CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

IN THE CASE OF:	
St. Joseph Regional Health Center	**Claim for:** **FYEs: 12/31/1996 and 1997**
Provider	
vs.	
Blue Cross/ Blue Shield Association TrailBlazer Health Enterprises, LLC	Review of: PRRB Dec. No. 2007-D7 Date: December 7, 2006
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the 60-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. Comments were received from the Intermediary and CMS' Center for Medicare Management (CMM) requesting reversal of the Board decision. The Provider submitted comments requesting affirmation of the Board's decision. Accordingly, the Board's decision is now before the Administrator for final administrative review.

ISSUE AND BOARD MAJORITY'S DECISION

The issue is whether the Intermediary's determination that the Provider should be reimbursed at the rural, as opposed to the urban inpatient prospective payment system (IPPS) rate for discharges at its Grimes St. Joseph (Grimes) facility, was proper.

The Board Majority found that the regulation at 42 CFR 412.63(b)(5) does not apply to facilities which have been designated as provider-based; thus, the services provided at the Grimes' facility should be paid at the urban rate. The Majority explained that the Provider was granted the right to designate the Grimes facility as an extension of the Provider's Bryan campus, rather than as a separate hospital facility. The Majority stated that the designation was consistent with a "provider-

based status," as reflected in Program Memorandum (PM) 96-07. The requirements for designation as a provider-based facility, the Majority explained, required major organizational changes, including accreditation under the umbrella of the main provider, financial integration and that patients treated at the provider-based facility be considered patients of the main provider. Such changes and others must be reviewed and approved by CMS.

The Majority continued to explain that, under the PM and the later codification of those guidelines in the regulation at 42 CFR 413.65, a provider-based designation means that the hospital and the provider-based facility are no longer treated as separate facilities, but rather are treated as a single inpatient hospital facility. Therefore, 42 CFR 412.63(b)(5), which states that IPPS payment is based upon the location of discharge, does not apply.

The Intermediary's position that 42 CFR 412.63(b)(5) applies to provider-based facilities is undermined by the adoption of 42 CFR 413.65(i)(2) in 2000. Although this regulation was published after the fiscal periods at issue, it is consistent with the PM in effect at the time of the Grimes transaction and clearly reflects CMS' expectation that provider-based status carries with it billing ramifications, specifically that the provider must bill as a single entity.

The Majority further pointed out that section 413.65(i)(2)-(3) also provides that if a provider failed to apply for and receive designation regarding its provider-based status but met certain good-faith requirements, CMS would not recoup overpayments based on the failure to achieve provider-based status. It is illogical that a provider which went through the provider-based application process and was approved by CMS as a provider-based facility would be given less consideration than those that failed to even seek the appropriate legal status.

With CMS' explicit approval, the Grimes facility participated in the Medicare program, not as a separate hospital but as an integral and subordinate part of the main campus. The Majority noted that CMS' position with regard to the inpatient hospital portion of the Grimes facility was also inconsistent with its treatment of the skilled nursing facility (SNF) portion of the same facility. In response to the Intermediary's questions to CMS about the Provider's reimbursement, CMS responded that the 12-bed SNF at the Grimes facility should be paid the urban rate of the main provider.

The Dissent stated that the Majority's decision to accept jurisdiction of the case for fiscal year ending (FYE) 12/31/96 was incorrect. The Dissent pointed out that the Provider failed to request a Board hearing within 180 days of the original notice of program reimbursement (NPR), yet the Majority found good cause for the late filing. This good cause finding was based on the grounds that a 1998 email from

the Intermediary, and a CMS letter in 2000, engendered confusion regarding the reimbursement rate for services furnished at the Grimes facility. However, notwithstanding such possible confusion, the Dissent maintained that, long before the FY 1996 hearing request was due, the Provider was aware of the Intermediary's conclusion that the proper reimbursement rate for the Grimes' facility was the rural IPPS rate.

The Dissent further observed that the Provider was notified by the Intermediary on February 18, 1998, that Grimes had been over-reimbursed at the urban rate and that recoupment would follow. For support, the Intermediary had cited to the regulation at 42 CFR 412.63(b)(5), which states that for discharges occurring on or after October 1, 1998, for hospitals that consist of two or more separately located inpatient hospital facilities, the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurs. Further, the Intermediary notified the Provider on April 20, 1998 that the CMS Regional Office (RO) had determined that discharges at the Grimes facility were required to be paid at the rural rate. Moreover, when the FY 1996 NPR was issued on September 9, 1999, the Provider received definitive proof of the proper reimbursement rate. Thus, the Dissent maintained that, the request for hearing, for FY 1996, was due on or before March 7, 2000, long after any confusion from related correspondence would have been resolved.

Turning to the substantive issue in the case, the Dissent disagreed with the Majority, based upon the express language of the regulation at 42 CFR 412.63(b)(5). The Dissent maintained that the Board was bound by the regulation, and, thus, the case should have been expedited for judicial review. The Dissent found no reason to defer to other law or policy when the situation was precisely that contemplated by section 412.63(b)(5), i.e., a single hospital with multiple facilities providing inpatient services at those different locations. The Dissent stated that it would not reach the good-faith language of section 413.65(j), as the Intermediary's adjustment was supported by the regulation governing during the 1996-97 cost years.

SUMMARY OF COMMENTS

The Intermediary requested that the Administrator review the Majority's decision upon the same procedural and substantive grounds as those set forth by the Dissent. The Intermediary maintained that the Majority's decision was erroneous as a matter of law.

CMM requested reversal of the Majority's decision and concurred with the Intermediary's comments as well as the Dissent. CMM contended that the Majority incorrectly concluded that the Provider had good cause for failing to timely request

an appeal of the FY 1996 NPR. CMM noted that the Majority based its good cause finding on the Provider's confusion related to the Intermediary's email and CMS' correspondence in August 1998. However, CMM pointed out, by the time the FY 1996 NPR was issued on September 9, 1999, the Provider had definitive proof that the Grimes reimbursement rate had been reduced to the rural PPS rate; any confusion about the proper reimbursement rate was resolved prior to the time the hearing request was due on March 7, 2000.

Moreover, CMM maintained, even if jurisdiction were properly granted in this case, the Majority's understanding of the applicable regulations and program policies was flawed. It is undisputed that the services at issue in this case were furnished at two separate facilities twenty miles apart. In addition, it is clear that 42 CFR 412.63(b)(5) requires that, hospitals consisting of multiple locations are reimbursed at the rate according to the area where the discharges occur. Accordingly, as the Dissent properly found, the above-cited regulation specifying location-specific reimbursement governs in this case, and the Board possesses no authority to find contrary to the regulation.

Further, CMM observed that, even if the Majority had been correct in its interpretation of the provider-based regulations at 42 CFR 413.65(j), that regulation was not in force during the 1996-1997 cost years, whereas section 412.63(b)(5) was in effect. Thus, section 412.63(b)(5) applies to the situation in this case and the issue of a “good-faith” exception set forth at section 413.65(j)(2) need not be reached.

CMM also maintained that the Majority's analysis was incorrect because it is based on a perceived inconsistency between provider-based status for inpatient hospital facilities under section 42 CFR 413.65 and location-specific payment under 42 CFR 412.63(b)(5). CMM noted that the Majority found that, where separate facilities are treated as parts of a single provider hospital under the provider-based regulations at section 413.65, section 412.63(b)(5) is not applicable. Yet, there is no language in either regulation to support this conclusion, and, in fact, there is no inconsistency between section 413.65 and section 412.63(b)(5). Indeed, section 412.63(b)(5) specifies the payment rates applicable to one hospital that is discharging patients from two different locations, while section 413.65 specifies the rules a multiple-facility hospital must meet to allow it to be considered one hospital. In sum, CMM concluded that, far from conflicting with each other, the two regulations support and clarify each other by establishing how such a facility is to be treated, for payment and other purposes, under Medicare.

The Provider requested affirmance of the Board's decision as the Board correctly found that 42 CFR 413.63(b)(5) does not apply to facilities that have been designated provider-based. That regulation, the Provider maintained, which applies

to separately located hospital facilities, cannot as a matter of law apply to an entity that is deemed to be provider-based as a main provider. The Provider pointed out that, contrary to the Intermediary's contention, 42 CFR 413.65 states that, once a facility qualifies as provider-based, it may bill for services of the facility as if that facility was provider-based. CMS acknowledged in the preamble to the regulations that when facilities are consolidated under a provider number, the amount reimbursed for services of the consolidated entity can be significantly greater than the sum of what would be paid to two or more individual facilities for the same services.

In addition, the Provider stated that, although section 413.65 was not in effect until after the cost years at issue in this case, the regulation was originally issued as a PM and was codified without material amendment and, therefore, furnished a useful definition and applicability of the "provider-based" designation. Moreover, the Provider maintained, 42 CFR 413.65(j) states that its exception applies to any period before the effective date of these regulations based upon the provider-based requirements in effect under Medicare program regulations or instructions. Neither the Intermediary, nor CMS has disputed that Grimes met the requirements for provider-based status.

Turning to the jurisdictional issue, the Provider maintained that no request for review of the Board's January 21, 2005 jurisdictional decision was timely made, i.e., within 15 days of that decision, as required by 42 CFR 405.1875; thus, a review at this point is untimely. Moreover, in general, correspondence between the Provider, the Regional Office, and the Intermediary caused enough confusion as to the payment status of Grimes to justify a good cause extension to the 180-day filing requirement. Accordingly, the Provider contended, the Board's decision should be affirmed in its entirety.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been considered and are included in the record.

Regarding the jurisdiction of the Provider's appeal in this case,[1] Section 1878(a) of the Social Security Act and the regulations at 42 C.F.R. §405.1835 set forth certain requirements for Board jurisdiction. A provider may obtain a hearing before the Board with respect to its fiscal intermediary's determination of its cost report, inter alia, only

[1] The jurisdictional aspect of the Board's decision is appropriately reviewed by the Administrator at this time, as the Board has issued its final decision disposing of the case.

if: the provider is dissatisfied with a final determination of its fiscal intermediary as to the amount of reimbursement due the provider for the period covered by such report; there is $10,000 or more in controversy; and the provider filed a request for a hearing within 180 days after the notice of the intermediary's final determination. Further, 42 CFR 405.1801(a)(3) states that for purposes of appeal to the Board, "intermediary determination" is synonymous with "final determination of the Secretary." Such an intermediary determination is referred to as a notice of program reimbursement or "NPR."

The regulation at 42 CFR 405.1841(a) sets forth the criteria for Board jurisdiction consistent with statute including the timeframe for filing. In addition, unlike the statute, the regulation provides for a good cause extension of time for late filing. In particular, paragraph (b) states that:

> A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more that 3 years after the date the notice of the intermediary's determination is mailed to the provider.

Certain other procedures not contemplated by the statute are set forth in the regulation. The regulation at 42 CFR 405.1885(a) allows for a reopening of a determination or an NPR if "made within 3 years of the date of the notice of the intermediary determination." In addition, the regulation found at 42 CFR 405.1889 provides that:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 405.1877 are applicable.[2]

As set forth in the regulation, the right to appeal a revised NPR is strictly a regulatory right under 42 CFR 405.1889.

The record shows that for the Provider's FY 1996, the Provider's original NPR was dated September 9, 1999, and reflected that the DRG payments attributable to discharges at Grimes were made pursuant to the rural rate.[3] By letter, dated November 9, 1999, the Provider requested that the Intermediary reconsider the payment of a rural rate for discharges occurring at Grimes. CMS, by letter dated

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[2] See also §2932B of the Provider Reimbursement Manual.

[3] The record shows that the Provider timely appealed the FY 1997 NPR, dated September 29, 2000, by letter dated February 28, 2000.

September 6, 2000, referred the Provider to the reclassification process available for hospitals for purposes of the IPPS payment rates.

The Intermediary issued a revised NPR, dated October 18, 2000, in order to award the Provider a routine cost limit (RCL) exception to the hospital-based skilled nursing unit. By letter dated February 28, 2001, the Provider appealed the rural rate adjustment with respect to Grimes, within 180 days of the revised NPR, but over 17 month after the date of the original NPR. The Board found that CMS' correspondence regarding the treatment of reimbursement for the Grimes facility created confusion giving rise to a good cause for late filing.

The Administrator notes that, regarding the jurisdictional issue involving the 1996 cost year, it is undisputed that the Provider filed its request for a Board hearing more than 180 days after the September 2, 1999 NPR, in violation of the regulation at 42 CFR 405.1841. The NPR reflected that Medicare reimbursement to Grimes was reduced by a correction to an overpayment made at the urban rate. This reduction was the issue appealed in the February 28, 2001 request for a hearing.

The regulations do not define good cause for purposes of extending the time for filing a hearing request before the Board. Good cause is generally regarded as being synonymous with a good reason, or justifiable purpose, in seeking an extension. A good cause is one that supplies a substantial reason, one that affords a legal excuse for delay, or an intervening action beyond the provider's control. The determination of whether good cause exist is within the discretion of the Board. However, any extension of the 180 day appeal period is only allowed pursuant to the regulation and, thus, must be construed narrowly.

Here the Provider cannot say that its failure to timely file was due to fraud, accident, surprise or extraordinary circumstances beyond its control. The Intermediary did not mislead and give the Provider the wrong deadline, nor did the Intermediary fail to notify the Provider of its appeal rights as required under the regulation. Regardless of any perceived confusion prior to the issuance of the NPR regarding the payment rate for Grimes, the adjustment on the original NPR was unambiguous. Consequently, the Administrator finds that the record does not support the Board's finding of good cause in this case.

In addition, although the appeal was filed within 180 days of the revised NPR, the rural rate payment was not at issue or adjusted in the revised NPR. Thus, Board jurisdiction cannot be found for this issue pursuant to the Provider's appeal of the revised NPR. Finally, the CMS letter dated September 6, 2000, is not a final determination as contemplated by the regulation and statute and, thus, also did not give rise to any appeal rights under the regulation or statute.

With respect to the FY 1997 cost year, the Administrator finds that the payment of the rural rate for the Grimes discharges for the cost year at issue was proper. In 1988, the Secretary addressed the situation where hospitals receiving payment under IPPS are multi-campus hospitals; that is, they consist of two or more separately located inpatient facilities. The Secretary addressed how to determine the IPPS rate for these hospitals when the various individual hospital facilities are located in areas with different prospective payment rates. The Secretary explained:

> Section 1886(d)(3)(D) of the Act, as amended by section 4002(c)(1)(D) of Pub. Law 100-203 provides that prospective payment rates are established "for hospitals located * * * in a large urban area or other urban area * * *" and "for hospitals located in a rural area * * *." That is, the prospective payment rate is based on the geographic location of the hospital at which the discharge occurs rather than on any other location, such as, for example, the location of the headquarters of the multicampus facility that owns and operates the various individual hospital facilities, or the location of the main hospital facility. Therefore, we proposed to amend §412.63 to provide that a multi-campus hospital that is participating in the Medicare program as a single provider must be paid prospective payment rates that are determined by the geographic location of each individual hospital facility within the multi-campus hospital. 53 Fed. Reg. 38476 (September 30, 1988) (Emphasis added.)

The Secretary responded to commenters' concerns that the proposal to pay multi-campus hospitals on the basis of the geographic location of each respective campus did not consider operational difficulties imposed by attempting to make payment on two separate bases to a hospital with a single Medicare billing number that files a single, fully combined cost report. The Secretary explained that:

> We recognize that this policy, as described in the proposed rule, presents difficulties in implementation. Therefore, we are implementing this policy prospectively, with discharges occurring on or after October 1, 1988. With respect to the operational difficulties raised by the commenter, including the method for calculating disproportionate share payments, we are currently ascertaining the number of multiple-site providers. After this information has been obtained, we will develop a system to permit intermediaries to differentiate separate campuses of a hospital, and to pay each campus according to the applicable rate for its geographic area. We note that since section 1886(d)(5)(F) of the Act requires that hospitals be differentiated by urban or rural location, eligibility for disproportionate share payments, as well as the calculation of the payments, must be determined according to the urban or rural location of an individual hospital campus.

> With respect to the additional costs of administering this policy, we believe that the program benefits resulting from hospitals being paid appropriately, and in particular according to the law as enacted, outweigh the costs inherent in administering this policy. 53 FR 38476 (September 30, 1988)

Accordingly, consistent with these pronouncements, the regulation at 42 CFR 412.63(b)(5), states that:

> For discharges occurring on or after October 1, 1988, for hospitals that consist of two or more separately located inpatient hospital facilities the national adjusted prospective payment rate is based on the geographic location of the hospital facility at which the discharge occurs. (Emphasis added.)

The Provider, St. Joseph Regional Health Center, was an acute-care hospital located in Bryan, Texas. In the Fall of 1996, the Provider submitted a Notification of Change of Ownership, stating that it planned to assume the ownership of Navasota Regional Hospital, located in Navasota, Texas, twenty miles away from the Provider, and operate it under the name of Grimes St. Joseph (Grimes), and initially using the same provider number as that of the Provider.

There is no dispute that this case involves a multi-campus hospital comprised of two separate inpatient facilities that operate under one provider number with the hospitals being located in two separate market areas. The main campus was located in an urban area and Grimes was located in a rural area. The Administrator finds that the plain reading of the above regulation requires that the Grimes facility be reimbursed at the rural IPPS rate for the cost year at issue.

The Provider has maintained that the Grimes facility qualifies for reimbursement at the higher urban IPPS payment rate through application of the PM and the regulation at 42 CFR 413.65. In addition, the Board points to 42 CFR 412.65(i) (2000) to suggest that the recoupment and consolidated billing provisions show that CMS intended that providers receive the benefit of the higher IPPS payment rates under these facts, regardless of the actual location of the provider-based facility.

However, the original 1988 preamble promulgating 42 CFR 412.63(b)(5) anticipated that, with respect to multi-campus hospitals, CMS would make payment on two separate bases to a hospital with a single Medicare billing number that filed a single, fully combined cost report. Thus, the fact that there is a single consolidated cost report and billing in this case is not determinative of a single

IPPS rate for both facilities. Rather, that issue was specifically addressed when the regulation was first promulgated.

In addition, in the preamble promulgating the rule at 42 CFR 413.65, the Secretary recognized the various circumstances under which a higher payment would be received where an entity was considered provider-based. Consistent with the provision of 42 CFR 412.63(b)(5), in no case, did the Secretary give the reason for a aggregate higher payments after a provider-based designation, as due to an increase in the IPPS payment rate for the provider-based facility. Instead, the Secretary explained that provider-based facilities received higher payment because of, inter alia, the difference in the scope of benefits paid to provider-based entities compared to free-standing entities. The Secretary stated that:

> If an institution that primarily provides inpatient care is able to participate in Medicare as part of a hospital, Medicare payment to the hospital will be made for the full range of inpatient hospitals services defined in Section 1861(b) of the Act. If the facility is not considered a part of a Medicare participating hospital, Medicare payment would only be made on a more narrow range of services. 67 Fed.Reg. 49982 (2003)

The Secretary also noted that the provider-based designation could affect outpatient payments stating that:

> Medicare.... payments to hospital departments that provide ... [certain] services to outpatients, or primary care, ophthalmology, or other specialty services to outpatients are affected by provider-based status, as would beneficiary liability for Medicare coinsurance amounts....

Finally, with respect to GME payments, the Secretary explained the impact of provider-based designation stating that:

> A merger of the two hospitals would aggregate the two hospitals' individual FTE caps into a merged FTE cap under the main hospital's provider number, and would require recalculation of the hospital's PRA and a merging of these entities' respective Medicare utilization, resulting in a level of Medicare GME payment to the merged hospital that exceeds the sum of the payments that would be made to each hospital as separate entities. 67 Fed Reg. 31482

The Secretary explained many circumstances where there would be an increased in the overall aggregate payment because of the provider-base designation. Throughout the various preambles and discussions, the Secretary did not suggest that an increased payment may result because a rural provider-based facility would start receiving its main campus' higher urban rate.

In conclusion, the Administrator finds that a rule of statutory construction, likewise applicable to regulations, is that regulations should be read in harmony and that the specific controls over the general. The regulation at 42 CFR 412.65 does not address the IPPS payment rate to be paid a multi-campus hospital. In contrast, the regulation at 42 CFR 412.63(b)(5), consistent with the statute at section 1886(d)(3)(D) and (E), specifically addresses the IPPS payment rate for multi-campus facilities.[4] This regulation has been in effective since the 1980s and was in effect for this cost year. Accordingly, the Administrator finds that the only regulation which properly addresses and resolves the issue in this case is 42 CFR 412.63(b)(5).

The Administrator notes that rural IPPS payment rate for the discharges for this year is consistent with the rural rate paid for discharges during the prior ownership of the Grimes facility. The purpose of the designation of the market areas under the statute is to adjust the DRG payment to recognize market conditions where a hospital is located. The provider-based designation in this case, neither alters the geographical location of the discharges, nor the law requiring the establishment of market areas for purposes of determining payment under IPPS.

In sum, the Administrator holds that the Board's decision in this case is vacated with respect to the Provider's FY 1996 and the Board's decision is reversed with respect to FY 1997.

[4] Moreover, 42 CFR 413.65 was not promulgated until 2000, after the cost year in this case, and its promulgation did not result in any revision to 42 CFR 412.63(b)(5).

DECISION

The Administrator holds that the Board's decision in this case is vacated with respect to the Provider's FY 1996 and the Board's decision is reversed with respect to FY 1997.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 2/16/07 /s/

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare and Medicaid Services