PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2022-D08

PROVIDER – Dickinson County Healthcare System	**HEARING DATE –** October 15, 2020
Provider No.: 23-0055	Cost Reporting Periods Ended – December 31, 2015, December 31, 2016
vs.	
MEDICARE CONTRACTOR – WPS Government Health Administrators (J-8)	**CASE NOS. –** 18-1559, 19-2776

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ISSUE STATEMENT

Whether the Medicare Contractor erred in its determination that the Provider did not qualify for the exception to the per-visit upper payment limit ("UPL") for rural health clinics ("RHCs") for the fiscal years ending December 31, 2015 and December 31, 2016 ("FYs 2015 and 2016").[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor correctly determined that the Provider did not qualify for the exception to the RHC per-visit UPL for FYs 2015 and 2016.

INTRODUCTION

Dickinson County Healthcare System ("Dickinson" or "Provider") is a sole community hospital ("SCH"), as determined in accordance with 42 C.F.R. § 412.92, located in Dickinson County in the Upper Peninsula of Michigan.[2] Dickinson County's assigned Medicare contractor is WPS Government Health Administrators ("Medicare Contractor").[3]

Dickinson operates ten provider-based rural health clinics ("RHCs").[4] RHCs are subject to the RHC per-visit UPL unless they are a provider-based RHC and the hospital with which they are affiliated meets certain criteria to qualify for an exception to the RHC per-visit UPL.[5] During its review of Dickinson's FY 2015 and 2016 cost reports, the Medicare Contractor considered whether Dickinson qualified for an exception to the RHC per-visit UPL. Following its audit of Dickinson's FY 2015 and 2016 cost reports, the Medicare Contractor determined that Dickinson did not meet the criteria to qualify for an exception to the RHC per-visit UPL for FYs 2015 and 2016 and, as a result, made adjustments to apply the RHC per-visit UPL[6] in determining reimbursable cost for each of Dickinson's ten RHCs for FYs 2015 and 2016. The adjustments reduced Dickinson's Medicare reimbursement by approximately $398,000 in FY 2015 and $391,000 in FY 2016.[7]

Dickinson timely appealed the Medicare Contractor's adjustments to the Board, and met the jurisdictional requirements for a hearing. The Board conducted a live video hearing on October 15, 2020. Dickinson was represented by Sara MacCarthy, Esq. of Hall, Render, Killian, Heath & Lyman, P.C. The Medicare Contractor was represented by Joseph Bauers, Esq. of Federal Specialized Services.

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[1] Transcript ("Tr.") at 5.
[2] Joint Stipulation and Motion ("Stipulations") at ¶ 1 (Oct. 14, 2020).
[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 term "Medicare contractor" refers to both FIs and MACs as appropriate.
[4] Stipulations at ¶ 2.
[5] *See* 42 U.S.C. § 1395l(f).
[6] The UPLs in effect were $80.44 for FY 2015 and $81.32 for FY 2016. Medicare Contractor's Consolidated Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3; Provider's Consolidated Final Position Paper ("Provider's FPP) at 1. *See also* Tr. at 9.
[7] *Id.* at 2.

STATEMENT OF THE REGULATORY AND FACTUAL BACKGROUND

A. Overview of the Relevant Authorities

Unless an exception applies, the Medicare program reimburses provider-based RHCs based on an all-inclusive rate that is subject to the RHC per-visit UPL. Provider-based RHCs that meet such an exception are paid on a cost basis.

The controlling statute for the RHC per-visit UPL is located at 42 U.S.C. § 1395l(f). Congress established the RHC per-visit UPL in 1987 for "independent" RHCs[8] and then extended it in 1997 to also apply to "provider-based" RHCs but exempted those provider-based RHCs in "***rural*** hospitals with less than 50 beds."[9]

In December 2000, as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), Congress expanded the exception by striking the word "*rural*" so that it applied to provider-based RHCs in "hospitals with less than 50 beds" and made this expansion effective July 1, 2001.[10] As a result of these changes, 42 U.S.C. § 1395l(f) now reads:

> MAXIMUM RATE OF PAYMENT PER VISIT FOR INDEPENDENT RURAL HEALTH CLINICS
>
> (1) In establishing limits under subsection (a) on payment for rural health clinic services provided by rural health clinics (*other than such clinics in hospitals with less than 50 beds*), the Secretary shall establish such limit, for services provided, for services provided prior to April 1, 2021-
>
> (A) in 1988, after March 31, at $46 per visit, and
>
> (B) in a subsequent year (before April 1, 2021), at the limit established under this paragraph for the previous year increased by the percentage increase in the MEI (as defined in section 1395u(i)(3) of this title) applicable to primary care services (as defined in section 1395u(i)(4) of this title) furnished as of the first day of that year.[11]

Thus, RHCs are subject to the RHC per-visit UPL unless they are a provider-based RHC in a hospital with less than 50 beds.

[8] Omnibus Reconciliation Act of 1987, Pub. L. 100-203, § 4067, 101 Stat. 1330, 1330-113 (1987).
[9] Balanced Budget Act of 1997, Pub. L. 105-33, § 4205, 111 Stat. 251, 376 (1997) (emphasis added).
[10] Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106-554, Appendix F at § 224, 114 Stat. 2763, 2763A-490 (2000).
[11] (Emphasis added.)

Additional guidance from CMS on how to qualify for the exception was ***subsequently*** detailed in the Medicare Benefit Policy Manual ("MBPM"), Ch. 13, § 70.1 (2013),[12] which states:

> A provider-based RHC that is an integral and subordinate part of a hospital (including a CAH), as described in regulations at 42 C.F.R. § 413.65, can receive an exception to the per-visit payment limit if:
>
> - the hospital has fewer than 50 beds as determined at 42 C.F.R. § 412.105(b); ***or***
> - the hospital's average daily patient census count of those beds described in 42 C.F.R. § 412.105(b) ***does not exceed 40*** and the hospital meets both of the following conditions:
>   - it is a sole community hospital as determined in accordance with 42 C.F.R. § 412.92 or an essential access community hospital as determined in accordance with 42 C.F.R. § 412.109(a), and
>   - it is located *in a level 9 or level 10* ***Rural-Urban Commuting Area (RUCA)***.
>
> The exception to the payment limit applies only during the time that the RHC meets the requirements for the exception.[13]

Accordingly, the MBPM provision provides for two different standards under which a hospital with a provider-based RHC can qualify for an *exception* to the RHC per-visit UPL. The first standard applies the exception to provider-based RHCs in a hospital having fewer than 50 inpatient beds. The second standard applies the exception to provider-based RHCs in a sole community hospital ("SCH") having a 40-or-less average daily inpatient census count.

B. The Exception for Provider-Based Hospitals with "Fewer than 50 Beds"

As discussed above, 42 U.S.C. § 1395l(f) specifically provides for the "fewer than 50 beds" exception. The Centers for Medicare and Medicaid Services ("CMS", formerly known as the Health Care Financing Administration ("HCFA")) appears to have implemented the "fewer than 50 beds" exception via program memorandum. The earliest identified guidance is a program memorandum dated January 1, 1998 (the "January 1998 Memorandum") stating that eligibility for the exception is to be determined using the methodology for counting beds laid out in 42 C.F.R. § 412.105(b):

> The RHC per-visit upper payment limit . . . is applicable to all RHCs (other than those in rural hospitals with less than 50 beds). RHCs should consult 42 CFR 412.105(b) to determine eligibility for exception to the per-visit upper payment limit. Note that

[12] MBPM, Ch. 13, § 70.1 (Rev. 166, Issued: 01-31-13, Effective 03-01-13) (copy at Exhibit C-12).
[13] (Emphasis added.)

> exception to the upper payment limit does not apply to provider-based FQHCs.[14]

As stated in the January 1998 Memorandum and restated in MBPM, Ch. 13, § 70.1 (2013), the "fewer than 50 beds" MBPM exception to the RHC per-visit UPL counts beds is based on the following instructions in 42 C.F.R. § 412.105(b):

> [T]he number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. This count of available bed days excludes bed days associated with-
>
> (1) Beds in a unit or ward that is not occupied to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system at any time during the 3 preceding months (the beds in the unit or ward are to be excluded from the determination of available beds during the current month);
>
> (2) Beds in a unit or ward *that is otherwise occupied* (to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system) that could not be made available for inpatient occupancy within 24 hours for 30 consecutive days;
>
> (3) Beds in excluded distinct part hospital units:
>
> (4) Beds otherwise countable under this section used for outpatient observation services, skilled nursing swing-bed services, or inpatient hospice services.
>
> (5) Beds or bassinets in the healthy newborn nursery; and
>
> (6) Custodial care beds.[15]

In FY 2015, the Medicare Contractor followed § 412.105(b) and determined that, based on the reported number of 35,040 bed days, Dickinson had an available bed size of 92.[16] Similarly, in FY 2016, the Medicare Contractor determined that, based on the reported number of 35,136 bed days, Dickinson had an available bed size of 91.[17]

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[14] HCFA Program Memorandum, HCFA Pub. 60A, Transmittal A-97-20 (Jan. 1, 1998) (available at Wolters Kluwer, CCH, Program Memoranda ¶45,951).
[15] (Emphasis added.)
[16] Stipulations at ¶ 29.
[17] *Id.* at ¶ 31.

C. *Exception for Provider-Based RHCs in an SCH having an average daily inpatient census of 40 or less.*

This exception is not explicitly stated in 42 U.S.C. § 1395l(f) and appears to be first stated in September 1998 by CMS (then known as "HCFA") as part of a program memorandum. This exception only applies to SCHs with an average daily census of 40 or less but only if the SCH also has a certain high degree of rurality. The parties disagree on what scale is used to measure rurality for the fiscal years at issue and the degree of rurality that is needed on that scale to qualify for the exception.

1. Regulatory background on the 40-or-less average daily inpatient census exception

The September 1998 memorandum is when CMS first stated the 40-or-less average daily inpatient census exception. Significantly, this is also when it appears as if CMS first adopted the use of the Urban Influence Code ("UIC") classification system as defined by the U.S. Department of Agriculture ("USDA"). While neither the parties nor the Board has been able to locate the September 1998 program memorandum, CMS documented its contents in a program memorandum dated December 6, 2001 as follows:

> Shortly following the implementation of the BBA provision, CMS announced an alternative bed size definition for ***very rural***, sole community hospitals with seasonal fluctuations in patient census. This alternative bed size definition was established by a memorandum, dated September 30, 1998, issued to all associate regional administrators. *This memorandum set forth **the alternative definition*** as well as four specific provider qualification conditions for applying it. The alternative definition and its qualifying conditions are as follows: A hospital-based RHC can receive an exception to the per-visit payment limit if its hospital has fewer than 50 beds as determined by using the hospital's average daily census count and the hospital meets all of the following conditions:
>
> A) It is a sole community hospital.
>
> B) *It is located in an 8-level or 9-level nonmetropolitan county **using urban influence codes as defined by the U.S. Department of Agriculture**.*
>
> C) *It has an average daily patient census that **does not exceed 40**.*
>
> D) It has significant fluctuations in its average daily census to the extent that the average daily census for 1 or more months is at least 150 percent of the lowest monthly average daily census.[18]

[18] Program Memorandum, CMS Pub. 60A, Transmittal A-01-138 (Dec. 6, 2001) (emphasis added) (copy included at Exhibit P-20).

Significantly, at this point, the UIC classification system was a 9-level scale and, thus, the requirement to have a level 8 or 9 reflected the highest degree of rurality.

Later, in a proposed rule published on February 28, 2000, the Secretary proposed to incorporate this exception into regulations. Specifically, the Secretary discussed the following:

> To assure continued access to primary care services in thinly populated rural areas where the hospital and its clinic(s) are the primary source of health care for their communities, we are proposing to adopt an alternative definition of hospital bed size.
>
> For hospitals that are the primary source of health care in their community as defined in § 412.92, we are proposing to look to the hospital's average daily census rather than bed size in determining whether RHC services are subject to the upper payment limit. We believe average daily census may be a more appropriate measure of inpatient capacity in certain situations (for example, rural areas that experience seasonal fluctuations due to logging or commercial fishing). *To identify hospitals located in **thinly populated** rural areas, we propose to use the Urban Influence Codes, a 9-category measure developed by the U.S. Department of Agriculture*. These codes rank all U.S. counties, ranging from 1 for large, densely populated metropolitan counties to 9 for the most remote, sparsely populated counties. This definition takes into account each county's largest city or town and its proximity to counties with large urban areas. *We propose to accept an 8-level and 9-level Urban Influence Code for purposes of this provision.* An 8-level code is a county not adjacent to metropolitan area, but has a town with a population of 2,500 to 9,999. A 9-level is a county not adjacent to a metropolitan area, with no place greater than a population of 2,500. . . . *We believe an 8 or 9-level **reflects a degree of rurality** to sufficiently target hospitals located in **extremely remote areas** that may need the flexibility in the bed definition to accommodate potentially significant fluctuations in patient census.*
>
> ***
>
> This proposed alternative definition for the aforementioned hospitals would recognize the needs of ***extremely rural*** hospitals with an average daily census of 40 or less to carry a larger number of available beds in order to address seasonal fluctuations. Absent seasonal fluctuations in patient census, it would be reasonable to expect a hospital with an average daily census of 40 acute care inpatients to require no more than 50 beds to meet random fluctuations in patient census. . . . *This alternative definition should afford every RHC that was truly targeted-clinics of sole*

> *community hospitals located* ***in sparsely populated rural areas****-an opportunity to receive an exception to the RHC payment limit.*[19]

Significantly, CMS issued this proposed rule ***prior to*** the December 2000 BIPA statutory change that expanded the exception for the payment limit from provider-based RHCs located in "rural hospitals with less than 50 beds" to those located simply in "hospitals with less than 50 beds."[20]

On December 6, 2001, CMS issued a Program Memorandum that revised the exception as follows:

> We are now modifying this alternative bed size definition so that RHCs *based in* ***very rural****, sole community hospitals* can qualify for the exception. The new alternative bed size definition, effective for cost reporting periods ending on or after June 30, 2001, is as follows: A hospital-based RHC can receive an exception to the per-visit payment limit if its hospital has *fewer than 50 beds as determined by using the hospital's average daily census count* ***and*** the hospital meets all of the following conditions:
>
> A) It is a sole community hospital.
>
> B) *It is located in an 8-level or 9-level* ***nonmetropolitan*** *county using* ***urban influence codes*** *as defined by the U.S. Department of Agriculture.*
>
> C) It has an average daily patient census that does not exceed 40.[21]

At this point, the UIC classification system was still a 9-level scale and, thus, the requirement to have a level 8 or 9 continued to reflect the highest degree of rurality.

At some later point,[22] the USDA *revised* the UIC classification system from a 9-level scale to a 12-level scale effective ***for 2003***. Under the prior 9-level scale UIC classification system *used*

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[19] 65 Fed. Reg. 10455, 10455-56 (Feb. 28, 2000) (emphasis added).

[20] *See supra* notes 8, 9 and accompanying text.

[21] Program Memorandum, CMS Pub. 60A, Transmittal A-01-138 (Dec. 6, 2001) (emphasis added) (copy included at Exhibit P-20).

[22] Stipulations at ¶ 16 states that "[i]n 2003," the USDA revised the UIC classification from a 9-level scale to a 12-level scale[]" citing to Exhibits P-47 and C-8 which do not state specifically when the USDA revised the UIC classification system. The Board's review of the record (including weblinks imbedded in USDA documents) confirms that it does not reflect when, in fact, the 12-level scale was formally adopted or published. The fact that the initial use of the 12-level scale is *for 2003* suggests that it may have been formally adopted in 2004 or published in 2004. *See* Exhibit P-47. This inference would be consistent with the Secretary's representation *in the June 27, 2008 proposed rule* that the 12-level scale was adopted *after* the Secretary's December 24, 2003 final rule. 73 Fed. Reg. 36696, 36705 (June 27, 2008) (stating: "*The December 24, 2003 final RHC rule used the 1993 Urban Influence Codes (UICs)*, then a 9-category measure developed by the U.S. Department of Agriculture (USDA), to identify hospitals which are located in sparsely populated rural areas. Hospitals with a level 8 or 9-level UIC and which have an average daily census of less than 50 patients would qualify for an exception to the RHC per visit

for 1993, Dickinson County was assigned to Level 8, indicating that the county was "not adjacent to a metro area and contains a town of 2,500-9,999 residents."[23] The UIC classification system *for 2003* introduced the concept of a "micropolitan area" and Dickinson County was assigned to Level 8 *for 2003* representing a "***micropolitan*** *area* not adjacent to a metro area."[24]

During 2003, CMS "transformed the [hard copy] CMS Program Manuals into a web user-friendly presentation and renamed it the CMS Online Manual system."[25] These manuals are now referred to as "internet-only" manuals.[26] One of these internet-only manuals is the Medicare Claims Processing Manual ("MCPM"), first published on October 1, 2003, which appears to incorporate the 40-or-less average daily census count exception stated in Transmittal A-01-138.[27] Specifically, MCPM, Ch. 9, § 20.6.3 (Rev. 1, Oct. 1, 2003) describes the 40-or-less average daily census count as follows:

> A hospital-based RHC can also receive an exception to the per visit payment limit if its hospital has an average daily patient census that does not exceed 40 and the hospital meets the following conditions: (a) It is a sole community hospital. (b) It is located in an 8-level or 9-level nonmetropolitan county using urban influence codes as defined by the U.S. Department of Agriculture.[28]

According to the MCPM Crosswalk, this provision was based on the following paper-based manual: Rural Health Clinic Manual, CMS Pub. No. 27 ("RHCM"), § 505. However, RHCM § 505 did not discuss the exceptions to the RHC per-visit UPL and, thus, inclusion of the 40-or-less average daily census count exception in the MCPM appears to be based on Transmittal A-01-138. Regardless, as the parties have noted, this MCPM provision did not address the USDA's revision to the UIC classifications *for 2003* which again was made presumably sometime in 2004.[29]

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") became law.[30] In particular, MMA § 902(a)(1) added 42 U.S.C. 1395hh(a)(3) to prohibit the adoption of final regulations more than 3 years after their proposal:

> (3)(A) The Secretary . . . shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

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payment limit. *The USDA has **since** changed* the UICs to a 12-category measure, with levels 9 through 12 comparable to the 1993 levels 8 and 9." (emphasis added.))

[23] Stipulations at ¶ 17.

[24] *Id.* at ¶ 18 (emphasis added).

[25] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals (page last modified Dec. 1, 2021) (last accessed Feb. 11, 2022).

[26] *Id.*

[27] Copy at Exhibit P-20.

[28] A similar revision was made on October 1, 2003 to the Medicare Intermediary Manual, CMS Pub. 100-04. Exhibits P-22, C-10.

[29] Stipulations at ¶ 19. *See also supra* note 22.

[30] Pub. L. 108-173, 117 Stat. 2066 (2003).

> (B) *Such timeline* may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but ***shall not be longer than 3 years*** *except under exceptional circumstances*. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.[31]

Of particular import to this case is the fact that MMA § 902(b) specifies that this prohibition was effective *immediately* (*i.e.*, effective as of December 8, 2003).[32]

Notwithstanding MMA § 902(b) and the fact that more than 3 years had transpired since the February 28, 2000 RHC proposed rule, the Secretary finalized the proposed exception to the RHC per-visit UPL.[33] While the preamble to the final rule did not discuss the MMA change, it did recognize the intervening BIPA statutory change:

> In 2000, section 224 of BIPA expanded the eligibility criteria for receiving an exception to the RHC annual payment limit, effective July 1, 2001. Specifically, this section of BIPA extends the exemption from the upper payment limit to RHCs based in small urban hospitals. Thus, all hospitals of less than 50 beds are now eligible to receive an exception from the per visit payment limit for their RHCs. Therefore, we are revising § 405.2462(a)(3) to reflect changes made by BIPA. Please note that we will continue to use the bed size definition at § 412.105(b) to determine which RHCs are eligible for the payment limit exception. *We will continue to apply to the alternative definition of bed size (patient census)* ***only extremely rural hospitals*** *operating under extenuating circumstances as set forth at § 405(a)(3)(ii)(A)*.[34]

The preamble to the final rule also included the following comment and response explaining the adoption of the exception for 40 or less average daily patient census:

> *Comment*: Two commenters recommended that the 40 or less average daily patient census requirement should be increased to 45. Hospitals in remote rural areas should not be required to hold their inpatient acute care occupancy to a level that is significantly below the 50-bed maximum requirement in the BBA. Very rural hospitals

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[31] *Id*. at 2375 (emphasis added).
[32] MMA § 902(a)(2).
[33] 68 Fed. Reg. 74792 (Dec. 24, 2003). *See also* Stipulation at ¶ 20.
[34] 68 Fed. Reg. at 74798 (emphasis added).

> do not have the ability to transfer, and should not be required to reject patients just to meet this requirement.
>
> *Response*: We believe this requirement is necessary and appropriate for this provision. The 40 or less average daily patient census requirement was established to meet the needs of small hospitals *in* ***extremely rural areas*** *experiencing seasonal fluctuations*. Without significant fluctuations in patient census, these hospitals would be operating with less than 50 staffed beds. Hospitals with an average daily patient census in excess of 40, in spite of seasonal fluctuations, would likely have to operate with more than 50 staffed beds, which is contrary to the statute.[35]

The finalized regulation for the exception was located at 42 C.F.R. § 405.2462(a)(3) and read, in relevant part:

> (3) If an RHC is an integral and subordinate part of a hospital, it can receive an exception to the per-visit payment limit if the hospital has fewer than 50 beds as determined by using one of the following methods:
>
> (i) The determination of the number of beds at § 412.105(b) of this chapter.
>
> (ii) The hospital's average daily patient census count of those beds described in § 412.105(b) of this chapter, and the hospital meets all of the following conditions:
>
> (A) It is a sole community hospital as determined in accordance with § 412.92 or 412.109(a) of this chapter.
>
> (B) *It is located in a level 8 or level 9* ***nonmetropolitan*** *county using* ***urban influence codes*** *as defined by the U.S. Department of Agriculture.*
>
> (C) It has an average daily patient census that does not exceed 40.[36]

This exception again used USDA UIC Codes.

However, this revised regulation was short-lived as the Secretary retroactively rescinded and voided it pursuant to MMA § 902(a)(1). Specifically, ***in the interim final rule*** published on September 22, 2006, the Secretary "removed" the above regulation and reverted to the prior regulatory language because more than three years had passed between the proposed rule and the final rule:

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[35] *Id.* at 74798-99 (emphasis added).
[36] *Id.* at 74816 (emphasis added).

> Since the publication of the RHC final rule *exceeded* the 3-year timeline for finalizing proposed rules set by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, we are suspending the effectiveness of the current provisions by *removing the RHC provisions set forth in the December 2003 final rule and reverting to those RHC provisions previously in effect.]* We intend to reissue new proposed and final RHC rules to reinstate the current provisions. *However, these revisions do not impact the effectiveness of the self-implementing provisions of the BBA or any provisions we had previously implemented or enforced through program memoranda.*
>
> **DATES**: Effective date: These regulations are effective on September 22, 2006.[37]

Specifically, regarding the December 2000 BIPA statutory change to the exception, the preamble to the interim final rule states:

> The BBA provisions relating to the payment limit for hospital-based RHCs (section 4205(a) of the BBA, amending section 1833(f) of the Act) are ***not*** *self-implementing* ***but*** *were implemented and enforced through a program memorandum in 1998*.[38]

Similarly, the preamble to the interim final rule also states:

> We find it unnecessary to undertake proposed rulemaking because this interim final rule with comment period does not make new policy but simply reinstates policy previously in effect relating to RHCs. This policy was in effect before the December 2003 rule became effective and has been subjected to public comments. Moreover, because *the 2003 rule was rendered ineffective by operation of law*, we can exercise no discretion regarding this matter *and must reinstate the regulation as it existed before December 24, 2003*. We intend to publish a new proposed rule for RHCs that will be subject to proposed rulemaking followed by a new final rule to reinstate our current RHC policy with any necessary changes.
>
> Further, we believe a delayed effective date is unnecessary because this interim final rule with comment period provides additional clarification to the RHC industry. *This rule clarifies that* ***any RHC provisions that have already been implemented or enforced*** ***will remain in effect*** *and will not be impacted by the regulatory*

[37] 71 Fed. Reg. 55341 (Sept. 22, 2006) (italics emphasis added.)
[38] *Id*. at 55343 (emphasis added).

> *provisions that we are revising in this interim final rule*. Allowing this rule to take effect immediately provides needed guidance and avoid any additional confusion experienced following the publication of the December 2003 final rule. Therefore, we find good cause to waive notice-and comment procedures, as well as the 30-day delay in effective date.[39]

Based on these preamble provisions, the Secretary appears to have *either*: (1) reverted back to the September 1998 memorandum; or (2) reverted back to the exception policy laid out in the MCPM, Ch. 9, § 20.6.3 (Rev. 1, Oct. 1, 2003).

On June 27, 2008, the Secretary issued a proposed rule to amend the RHC regulations "to utilize RUCAs 9 and 10 to determine eligibility for an exception to the per visit payment limit" based on a 40-or-less average daily census count .[40] In making this proposal, the Secretary recognized that the USDA had *revised* the UIC classification system from a 9-level scale to a 12-level scale "since" (*i.e.*, following) the issuance of the December 24, 2003 final rule.[41] Accordingly, the proposed rule would "utilize the RUCA methodology instead of the UIC methodology" that was applied under the current policy as "implemented through a program memorandum on December 6, 2001."[42] The proposed rule noted that the BIPA changes were implemented through the December 6, 2001 program memorandum but then stated that one criterion of the "current policy" for determining eligibility for an exception to the per visit payment limit based on a 40-or-less average daily census count is having "a level 9 or 10 RUCA."[43]

However, CMS did not finalize the 2008 RHC proposed rule. Rather, CMS withdrew it exactly three years later, on June 27, 2011.[44]

On January 31, 2013, CMS issued Transmittal 166 (Change Request 7824) to revise Chapter 13 of the MBPM.[45] The Transmittal explained that the revisions were effective March 1, 2013 and "reorganized . . . and updated [Chapter 13] to include more comprehensive information."[46] The Transmittal also stated that "[t]here are no new policies contained in the manual."[47] MBPM, Ch. 13, § 70.1, as revised by the Transmittal, includes "a level 9 or level 10 Rural-Urban Commuting Area (RUCA)" as one of the criteria for determining eligibility for an exception to the RHC per-visit UPL based on a 40-or-less average daily census count.[48] The USDA developed the RUCA classification system to classify U.S. census tracts using measures of population density, urbanization, and daily commuting and the primary classification system is based on a scale of 1 to 10.[49]

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[39] *Id.* at 55344 (emphasis added).
[40] 73 Fed. Reg. 36696, 36705 (June 27, 2008).
[41] *Id.*
[42] 73 Fed. Reg. 36696 (June 27, 2008).
[43] *Id.*
[44] Exhibit P-27. *See also* Stipulations at ¶ 25.
[45] Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R166BP.pdf.
[46] *Id.*
[47] *Id.*
[48] *Id. See also* Stipulations at ¶ 26.
[49] *See* https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/.

On December 31, 2015, CMS issued Change Request 9397, reorganizing and updating Chapter 9 of the MCPM regarding payment for RHC services *effective March 31, 2016*.[50] The change request eliminated MCPM, Ch. 9, § 20.6.3 so that the MCPM no longer included any description of the exception to the RHC per-visit UPL but rather only generically refers to the existence of an "exemption" in MCPM, Ch. 9, § 20.2 without any cross-reference.[51]

2. Degree of rurality assigned by the USDA to Dickinson County, Michigan

Dickinson's main provider is located at 1721 South Stephenson Avenue, Iron Mountain, Michigan.[52] For 1993, the USDA assigned Dickinson County, Michigan a UIC of 8 based on a UIC classification scale running from 1 to 9.[53]

For 2003 and 2013, USDA continued to assign Dickinson County, Michigan a UIC of 8. However, this assignment was based on a *revised* UIC classification scale running from 1 to 12.[54] Dickinson maintains that it met the criteria specified for the 40-or-less daily census count exception standard specified in MCPM, Ch. 9, § 20.6.3 (Rev. 1, Oct. 1, 2003). In particular, Dickinson maintains it met the requirement therein that it be "located in an 8-level or 9-level *nonmetropolitan* county using urban influence codes as defined by the U.S. Department of Agriculture."[55]

Dickinson's main provider's location is in Census Tract No. 26-043-9504.00.[56] Census Tract No. 26-043-9504.00 was assigned a RUCA Code of 4 on a scale from 1 to 10 in 1990, a 4 on a scale from 1 to 10 in 2000, and a 4 on a scale from 1 to 10 in 2010.[57] Under the criteria for the 40-or-less daily census count exception standard specified in MBPM, Ch. 13, § 70.1 (2013), a qualifying hospital with provider-based RHCs must be located in a level 9 or 10 RUCA. It is undisputed that Dickinson would not qualify for that exception.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Dickinson claims that, pursuant to MCPM, Ch. 9, § 20.6.3 (2013), it is eligible for the exception to the per-visit payment limit for provider-based RHCs for both FYs 2015 and 2016 based on either of the two different standards – the "less than 50 beds" standard and the 40-or-less daily census count exception.[58] As set forth below, the Board analyzed each exception standard and finds that Dickinson failed to meet either standard.

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[50] Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3434CP.pdf.
[51] *Id. See also* Stipulations at ¶ 27.
[52] Stipulations at ¶ 4.
[53] *Id.* at ¶ 3.
[54] *Id.*
[55] *See, e.g.,* 68 Fed. Reg. 74792, 74802 (Dec. 24, 2003) (emphasis added) (Copy at Exhibit P-21); Medicare Intermediary Manual, CMS Pub. 100-04, § 20.6.3 (Rev. 1, 10-01-03) (Copy at Exhibit P-22).
[56] Stipulations at ¶ 5.
[57] *Id.* at ¶ 6.
[58] Provider's FPP at 10-12.

A. First Exception Standard Based on Having Fewer Than 50 Beds Available for Inpatient Care

Under both MCPM, Ch. 9, § 20.6.3 (2013) and MBPM, Ch. 13, § 70.1 (2013), a provider-based RHC may receive an exception to the per-visit payment limit if the hospital with which it is associated has *fewer than 50 beds* "as determined at 42 C.F.R. § 412.105(b)." This standard is directly based on the exception in 42 U.S.C. § 1395l(f) for "such clinics in hospitals with *less than 50 beds*."[59] CMS has consistently interpreted and applied this exception standard since it was first laid out in the 1998 memorandum. Dickinson argues that it meets this "fewer than 50 beds" criteria for FYs 2015 and 2016 and, thereby, qualifies for an exception to the per-visit limit for both fiscal years.[60]

Under 42 C.F.R. § 412.105(b)(2), a bed is not considered "available" if it could not be available for inpatient occupancy within 24 hours for 30 consecutive days. Dickinson notes that its average daily inpatient census was 29.1 in 2013, 31.2 in 2014, 26.2 in 2015 and 29.2 in 2016. Accordingly, in FYs 2015 and 2016, consistent with its experience in the prior years, Dickinson staffed for an average of 29 medical, surgical, pediatric and intensive care unit patients.[61]

Dickinson explains that it planned and staffed for an average daily census of 29, and its staffing records reflect that it employed an appropriate number of nurses to staff for an average of 29 inpatients.[62] Given that Dickinson's average daily census never exceeded 30 in the relevant time frame, Dickinson asserts that it, quite appropriately, maintained its employed staff at a level sufficient to provide services for that number of patients so as to avoid unnecessary costs.[63] Dickinson further asserts that, in order to have had 50 or more available bed days, § 412.105(b)(2) specifies that it needs to have had, within 24 hours, 50 or more beds *available **for 30 consecutive days***;[64] and that, as a result, Dickinson could not have staffed an average daily census of 50 patients based upon the limited number of nurses it employed *for 30 consecutive days*. Rather, it would have had to increase its employment of nurses more than ninety percent from its actual experience for FY 2015, and more than seventy percent for FY 2016. Dickinson further notes that, given its location, in a rural area in the Upper Peninsula of Michigan, the process of hiring nursing staff takes several months.[65]

Dickinson contends that, through the crisis staffing procedures that it had adopted, Dickinson was capable of handling the *temporary* spikes in its patient census that it occasionally experienced for one or two days, but its employed nursing staff could not possibly attend to 50 beds *over an extended time period*.[66] Thus, Dickinson maintains that it did not have 50 available beds for FYs 2015 or 2016, because it could not have made that number of beds available and

[59] (Emphasis added.)
[60] *Id.* at 20-22.
[61] *Id.* at 21 (citing Exhibits P-36, P-37).
[62] *Id.* (citing Exhibits P-38, P-41).
[63] *Id.* at 21-22.
[64] *See, e.g.*, Tr. at 48-49, 77-80, 104-05, 113.
[65] *See* Provider's FPP at 21-22.
[66] *Id.* at 22.

staffed them for a 30-day period.[67] As such, Dickinson maintains that it met the "fewer than 50 beds" criteria to qualify for an exception to the RHC per-visit UPL.[68]

The Medicare Contractor explained that, during its review of Dickinson's FY 2015 cost report, the Medicare Contractor identified the number of available beds in accordance with 42 C.F.R. § 412.105(b), using the number of available beds claimed by Dickinson and dividing that amount by the number of days in the cost reporting period. Dickinson claimed 35,040 available bed days. The Medicare Contractor started with the 35,040 available bed days then subtracted the 212 swing bed days and 1,217 observation days, leaving 33,611 available bed days. The 33,611 days were divided by 365 days, equating to 92 beds. The Medicare Contractor argues that, clearly, Dickinson did not have fewer than 50 beds based on the data Dickinson itself certified as accurate when it filed its cost report.[69]

As set forth below, the Board finds that Dickinson has a fundamental misunderstanding of how 42 C.F.R. § 412.105(b) operates to determine the number of beds in a hospital. This regulation states that "the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period."[70] Subparts (1) – (6) of this regulation describe what beds days should be excluded from the available bed days count. Subpart (2) specifically excludes "[b]eds in a unit or ward that is otherwise occupied (to provide a level of care that would be payable under the acute care hospital inpatient prospective payment system) that could ***not*** be made available for inpatient occupancy ***within 24 hours*** *for 30 consecutive days*."[71] In other words, under Subpart (2), beds from a ward or unit that otherwise is being used (*e.g.*, a Med. Surg. Unit) must be included in the bed count for a month *if* those beds could be made available within 24 hours at some point during the last 30 consecutive days (*i.e.*, available even for a single day during the last consecutive 30 days).[72]

CMS provides further guidance on what constitutes "available beds" in the Provider Reimbursement Manual, Pub. 15-1 ("PRM 15-1"), § 2405.3(G):

> To be considered an available bed, a bed must be permanently maintained for lodging inpatients. It must be available for use and housed in patient rooms or wards (i.e., not in corridors or temporary beds). . . . The term "available beds" as used for the purpose of counting beds is not intended to capture the day-to-day fluctuations in patient rooms and wards being used. Rather, the count is intended to capture changes ***in the size of a facility*** as beds are added to or taken out of service.

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[67] *Id.*
[68] *Id.*
[69] Medicare Contractor's FPP at 4-5. The Medicare Contractor noted that it did not find any changes to the facts on this issue during its review of the FY2016 cost report. *Id.* at 5.
[70] 42 C.F.R. § 412.105(b).
[71] (Emphasis added.)
[72] *See* 69 Fed. Reg. 49093, 49095 (Aug. 11, 2004) (stating "Therefore, in order for ***any bed*** within a unit or ward that would otherwise be considered occupied to be excluded because it is unavailable, the bed must remain unavailable for 30 consecutive days." (emphasis added)).

> In the absence of evidence to the contrary, beds available at any time during the cost reporting period are presumed to be available during the entire cost reporting period. *The hospital bears the burden of proof to exclude beds from the count.*[73]

In the preamble of the 2005 Final Rule ("Final Rule"), CMS reiterated that "[o]ur current policy is intended to reflect a hospital's available bed count as accurately as possible, achieving a balance between capturing short-term shifts in occupancy and long-term changes in capacity."[74] In the preamble to the Final Rule, CMS clarified that "if a bed can be staffed for inpatient care either by nurses on staff or from a nurse registry within 24 to 48 hours, the unoccupied bed is determined available."[75] CMS further explained that:

> [I]n order for any bed within a unit or ward that would otherwise be considered occupied to be excluded because it is unavailable, the bed must remain unavailable for 30 consecutive days. In other words, if an individual bed or group of beds within an otherwise occupied unit or ward could not be made available within a 24-hour period for whatever reason (for example, renovations, use as office space, use for provision of ancillary services) for 30 consecutive days, the beds should be excluded from the hospital's available bed count for those 30 consecutive days. This policy would apply to all situations that would render a bed unavailable, not just to the examples listed above.[76]

Here, Dickinson filed its 2015 and 2016 cost reports with the representation that it had 92 and 91 beds available during those years and, for purposes of this appeal, is now claiming that those numbers were reported in error.[77] The Board finds that PRM 15-1 § 2405.3(G) imposes the burden on Dickinson to prove that beds should be excluded from the count and that Dickinson was obligated to provide sufficient information to the Medicare Contractor to that effect and now to the Board. The Board finds that Dickinson has failed to meet its burden of proof to exclude any beds from its count that Dickinson had previously claimed and reported on its as-filed cost report for FYs 2015 and 2016. A review of the record reveals that Dickinson had 96[78] total beds in FYs 2015 and 2016 and that these beds were located in three separate units,[79] 82 in Med Surg Peds,[80] 10 in Obstetrics, and 4 in ICU.[81] Dickinson focused on the 82 Med-Surg-Peds beds and

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[73] (Emphasis added.)
[74] *Id.* at 49094.
[75] *Id.*
[76] *Id.* at 49095.
[77] Tr. at 49-51. The witness explained the difference between these 2 years is due to how observation bed days were accounted for and the fact that 2016 was a leap year and, as a result, had an extra day (i.e., 366 days as opposed to 365 days). Tr. at 151-155.
[78] *Id.* at 127.
[79] *Id.* at 129.
[80] *Id.* at 129-130. Dickinson's witness testified that this is one unit occupied the entire second floor of the hospital.
[81] *Id.* at 131.

confirmed that they were ***all*** located on the second floor in one unit[82] across 36 rooms of which some were private and others semi-private.[83] Indeed, testimony from Dickinson's witness who was the Vice President of Clinical Services confirmed that ***all*** of its beds in the Med-Surg-Peds Unit were fully operational within 24 hours:

MR. ZIEGLER: Okay. So, and tell me if this is a true statement or not. So -- And again, staffing, so that's your key argument really is because these beds, as far as from the medical standpoint, they have the beds in them, but because of your census, you're not utilizing those beds. So they're rooms with beds in them that could be available, but they're not because you can't staff them. That's basically your argument, correct?

THE WITNESS: That is absolutely correct.

MR. ZIEGLER: Not because of medical reasons. You still have the oxygen levels in them and whatever. You could put somebody in that bed, but you're just not going to do it because you just don't have the staff or the census to occupy those beds.

THE WITNESS: That's correct.[84]

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THE WITNESS: So on Med-Surg Peds in 2015 and 2016, there were 82 beds, 36 rooms. They all had oxygen. They were all set up for use. But we did not use them all.[85]

This witness further suggested that Dickinson did, in fact, use all the rooms in the Med-Surg-Peds unit by rotating use of the rooms for patients that were unoccupied and clean:

MR. ZIEGLER: . . . . So that's a tremendous amount of beds that are sitting unoccupied. But it's not like we have a separate unit where it's divided off where we could say, well we haven't used those beds, so those beds are clearly out of service, right?

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[82] *Id.* at 127-29. Dickinson's witness explained that the 82 beds for Med Surg Peds "is actually one unit under – it has our pediatric, a medical and a surgical component to it. It's one unit with one manager." She further clarified that the beds in the unit "can be used by both patient types" and that "[t]hey're not designated exclusively for one type of patient." *Id.* at 127-128.

[83] *Id.* at 127, 143.

[84] *Id.* at 133-134.

[85] *Id.* at 143.

THE WITNESS: Correct. . . .[86]

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MR. ZIEGLER: That's currently, but how about this time period, 2015 and '16?

THE WITNESS: You would have saw empty rooms and *what we tried to do is we tried to use those rooms* to keep, even though we had semi-private rooms, patients don't like to be in a room with another patient unless it's a relative, so we tried to keep all of our patients in private rooms.

MR. ZIEGLER: Okay.

THE WITNESS: So we tried to utilize some of those rooms, but you know, to keep them private.[87]

The Board recognizes that Dickinson has alleged that it was unable to provide sufficient nurses to staff a census of 50 or more inpatients *for 30 consecutive days* ***consistent with the staffing levels*** described in its "Direct Care and Support Staffing Plan" for the Med-Surge-Peds unit at Exhibit P-37.[88] However, Dickinson's witness confirmed that Dickinson's daily inpatient census did, in fact, reach as high as 48 inpatients *during 2015* and, in these instances, its crisis staffing plan at Exhibit P-43 (which goes up to a patient census of 60) was utilized to manage those inpatients.[89] Further, Dickinson's witness confirmed that the nurse-to-patient staffing ratios in the staffing plan at Exhibit P-37 are not based on any actual state or Medicare minimum staffing requirements and, as such, that plan is simply guidance or goals.[90] Thus, there is no evidence that any beds in the Med-Surg-Peds unit can be excluded under the criteria in 42 C.F.R. § 412.105(b)(2) where beds in an occupied unit are excluded *only if* those beds "could not be made available for inpatient occupancy within 24 hours for 30 consecutive days" (*i.e.*, could not be made available, even temporarily for one day, at any point during the 30-day period). Here, as described above, the record clearly demonstrates that Dickinson could have made 50 or more beds available during FYs 2015 and 2016 even if only temporarily for periods of 24 to 48 hours.

Based on the above, the Board finds that Dickinson is not eligible for an exception to the RHC per-visit UPL based on the fewer than 50-beds standard because, under the criteria in 42 C.F.R. § 412.105(b)(2), Dickinson had *50 or more* beds available during FYs 2015 and 2016.

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[86] *Id.* at 129-130.
[87] *Id.* at 131.
[88] *See, e.g.*, Tr. at 48-49, 77-80, 104-05, 113.
[89] *Id.* at 135-36, 144; Provider's FPP at 21. *See also* Tr. at 106-109. The Board further notes that, by letter dated April 26, 2019 (Exhibit P-40), Dickinson asserted that its average daily census for 2016 was 24.2 but then proposed to the Medicare Contractor to amend its 2016 available beds ***to 48.43*** just below the 50-mark level. However, Dickinson failed to explain either in that letter or as part of the record for this appeal (whether in its briefs or at the hearing) how it arrived at this proposed number. *See, e.g.*, Tr. at 69-70, 74.
[90] *Id.* at 136-37. *See also id.* at 98-109.

B. SECOND EXCEPTION STANDARD BASED ON HAVING AN AVERAGE DAILY INPATIENT CENSUS COUNT OF 40 OR LESS

The time period at issue in the consolidated hearing involves Dickinson's FYs 2015 and 2016. *At the beginning of Dickinson's FY 2015* (*i.e.*, as of January 1, 2015), CMS provided for a second standard for the exception to the RHC per visit UPL applied to certain provider-based RHCs and presented this exception in two places: MCPM, Ch. 9, § 20.6.3 (2003) and MBPM, Ch. 13, § 70.1 (2013).[91] Under this second exception standard, the hospital with which the RHC is associated must be an SCH and have an "average daily patient census count of those beds described in 42 C.F.R. § 412.105(b) [that] does not exceed 40." In addition, to qualify under this second exception standard, the SCH must have a certain degree of rurality. However, these manual provisions each set forth a different standard for determining the SCH's degree of rurality:

1. Under MCPM, Ch. 9, § 20.6.3 (2003), the SCH must be "located in an 8-level or 9-level nonmetropolitan county using urban influence codes as defined by the U.S. Department of Agriculture." The Board will hereinafter refer to this as the "MCPM-UIC rurality standard."

2. Under MBPM, Ch. 13, § 70.1 (2013), must be "located in a level 9 or level 10 Rural-Urban Commuting Area (RUCA)." The Board will hereinafter refer to this as the "MBPM-RUCA rurality standard."

To compound matters, effective December 21, 2015, CMS eliminated MBPM, Ch. 13, § 70.1 (2013). The parties dispute which of these rurality standards (*i.e.*, the MCPM-UIC rurality standard vs. the MBPM-RUCA rurality standard) would apply to the fiscal years at issue (*i.e.*, FYs 2015 and 2016). Further, with regard to the MCPM-UIC standard, Ch. 13, § 70.1 (2013), the parties dispute how to determine whether Dickinson would meet the requisite UIC degree of rurality.

Dickinson argues that the Medicare Contractor's decision to deny Dickinson's request for an exception to the RHC per-visit UPL and to apply that UPL to Dickinson's RHCs was contrary to law and arbitrary and capricious. Dickinson maintains the Medicare Contractor's decision rests on the mistaken assumption that the Medicare Contractor was required to rely on the subregulatory MBPM-RUCA rurality standard published in 2013 to the exclusion of the longstanding MCPM-UIC rurality standard which had been in use continuously since September 1998. Dickinson maintains that, in reaching its decision, the Medicare Contractor committed clear legal error.[92] Dickinson asserts that, had the Medicare Contractor applied the MCPM-UIC rurality standard, it would have qualified under the second exception because, under that standard, it needed only to be in a county assigned a level 8 or higher UIC and, for 2013, USDA assigned Dickinson County, Michigan to a level 8 UIC.

First, Dickinson contends that the Medicare Contractor's position fails to recognize that, in relying on the MBPM-RUCA rurality standard rather than the MCPM-UIC rurality standard, the Medicare Contractor altered a substantive legal standard that had been in place more than 15

[91] Copy at Exhibit C-12.
[92] Provider's FPP at 10.

years. As a result, Dickinson contends that this approach altered the payment for services, and such a change can *only* be accomplished through notice-and-comment rulemaking in these circumstances consistent with 42 U.S.C. § 1395hh(a)(2) which states, in pertinent part: "No rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . under this subchapter shall take effect unless it is promulgated by the Secretary by regulation . . . ." In short, Dickinson contends that CMS's purported repeal of the MCPM-UIC rurality standard is invalid and will remain so unless and until CMS initiates and completes the notice-and-comment rulemaking process to promulgate a regulation addressing the criteria used for the alternative exception (and, to date, it has not done so). Dickinson further notes that the 2008 Proposed Rule to adopt the MBPM-RUCA rurality standard was never finalized and, in fact, was withdrawn in 2011.[93]

In contrast, Dickinson asserts that the MCPM-UIC rurality standard is valid because it is longstanding and was adopted through notice and comment rulemaking as part of the December 24, 2003 final rule. Dickinson expounds on this argument, alleging that CMS established its policy of using the MCPM-UIC rurality standard in 1998, and that the agency *reiterated* this policy in 2001. In October 2003, CMS memorialized this policy as part of the MCPM. Thus, Dickinson contends that the MCPM-UIC rurality standard has remained undisturbed and in effect since 1998 until CMS rescinded it effective in March of 2016.[94]

Dickinson states that, in light of the history of using the MCPM-UIC rurality standard from 1998 through March 2016, the Medicare Contractor has a responsibility to apply CMS' manuals and to communicate the reasons for its adjustments when it issues its NPR. As the longstanding MCPM-UIC rurality standard was in effect throughout FY 2015 and part of FY 2016 (before its purported rescission), the Medicare Contractor should have applied it "as written" rather than substituting the 2013-published MBPM-RUCA rurality standard for it.[95]

Second, Dickinson argues that the Medicare Contractor assumed that, where CMS has issued two alternative pieces of guidance, the Medicare Contractor is obligated to apply the one enacted more recently. In effect, the Medicare Contractor's conclusion is that the more recent guidance *repeals* existing guidance by implication. However, Dickinson maintains that neither the MBPM change that promulgated the MBPM-RUCA rurality standard nor the MBPM itself contain any indication that CMS intended to otherwise repeal the existing MCPM-UIC rurality standard that had been in place since 1998.[96]

Third, Dickinson contends that, notwithstanding the fact that the MCPM-UIC rurality standard was not repealed until March of 2016, the Medicare Contractor's position would improperly apply

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[93] *Id.* at 10-11.
[94] *Id.* at 12. *See also id.* at 7 (stating: "On December 31, 2015, CMS issued Change Request 9397 ("**UIC Change Request**"), which rescinded the UIC Guidance. (**Exhibit P-32**). However, by its terms, this change was not effective until March 31, 2016. Thus, from January of 2013 through March of 2016, CMS's manuals contained two alternative sets of criteria relating to the Rural Exception, the UIC Guidance dating back to 1998, and the RUCA Guidance first offered as an alternative measure in 2013.").
[95] *Id.* at 12-13.
[96] *Id.* at 11.

CMS' repeal of the MCPM-UIC rurality standard *retroactively* to FY 2015. Dickinson asserts that this application is "prohibited by 42 U.S.C. § 1395hh" but does not elaborate upon this argument.[97]

The Medicare Contractor argues that the 2013 reorganization of the MBPM required the use of the MBPM-RUCA rurality standard. In support, the Medicare Contractor notes that, years prior to this reorganization, CMS had clearly stated in its proposed rule published June 27, 2008[98] that it intended to utilize RUCA codes over UIC codes for determining rurality because RUCA codes provided a more accurate assessment of a local area's degree of rurality. The Medicare Contractor contends that, by 2013, CMS had already utilized RUCA codes for several years for purposes of determining the degree of rurality in both the hospital and ambulance payment systems. In further support of using the MBPM-RUCA rurality standard over the MCPM-UIC rurality standard, the Medicare Contractor notes that the MCPM-UIC rurality standard is out-of-date because it fails to acknowledge or account for the fact that, starting for 2003, the UIC classification system was expanded from a 9-level classification system to a 12-level classification system.[99]

The Medicare Contractor further points out that Dickinson fails to acknowledge that the UIC guidance was implemented through policy when the UIC codes represented drastically different areas. The UIC classification system used for 1993 was in effect until at least 2003 and, importantly, was the system considered and relied upon when CMS conceived the policy-implemented alternative exception. Under this 1993 UIC classification system, there were only 9 code level where code levels 8 and 9 were the *most* rural designations, representing areas containing less than 10,000 residents, not adjacent to a metro area.[100]

The Medicare Contractor notes that when the USDA revised the UIC codes for 2003, it expanded the classification system from a 9-level system to a 12-level system and, accordingly, revised the definition of ***all*** code levels (including but not limited to code levels 8 and 9).[101] Under the revised system, the most rural UIC code levels were 10, 11, and 12. Further, under the revised system, code level 8 relates to *micropolitan* (up to 50,000 residents) that is not adjacent to a metro area. In contrast, under the prior system, a code level 8 related to rural areas not adjacent to a metro area and contained a town up to 9,999 residents.[102]

The Medicare Contractor contends that Dickinson failed to qualify under the MCPM-UIC rurality standard, when the revised UIC classification system *and* the intent behind the adoption of the MCPM-UIC rurality standard are considered. The Medicare Contractor contends that, since at least 2003, Dickinson has not been located in an area intended for exception (based on the USDA's definitions). The Medicare Contractor contends Dickinson improperly glosses over this fact by simply asserting that, under the MCPM-UIC rurality standard, they simply need only be located in an area assigned a code level 8 under the most-recent USDA UIC assignment. As previously noted, a code level 8 under the 1993 9-level UIC classification system had a materially different definition than a code level 8 under the 2003 12-level UIC classification

[97] *Id.* The Board notes that, in making this argument, Dickinson does not cite to or discuss 42 U.S.C. § 1395hh(e) entitled "Retroactivity of Substantive Changes; Reliance Upon Written Guidance."
[98] Copy at Exhibit C-7.
[99] Medicare Contractor's FPP at 7-9.
[100] *Id.* at 10.
[101] *Id.* at 11.
[102] *Id.* at 10 n.27.

system. Based on the USDA's definitions effective for 2003 forward, Dickinson has not been located in the type of rural area intended for exception since at least 2003.[103]

The Medicare Contractor maintains that the current 12-level UIC classification system, that began for 2003, is incompatible with the MCPM-UIC rurality standard which was based on the 9-level 1993 UIC classification system. Under the MCPM-UIC rurality standard only UIC code level 8 and 9 are applicable. The Medicare Contractor argues:

> [I]f the intent of the policy-implemented alternative exception was to ensure healthcare coverage for the most rural areas, and the intent was to only accept UIC codes that represented a "degree of rurality to sufficiently target hospitals located in extremely remote areas that may need the flexibility in the bed definition to accommodate potentially significant fluctuations in patient census", and the expansion of the UIC codes from 2003 was considered along with the USDA's definitions, UIC code 8 (which [Dickinson] was classified) does not represent the type of area intended for the exception.[104]

The Medicare Contractor asserts that CMS stated as much in the following excerpt from the June 27, 2008 Federal Register:

> The December 24, 2003 final RHC rule used the 1993 Urban Influence Codes (UICs), then a 9-category measure developed by the U.S. Department of Agriculture (USDA), to identify hospitals which are located in sparsely populated rural areas. Hospitals with a level 8 or 9-level UIC and which have an average daily census of less than 50 patients would qualify for an exception to the RHC per visit payment limit. The USDA has since changed the UICs to a 12-category measure, with levels 9 through 12 comparable to the 1993 levels 8 and 9.[105]

The Medicare Contractor concludes that, because Dickinson is located in a level 8 area under the 12-category measure which, according to CMS, is not even comparable to levels 8 and 9 on the nine-category measure scale, Dickinson clearly did not qualify for the alternative exception when the USDA revised the definitions and UIC codes in 2003, or at any time thereafter.[106]

Before addressing the conflict between the MCPM and MBPM manual provisions regarding what criteria to use for the second exception standard (whether under MCPM, Ch. 9, § 20.6.3 (2003) or MBPM, Ch. 13, § 70.1 (2013)), the Board must first determine whether the second exception standard itself is valid. At the outset, the Board recognizes that, pursuant to 42 C.F.R. § 405.1867, it must "afford great weight to interpretive rules, general statements of policy, and

[103] *Id.* at 9-11.
[104] Medicare Contractor's FPP at 11.
[105] *Id.* at 11 (italicized in original).
[106] *Id.*

rules of agency organization, procedure, or practice established by CMS." However, the Board also recognizes that this regulation further specifies that the Board "must comply with all the provisions of Title XVIII of the Act and the regulations issued thereunder." Here, the controlling statute is 42 U.S.C. § 1395l(f) which specifies that RHCs "*in hospitals with less than 50 beds*" are exempt from the RHC per-visit UPL. As described more fully below, the Board finds that the second exception standard (whether under MCPM, Ch. 9, § 20.6.3 (2003) or MBPM, Ch. 13, § 70.1 (2013)) is a "substantive legal standard" that was required to go through substantive notice and comment rulemaking per 42 U.S.C. § 1395hh(a)(2) and that the second exception standard (whether under MCPM, Ch. 9, § 20.6.3 (2003) or MBPM, Ch. 13, § 70.1 (2013)) has not been properly promulgated through that process.

First, the controlling statute at 42 U.S.C. § 1395l(f) applies to RHCs "in ***hospitals*** with less than ***50*** beds."[107] There is no mention of the second exception standard that applies only to RHCs ***in SCHs*** with "average daily patient census count of those beds described in 42 C.F.R. § 412.105(b) [that] does not exceed ***40***."[108] Also, the second exception is not directly based on a "less than 50 beds" standard. Rather, it appears to be a proxy standard using an "average daily patient census count . . . [that] does not exceed 40."[109] Accordingly, an SCH could have more than 50 beds but have an average daily census count that is 40 or less and still qualify using the second exception standard.[110] Indeed, this is illustrated by Dickinson's argument that, even if it fails to qualify under the first exception standard (*i.e.*, even if it has 50 or more beds, as described in 42 C.F.R. § 412.105(b)), it should still qualify using the second exception standard. Based on these findings, it is clear that the second exception standard is neither a simple application nor a logical interpretation of the controlling statute.

Since the second exception standard would permit qualifying RHCs to not be subject to the RHC per-visit UPL, the second exception standard materially affects reimbursement for a subset of RHCs. Accordingly, the rulemaking requirements in 42 U.S.C. § 1395hh(a)(2) are applicable. In this instance, neither the MBPM, nor the MCPM provisions detailing the second exception standard, went through *proper* rulemaking. In this regard, the Board notes that, although the MCPM provisions did go through a rulemaking process, that rulemaking process was not valid according to MMA § 902(a)(1) and, accordingly, was rescinded and retracted by the Secretary.[111] Pursuant to this MMA provision, subject to limited exceptions, the Secretary may not impose a "rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard" unless the Secretary provides "notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon."[112] In *Azar v. Allina*

[107] (Emphasis added.)
[108] *See* MCPM, Ch. 9, § 20.6.3 (2003) (emphasis added); MBPM, Ch. 13, § 70.1 (2013) (emphasis added.)
[109] Exhibit P-30 at 1 (copy of MCPM §20.6.3 entitled "Exceptions to Maximum Payment Limit (Cap) in Encounter Payment Rate for Provider-Based RHCs, Centers for Medicare and Medicaid Services"). Any nexus between the 40 daily census count and the less-than-50 beds standard is not self-explanatory as demonstrated by the discussion in the preamble to the Final Rule proposing to adopt this standard. 65 Fed. Reg. 10450, 10455-56 (Feb. 28, 2000).
[110] 42 C.F.R. §412.92(a) specifies the criteria for classification as an SCH and, under these criteria, a hospital with more than 50 beds may qualify as an SCH.
[111] *See supra* notes 30-37 and accompanying text.
[112] MMA § 902(a)(1) (codifying 42 U.S.C. § 1395hh(a)(2), (b)(1)). *See also Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1817, 204 L.Ed.2d 139 (2019).

Health Servs., the Supreme Court held that the notice and comment requirement extends, at least in some cases, to informal statements of policy and interpretive rules.[113]

Notwithstanding its finding that formal rulemaking was required to establish the second exception standard, the Board did review the second exception standard as stated in both MCPM, Ch. 9, § 20.6.3 (2003) and MBPM, Ch. 13, § 70.1 (2013). The record shows that Dickinson was not "located in a level 9 or level 10 Rural-Urban Commuting Area (RUCA)" during the fiscal years at issue. Rather, it was in a level 8 RUCA. As such, it is undisputed that Dickinson does not meet the requirements for the second exception standard as stated in MBPM, Ch. 13, § 70.1 (2013).

Further, the Board recognizes the long and evolving history of the RHC per-visit UPL exception standard as stated in MCPM, Ch. 9, § 20.6.3 (2003) and, as discussed above, that this exception standard was intended for very rural RHCs.[114] Prior to 2003, a UIC code 8 or 9 defined a county as a nonmetropolitan area with a town of *less than* 10,000 residents. In 2003, the USDA revised the UIC codes, going from a 9-level scale to a 12-level scale. Under the 2003 revision, the most rural UIC codes were 10, 11, and 12:

10 Noncore adjacent to micro area and does not contain a town of at least 2,500 residents

11 Noncore not adjacent to a metro/micro area and contains a town of 2,500 or more residents

12 Noncore not adjacent to a metro/micro area and does not contain a town of at least 2,500 residents.[115]

The 2003 UIC code 8 relates to *micropolitan* areas (up to 50,000 residents)[116] that are not adjacent to a metro area. Based on the USDA's definitions, Dickinson has not been located in the type of *very* rural area intended for exception since the UIC codes were updated in 2003. As a result, the Board finds that, even under the assumption that the October 2003 MCPM manual provision remains the controlling manual provision with respect to the RHC per-visit UPL, Dickinson does not meet the qualifying criteria for the alternative exception.

In further support of this finding, the Board notes that applying Dickinson's preferred reading of the exception would lead to absurd results. As noted in both the 2001 program memorandum[117] and the preamble to the later-revoked 2003 final rule,[118] this exception standard was only to apply to "very rural" SCHs. The exception specifies that the measure of the degree of rurality requires that a qualifying SCH, with provider-based RHCs, be "located in an 8-level or 9-level

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[113] 139 S. Ct. at 1814 ("[T]he phrase 'substantive legal standard,' which appears in § 13955hh(a)(2) . . . cannot bear the same construction as the term 'substantive rule' in the APA. We need not, however, go so far as to say that the hospitals' interpretation, adopted by the court of appeals, is correct in every particular [circumstance].").
[114] *See supra* notes 18, 21, 34-35 and accompanying text.
[115] Exhibit C-8 at 1.
[116] Both parties represent that the USDA defines a micropolitan as comprising up to 50,000 residents. *See* Provider's FPP at 6; Provider's Reply Brief at 4-5; Medicare Contractor's FPP at 8, 10.
[117] Program Memorandum, CMS Pub. 60A, Transmittal A-01-138 (Dec. 6, 2001) (emphasis added) (copy included at Exhibit P-20).
[118] 68 Fed. Reg. 74792, 74798-99 (Dec. 24, 2003).

nonmetropolitan county using urban influence codes as defined by the U.S. Department of Agriculture."[119] However, Dickinson's preferred reading would ignore the facts that the USDA subsequently both revised the UIC codes and expanded to a 12-leve scale and that the most rural SCHs with a level 10, 11 or 12 UIC code on the 12-level scale would not qualify under Dickinson's preferred reading of the second exception standard.

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Based on the above, the Board finds that the Dickinson does not qualify for an exception to the RHC per-visit UPL.

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor correctly determined that Dickinson did not qualify for the exception to the RHC per-visit UPL for FYs 2015 and 2016.

Board Members Participating:

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For the Board:

2/15/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[119] *See* Exhibit P-30 (emphasis added).