CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

IN THE CASE OF:	**CLAIM FOR:**
Iron County Community Hospital	**Medicare Reimbursement ESRD Exception Cycle 03/01/00 – 08/28/00**
Provider	
vs.	**REVIEW OF:**
Blue Cross and Blue Shield/ United Government Services	**PRRB Dec. No. 2003-D61 Dated: September 25, 2003**
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 sixty-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. CMS' Center for Medicare Management (CMM) requested review. The parties were then notified that the Administrator would review the Board's decision. Subsequently, the Intermediary and the Provider submitted comments, and CMM submitted additional comments. Accordingly, the Board decision is now before the Administrator for final administrative review.

The issue is whether CMS' determination, concerning the Provider's end stage renal disease (ESRD) exception request, was proper.

The Board found that CMS' denial was improper as the Provider documented that it was an isolated essential facility (IEF), and that its costs were related to its IEF status. Indications of the Provider's isolation included the fact that the Provider was the only dialysis facility in Iron County, a large rural county 177 miles from the nearest metropolitan statistical area (MSA). No public transportation was available, and heavy snowfall, cold temperatures, and hazardous driving conditions during the winter made travel for the Provider's "frail, elderly patients" difficult. Medicare had certified the Provider as a sole community hospital. As to the Provider's essential quality, the Board found that the closest alternative dialysis center was located more than 30 miles from the Provider and was not able to accommodate all of the Provider's patients. Some of the

Provider's patients would incur increased costs and travel time, i.e., additional hardship, as addressed at §413.186(a)(2), if they had to go elsewhere for dialysis treatments. An Intermediary witness at the hearing acknowledged that the extra annual cost of $2500 and the increase in the average per treatment commute time of one hour six minutes would create additional hardship for the Provider's patients.

The Board further found that the Provider documented that its higher costs were due to its isolated and essential nature. Three employees were needed to set up and maintain the Provider's dialysis machines per shift. With slightly more than six patients per day, the Provider's average number of treatments per full-time equivalent (FTE) was significantly below that of the smallest facilities in the country. A quantification of that amount was made using certain operating statistics and staffing levels. The Board found that the low volume accounted for $53.38 in excess of the composite rate. The Provider's staffing mix, required to meet CMS standards and patient safety, caused $21.60 in excess of the composite rate, and the Provider's underutilization caused a $37.08 excess.

In addition, the Board found that the next closest facility to the Provider had a higher cost per treatment (CPT) than the Provider requested. Thus, it would be illogical to shift the Provider's patients to this facility. Not only would it cost more to Medicare, but it would also cause increased and hazardous travel time for the patients. It might also be detrimental to the patients' already compromised health. Such a result would be contrary to the spirit and the letter of the regulations. Thus, the Board reversed CMS' denial of the Provider's exception request.

CMM requested reversal of the Board's decision because the Provider failed to meet any of the regulatory requirements for eligibility as an IEF. CMM maintained that the Provider was not the only supplier of dialysis in its geographic area, contrary to the criteria at §413.186(a)(1). Rather, the Intermediary's contact with five ESRD facilities near the Provider indicated that these facilities could take on more dialysis patients if the Provider were not in existence. CMM noted that CMS does not have any standard mileage criterion for defining an IEF. The five facilities the Intermediary contacted were: Dickinson County Health Care Dialysis, Marquette General Hospital, Howard Young Medical Center, Bay Area Medical Center, and St. Francis Hospital (Midwest Kidney Centers). All facilities indicated either that they had openings for dialysis or that they were willing to expand to accommodate the Provider's patients.

In addition, the Provider failed to demonstrate that its patients would be unable to obtain dialysis services elsewhere without substantial additional hardship, in contravention of the requirements at §413.186(a)(2). CMM pointed out that the Board concluded otherwise based on general Provider statements, principally about its amount of snowfall. However, CMM maintained that the Provider "apparently agree[d]" that "excellent … maintenance equipment" prevented its roads from being inaccessible due to snowfall. CMM also argued that the Provider failed to establish a link between each excess cost

category (i.e., salaries, benefits, supplies, etc.) and its claimed IEF status, in violation of the requirements at §413.186. CMM stated that the Board's computation of the Provider's excess costs added up to a figure in excess of the entire additional amount requested. Moreover, while the Provider stated that three employees per shift were needed to set up and maintain dialysis machines, CMM observed that salaries were not unique characteristics of IEFs; all ESRD facilities incur such salary expenses regardless of location. Furthermore, the Board's conclusion that all of the Provider's excess costs were justifiable was improper, as CMS made no determination as to the amount of justifiable IEF costs. In this regard, CMM pointed out that the Board is an appellate, not a *de novo*, tribunal. In fact, CMM contended, the record suggested that non-IEF factors caused the Provider's excess costs, e.g., operating inefficiencies.

The Intermediary requested reversal of the Board's decision. Contrary to the Board's finding, the record showed that the nearest facility to the Provider, approximately thirty miles away, could absorb the Provider's patients. Thus, the "essential" test for an IEF exception was not met. The record also reflected that a patient who would be served at an alternate facility would incur an additional average expense of $48 per week, plus an additional one hour in travel time, neither of which meets any objective test of "substantial" hardship. Moreover, there was no regulatory relevance to the Board's finding that the facility closest to the Provider had a higher average cost than the Provider. Furthermore, the Intermediary pointed out that the Board's computation of the Provider's requested rate amounted to an additional $111.62 (i.e., $53.38 for "low productivity," $21.16 for "staffing mix," and $37.08 for "under-utilization), more than the $84.13 reflecting the difference between the Provider's current rate of $127.82 and its requested rate of $211.95. All three cost components reflected under-utilization or idle capacity. For all of these reasons, the Intermediary maintained that full relief should not be granted.

The Provider requested affirmance of the Board's decision, and pointed out that it had requested an additional $84.13 over its composite rate. The Provider explained that it had been established to help serve patients who had elected not to seek dialysis because of the "hardship" of commuting to a facility which could be two hours away. The Provider further pointed out that the Intermediary recommended approval of the exception request to CMS.

Turning to the IEF criteria, the Provider observed that it was isolated because: it was located outside of an MSA; it was 177 miles to Green Bay and was the only dialysis provider in its county; and, it furnished dialysis to a permanent population. Moreover, Dickinson County Healthcare (Dickinson) was at 100 percent capacity, so could not treat all of the Provider's patients, and not any resulting from Provider growth. It would be a hardship for a seventy year old patient to have to travel to the next closest facility, seventy miles away, to receive lifesaving treatment. The Provider further maintained that the likelihood that the nearby facilities would have to pay overtime to accommodate the

Provider's patients was not considered in CMS' analysis. The fact that the Provider Hospital was a sole community hospital also indicated its isolation. Moreover, the Provider argued that, contrary to CMM's comments, it did document that its excess costs were attributable to its IEF character. The Provider's low volume of fourteen patients and only 2,059 treatments, and its high costs for such volume, indicated an IEF, pursuant to §2725.3D of the Provider Reimbursement Manual (PRM).

Turning to the "essential" requirement, the Provider stated that it proved that a significant number of its patients could not obtain dialysis elsewhere without significant hardship. The Provider set forth scenarios where a typical patient would incur an at least an additional $19,000 per year, to obtain dialysis elsewhere. At the hearing, the Intermediary witness testified to at least a $2500 per year increase, which she indicated would be a hardship. The Provider also claimed that it documented a significant increase in travel time for each patient, in good weather, and significant snowfall would double the travel time. Moreover, the Provider argued that the acuity of its patient population exceeded the national average, a factor not considered by CMS. The Provider stated that it employed three full-time equivalents (FTEs) per shift, and treated slightly more than six patients per day, making its average number of treatments per FTE significantly below that of the smallest facilities in the country. These facts accounted for $53.38 of its costs in excess of the composite rate. Further, the staffing mix required to meet CMS standards and ensure patient safety caused $21.60 in excess costs. Underutilization of the Provider, at 82.5 percent, attributed to an excess of $37.08. The Provider noted that its CPT amounted to $210.42, while Dickinson's CPT was $271.97, which CMS did not seem to consider.

The Provider next addressed "Intermediary questions" about whether under-utilization overlapped productivity and required staffing mix. The answer was no, the Provider stated, "because the productivity and staffing mix calculations assume[d] that the Provider ha[d] the same utilization as [did] the national standard providers…." Moreover, because the Intermediary testified that 75-80 percent utilization is good, and the Provider was operating at 82.5 percent, provider utilization was consistent with the standard. The Provider stated that it documented that the utilization calculation which assumed that, because of low volume, the Provider could achieve 100 percent utilization, was not correct. The Provider further protested that CMS' denial letter failed to address its productivity, staffing mix, national standards, the lack of public transportation, the significant cost increases, the hardship of senior patients with complicated illnesses, the impact of snowfall, and the increased distances the patients would have to travel to another ESRD facility. Moreover, contrary to CMS' denial letter, the Provider did not attempt to quantify "turnover," "patient acuity," or "overtime" as reasons for its excess costs. The Provider also emphasized that overhead costs are not easily absorbed by a smaller volume. In sum, the Provider maintained that the Board's decision was proper.

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

The Administrator summarily affirms the Board's decision in this case, with the clarification that the Provider's exception rate relief based on its IEF status will be $211.95 or $84.13 above its pre-exception rate of $127.82, as the Provider requested in its exception package of July 28, 2000.

DECISION

The Administrator affirms the decision of the Board in this case, with the above clarification.

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

Date: 11/28/2003

/s/
Leslie V. Norwalk
Acting Deputy Administrator
Centers for Medicare and Medicaid Services