do not reside in the service area. Since the regulations specifically refer to residents, these vacation discharges should be excluded from the computation. Also, there is no provision in the regulations which would allow these discharges to be included.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395oo(d)	-	Decisions of the Board
§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Regulations - 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 405.476 (Redesignated as §§ 412.90 and 412.92)	-	General
§ 412.90	-	Special Treatment Facilities General Rules
§ 412.92 et. seq.	-	Special Treatment: Sole Community Hospitals
§ 405.1869	-	Scope of Board's Decision Making Authority

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2810	-	Special Treatment: Sole Community Hospitals
§ 2810(A)(2)(c)	-	Criteria for Sole Community Hospital Classifications - All Other Hospitals
§ 2810(B)(3)(a)	-	Requesting Sole Community Hospital Classification - Utilization Data

Intermediary Letter No. 78-17, Medicare and Medicaid Guide (CCH) Transfer Binder ¶ 28,972, 9696, 9698 (Apr. 1978)

4. Federal Register:

   53 Fed. Reg. 19518 (1988)

   53 Fed. Reg. 38510 (1988)

5. Cases:

   Baker v. Carr, 369 U.S. 186 (1962).

   Graham Hospital Association v. Heckler, 739 F.2d 285 (1984).

   Itasca Memorial Hospital v. Sullivan, Report and Recommendation of McNulty, U.S. Magistrate, U.S.D.C. Minn., Third Division, No. 5-88-0195, August 7, 1989.

   Karcher v. Daggett, 462 U.S. 725 (1983).

   Reynolds v. Simms, 377 U.S. 533 (1964).

   Well v. Rockefeller, 311 F. Supp. 48 (1970).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony elicited at the hearing, and the post hearing brief, makes the following findings of fact and conclusions of law.

The Board finds that the governing regulations at 42 C.F.R. § 412.92(b) do not provide a time frame for HCFA to make a decision on an application for sole community hospital status. Further, the Board notes that the regulation itself contemplates the possiblity of retroactive approval stemming from either a court order or a Provider Reimbursement Review Board decision.

The Board finds that the Provider offered new evidence at the hearing, consisting of Provider Exhibits P-22 through P-25, to show that it qualifies for SCH status.

The Board notes that pursuant to the stipulation agreed to by both parties prior to and during the Board hearing, the parties agree that if the Board accepts the new evidence the Provider will qualify for SCH status. Enclosure I to Provider Exhibit P-22 demonstrates that the Provider has met the standard in 42 C.F.R. § 412.92 that would qualify the Provider for SCH status.

The Board recognizes that both the statute, 42 U.S.C. 1395oo(d) and the regulations, 42 C.F.R.
§ 405.1855 allow the Board to consider new evidence at the Board hearing.

The Board finds that, upon review, the new evidence submitted by the Provider at the hearing is relevant to the determination of the Provider's SCH status. Therefore, the Board agrees to accept the new evidence.

Based on the above, the Board is faced with the issue of whether the Provider should have been granted SCH status for the cost reporting period ended March 31, 1991. In view of the facts presented, the Board believes that the Provider adequately demonstrated that it met all requirements and is entitled to SCH status, for the above mentioned period.

DECISION AND ORDER:

The Health Care Financing Administration's denial of the Provider's request for SCH status, implemented by the Intermediary, was not proper, and is hereby reversed. The Provider shall be granted SCH status effective September 24, 1992, which is 30 days after HCFA denied the Provider's original application. The effective date is established pursuant to 42 C.F.R.
§ 412.92(2)(ii)(B).

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: March 26, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman